



## HOW TO PAY FOR IT

# MAT in Community Health Centers

**H**ealth centers in California have increasingly focused on designing approaches to identify and treat substance use disorder. One such approach is medication-assisted treatment, which includes the use of Food and Drug Administration-approved medications in combination with counseling and behavioral therapies.<sup>1</sup>

To integrate medication-assisted treatment (MAT) into primary care, health centers must engage providers and staff, design the clinical model, determine how to identify patients, redesign workflow, and promote cross-discipline coordination. To help pay for the expenses associated with these activities, the US Health Resources and Services Administration's Substance Abuse Service Expansion offered a grant program, and in federal fiscal year 2016, 36 California health centers each received between \$300,000 and \$400,000. Building on this investment, the Department of Health and Human Services announced in June 2018 that an additional \$350 million would be available to support MAT implementation. Health centers are eligible for three categories of funds: \$100,000 in base funding, \$150,000 in one-time funding to support infrastructure investments, and \$250 per MAT patient reported in 2017.<sup>2</sup>

While this funding has been crucial to expanding the availability of MAT, health centers are still grappling with how to sustain these programs if grant funding ends. Reimbursement for MAT services is challenging, in large part, because health centers are paid a bundled rate for clinician visits under the prospective payment system (PPS). Services must be provided by a "Federally Qualified Health Center (FQHC) practitioner," and not all medical professionals involved in MAT are included in this definition (e.g., certified alcohol and drug counselors, registered nurses).<sup>3</sup>

Complicating reimbursement is the one-visit rule that prevents California health centers from being paid for both physical health and behavioral health services delivered on the same day. In addition, the PPS bundled rate is inclusive of wraparound services (e.g., care coordination), which may be more intensive for MAT patients and are viewed as critical to the success of delivering MAT in primary care.<sup>4</sup>

Funding concerns remain central as policymakers and health care providers gain a better understanding of how to expand access to MAT in primary care. This paper summarizes five funding approaches health centers may wish to consider and offers examples where available.

# Federally Funded MAT Expansion

In 2017 and 2018, California received \$240 million as part of the federal 21st Century Cures Act to support [MAT expansion](#) throughout the health care system. California is using these funds to add new MAT access points in primary care clinics, mental health clinics, jails, residential treatment facilities, hospitals, emergency departments, and other locations. Health centers can apply for funding to cover staffing and start-up costs, as well as receive training and technical assistance as part of a learning collaborative.

Health centers may also opt to participate in the state's hub-and-spoke program, which builds relationships with opioid treatment programs (previously known as methadone clinics) and offers coverage for some uncompensated care (e.g., treatment services for uninsured and underinsured patients). Funds in this program can be used to pay for MAT team member staffing and training, as well as select program costs.

Current funding must be spent by September 2020; new federal funding is expected, but details are unavailable at the time of publication.

## FEDERALLY FUNDED MAT EXPANSION: PRO AND CON

- +** Funds can be used to pay for team member salaries that are central to many MAT clinical delivery models (e.g., substance abuse counselor, licensed vocational nurse) but whose time would not otherwise be eligible for reimbursement under the PPS. Funds can also be used to pay for care for uninsured patients.
- Current funding is only available through September 2020, and future funding has not been announced. Documentation requirements for care of under- and uninsured patients can be time-consuming.

## Training and Start-Up

Several sources for financial assistance or incentives can support clinical education or program start-up costs. One-time financial incentives to offset time spent away from clinical practice to undergo training required to prescribe buprenorphine (waiver training) is the most commonly available support.

California's MAT Expansion Project has funding to support clinicians getting waiver training as well as program start-up funds.<sup>5</sup> Some Medi-Cal managed care plans also offer start-up funds (see box).

Prescribers seeking a waiver to prescribe buprenorphine — known as the X-waiver — can access no-cost training, as well as other clinical training opportunities, through the MAT expansion website.<sup>6</sup> For example, the Providers Clinical Support System offers free waiver trainings for physicians, nurse practitioners, and physician assistants.

### Startup Funds from Health Plans

Partnership HealthPlan and Central California Alliance for Health have training incentives ranging from \$500 to \$1,000. Inland Empire Health Plan offers stipends to support substance use disorder (SUD) certification for behavioral health providers.

Consider contacting other local health plans for support.

## TRAINING AND START-UP: PRO AND CON

- +** Where available, these funds offer a valuable opportunity to support new MAT programs. New federal funding (through the SUPPORT for Patients and Communities Act, signed into law on October 24, 2018) is expected to extend MAT funding through 2021 or beyond.
- Only certain health plans offer funds targeting program start-up and clinician training. Clinicians would benefit from additional educational and training beyond what is required to receive the X-waiver. Federal funding is typically released one year at a time, and the program requirements change.

## Visit Design

As health centers design MAT programs, some look to existing payment models and then structure their programs accordingly. Options that health centers may want to consider include shared medical appointments, flipped visits, drop-in visits, and integrating medication management. Here are descriptions of each:

- ▶ **Shared medical appointments.** Also known as group visits, shared medical appointments typically include a brief educational presentation from a clinician or expert, participant discussion, and a clinician encounter. This approach can be used for induction (new starts), maintenance (medication refills), or to review a preset curriculum. Shared medical appointments enable clinicians to efficiently see a larger number of patients in a relatively short amount of time, while also providing peer support to patients. Either the clinician can lead the visit, or the visit can be led by another trained member of the care team. Under current California FQHC regulations, health centers can get reimbursed for each group visit participant only if the group visit is coupled with an individual face-to-face encounter. This visit can take place before, after, or during the group visit. In the latter case, patients would be pulled out of the group individually and rejoin once the encounter was complete. Health centers should ensure that documentation is sufficient to justify the billing codes that are used.
- ▶ **Flipped visits.** Health centers using this model leverage a nonbillable Medi-Cal provider (e.g., nurse, medical assistant, addiction counselor) to see patients for counseling, care coordination, or both. This visit is concluded with a clinician face-to-face encounter. This face-to-face visit serves as the billable encounter. However, in order to comply with California regulations, the visit must be medically necessary and documentation must justify the billing code.
- ▶ **Drop-in services.** When arrangements are made with the local Medi-Cal managed care plan, health centers can offer drop-in services for patients assigned to their clinic for primary care and for patients assigned elsewhere. This model can provide a bridge for patients starting treatment in the hospital or emergency department (ED) until they can be established with a primary care provider or at a higher level of care (e.g., an opioid treatment program). Some Medi-Cal managed care plans have established a mechanism to pay for MAT services delivered by waived providers on a fee-for-service basis (billing an evaluation and management code) for patients who are not assigned to that clinic for primary care. If the patient is enrolled in Medi-Cal, the clinic can also bill the visit at the PPS rate. Health centers choosing this model will need to either work with the patient to direct them toward a source of ongoing care after MAT stabilization or ask the patient to contact their Medi-Cal managed care plan to change their assigned primary care provider.
- ▶ **Medication management.** Some health centers have added the medication management of SUD to their general array of clinical services covered by Medi-Cal managed care plans.<sup>7</sup> This streamlined model is similar to managing other chronic diseases (e.g., diabetes), where the costs of medical assistants performing panel management tasks are built into the PPS rate or managed care payment. Behavioral health services, where available, are completed by Medi-Cal providers (e.g., licensed clinical social workers) and are also included in the PPS rate. Where behavioral health services are not available, patients may be referred to virtual behavioral health services or to recovery and self-help groups. Buprenorphine is provided through home induction,<sup>8</sup> which does not require additional clinic time.

---

### VISIT DESIGN: PRO AND CON

- Implementing these visit designs generally does not require major infrastructure changes beyond adjusting appointment systems and workflow. They maximize clinician time and also encourage all staff to work at the top of their license. Bringing patients in more often (e.g., for monthly group visits) provides additional support for patients. Offering drop-in services expands access to MAT.
- Additional staff training is likely required, particularly in health centers that don't already have MAT programs and flipped/group visits in place. Depending on the structure of the group or flipped visit, some health centers may find the model's scheduling changes and workflow disruptive, particularly in group visits led by a staff member and where patients are seen one by one during the group portion of the visit. In addition, physical space requirements for group visits may present a challenge for some.

## Value-Based Payment Methodologies

Value-based payment is increasingly used to acknowledge improvements to quality and can support the costs of team-based care; however, PPS regulations present challenges to health centers interested in pursuing value-based payment opportunities. Health centers should conduct due diligence about which additional reimbursement care is considered to be in addition to, rather than duplicative of, PPS rates. The [California Primary Care Association](#) has done extensive research on these issues and can be a resource to health centers interested in learning more.

The National Council for Behavioral Health defines a “case rate” as a single payment to cover the cost of a case based on an outcome decided upon by a payer.<sup>9</sup> Rates reflect the average cost for a defined episode of care. For MAT, this episode of care typically includes initial consultation and any follow-up MAT services. The benefit to providers offering MAT is that a case rate is likely to more accurately reflect the intensity of services and team-based approach to care delivery as compared to the standard PPS rate. In addition, this model was credited with the rapid expansion of MAT in primary care in France and contributed to a 79% drop in heroin overdose rates.<sup>10</sup>

Case rates have proven successful in non-FQHC settings. For example, Inland Empire Health Plan contracted with the Desert Pain Clinic and provided a case rate to cover all services (e.g., medical management, including transition from high-dose opioids to buprenorphine; behavioral therapy; physical

therapy; complementary medicine) for six months, because a pilot determined that overall costs were lowered beyond the cost of the intervention and that patient outcomes improved. Michigan’s Spectrum Health established a case rate with the Complex Care Clinic, identifying the most frequent users of ED services and providing integrated behavioral and physical health care for a population with a high incidence of SUD.

In 2015, El Dorado County Community Health Center began working with a Medi-Cal plan to explore the feasibility of a case rate to deliver MAT using a team-based approach. Preliminary data analysis showed that the program yielded savings due to reduced ED and inpatient use, and that such savings were sufficient to cover increased costs associated with MAT delivery.<sup>11</sup> El Dorado and the health plan are continuing to explore the feasibility of establishing a case rate.

In addition to enhanced and case rates, some alternative payment models have been designed but are not widespread. Examples include:

► **Addiction Recovery Medical Home.** Proposed by Leavitt Partners and the National Council on Alcohol and Drug Dependence,<sup>12</sup> this model offers a phased approach to payment: fee-for-service payments during prerecovery and stabilization, capitation during recovery initiation and active treatment (including a component based on achievement of quality scores, with a bonus threshold), and lower capitation amounts once patients are in recovery and need fewer services.

► **Patient-Centered Opioid Addiction Treatment Alternative Payment Model.** The American Society of Addiction Medicine proposed an alternative payment model<sup>13</sup> that includes two components: a one-time payment to cover the costs of MAT induction and a lower monthly fee to cover the bundled costs associated with ongoing treatment. Ongoing treatment services include medication management, psychological treatment, and social services. Payments would be adjusted based on patient complexity, as well as on provider performance on a range of measures (e.g., quality, spending, outcome measures).

► **Enhanced payments.** In 2017, the Central California Alliance for Health established the Enhanced Primary Care Pain Management program to increase the number of providers who offer MAT to Medi-Cal members.<sup>14</sup> The program allows waived clinicians to receive enhanced payment for initial and follow-up consultative evaluation and management services related to opioid use.<sup>15</sup> These payments require prior authorization and are also subject to other requirements. The Central California Alliance for Health piloted this payment with private providers because FQHCs could not accept the payment outside of the PPS system.

While value-based payment programs provide greater flexibility to integrate behavioral health care approaches — additional services, varying appointment types, virtual visits, and communication — early state efforts to explore these systems in California FQHCs have been put on hold at the time of

publication. The California Primary Care Association notes that payments to health centers for services need to be congruent with applicable laws, regulations, and guidance. Until the California Department of Health Care Services (DHCS) issues guidance on how case rates impact PPS rates, FQHCs should not proceed with these options.

---

#### VALUE-BASED PAYMENT METHODOLOGIES: PRO AND CON

---

- +** Alternative payment models recognize that the traditional method of paying for services in health centers doesn't reflect the true costs of providing MAT, and that reimbursing for MAT at a higher rate is still cost-effective. MAT has been shown to lower rates of hospitalizations and ED visits, cutting health care expenditures by more than 50%.<sup>16</sup>
  - Few alternative payment methodologies for MAT have been implemented in California. In addition, case rates can be complicated for health centers, as it is considered payment for medical services and therefore is included in PPS rate calculations. No Medi-Cal managed care plan in California has yet to establish this payment model with FQHCs.
- 

## Drug Medi-Cal Organized Delivery System

In 2017, an additional pathway to payment for MAT was established as part of the Drug Medi-Cal Organized Delivery System (DMC-ODS). DMC-ODS operates as a voluntary county-level pilot program and is designed to expand, improve, and reorganize Medi-Cal's system for treating people with SUD. As of November 2018, 40 counties had submitted implementation plans and of these, 22 counties have launched their DMC-ODS programs.<sup>17</sup> Participating counties must cover MAT offered by opioid treatment programs. These counties also have the option to cover MAT delivered in other settings, including through contracts with health centers; however, MAT in other settings must be paid for with county funds. Payment rates are developed by each county and therefore vary.<sup>18</sup>

DHCS notes that health centers that opt to provide MAT within the DMC-ODS must do so outside their PPS rate and may need to undergo a DHCS scope-of-services PPS rate-setting change.<sup>19</sup> Health centers can access the change request form on the DHCS website.<sup>20</sup> However, a rate-setting change is not required if the health center can demonstrate there is no overlap between Drug Medi-Cal and PPS. Additional guidance is available in the California Primary Care Association's [Leveraging Federally Qualified Health Centers in California's Behavioral Health Care Continuum](#) (PDF).

---

#### DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM: PRO AND CON

---

- +** DMC-ODS offers another pathway for health centers in participating DMC-ODS counties to be paid for providing MAT, including reimbursement mechanisms for drug and alcohol counselors and other SUD services.
  - Some counties may not choose to pay for MAT provided outside of opioid treatment programs. While expanding access to treatment for patients, DMC-ODS contracts may introduce administrative complexity; the California Primary Care Association describes contractual, legal, and other concerns for health centers to consider.<sup>21</sup> In addition, some health centers have expressed concern about adequacy of payment rates.
-

## Conclusion

California has launched a concerted effort to integrate MAT into all health care touchpoints, including primary care, hospitals, EDs, mental health clinics, residential treatment facilities, jails, and other settings.<sup>22</sup> Although federal and state investment has enabled health centers to design programs, sustaining them requires payment that reflects the true costs of care delivery.

California's work to address the opioid crisis has laid the foundation to enable better identification and management of SUD. Other states have done similar work and may serve as a model for policymakers and health plan partners. For example, the Maryland Department of Health established a bundled payment for MAT that includes a range of services (e.g., in-person meetings, drug ordering and administration, drug screens, etc.), along with separate reimbursement for MAT induction, medication management, and individual and group counseling.<sup>23</sup> Similarly, Maine has a Medicaid waiver that includes a per-member-per-month payment on top of fee-for-service payment. A range of professionals (e.g., nurse care manager, opioid dependency clinical counselor, peer recovery coach) are included in the multidisciplinary care team.<sup>24</sup> As such payment models proliferate, the hope is that California will continue to innovate to ensure that all patients who rely on MAT can access these services. In the meantime, many community health centers are making it work with existing funding streams.



### About Center for Care Innovations

CCI — the Center for Care Innovations — transforms care for vulnerable populations by inspiring, teaching, and spreading evidence-based practices and innovation among the organizations that serve them. CCI is a vital source of ideas, best practices, and resources for California's health care safety net.

CCI carries out its mission by designing and implementing programs, providing training and technical assistance, and building learning networks to share best practices for health care safety net organizations.

For more information, visit [www.careinnovations.org](http://www.careinnovations.org).

### The Authors

Sandra Newman, MPH, LSN Health Strategy  
Tammy Fisher, MPH, Center for Care Innovations

### About This Series

The California Health Care Foundation commissioned *How to Pay for It*, a series of short papers that focuses on reimbursement mechanisms for strategies that advance integration of behavioral health and medical care.

### About the Foundation

The California Health Care Foundation is dedicated to advancing meaningful, measurable improvements in the way the health care delivery system provides care to the people of California, particularly those with low incomes and those whose needs are not well served by the status quo. We work to ensure that people have access to the care they need, when they need it, at a price they can afford.

CHCF informs policymakers and industry leaders, invests in ideas and innovations, and connects with changemakers to create a more responsive, patient-centered health care system.

For more information, visit [www.chcf.org](http://www.chcf.org).

## Endnotes

1. "Medication-Assisted Treatment," Substance Abuse and Mental Health Services Administration, last modified February 7, 2018, [www.samhsa.gov](http://www.samhsa.gov).
2. *FY 2018 Expanding Access to Quality Substance Use Disorder and Mental Health Services (SUD-MH) Funding Opportunity: Frequently Asked Questions (FAQs)*, Health Resources and Services Administration, 2018, [bphc.hrsa.gov](http://bphc.hrsa.gov) (PDF).
3. The Centers for Medicare & Medicaid Services defines FQHC practitioners as including physicians, nurse practitioners, physician assistants, certified nurse midwives, clinical psychologists, clinical social workers, or certified diabetes self-management training / medical nutrition therapy provider.
4. Roger Chou et al., *Medication-Assisted Treatment Models of Care for Opioid Use Disorder in Primary Care Settings* (Rockville, MD: Agency for Healthcare Research and Quality, December 2016), [www.ncbi.nlm.nih.gov](http://www.ncbi.nlm.nih.gov).
5. *California MAT Expansion Project 2.0 State Overdose Response (SOR) Funding*, California Department of Health Care Services (DHCS), n.d., [www.dhcs.ca.gov](http://www.dhcs.ca.gov) (PDF).
6. "Calendar of Events," CA Hub and Spoke System: MAT Expansion Project, n.d., [www.uclaisap.org](http://www.uclaisap.org).
7. Sarah Brooks (chief, Managed Care Quality and Monitoring Div., DHCS) to all Medi-Cal Managed Care Plans, all-plan letter 15-008, April 16, 2015, [www.dhcs.ca.gov](http://www.dhcs.ca.gov) (PDF).
8. Joshua D. Lee et al., "Buprenorphine — Beginning Treatment," supplement to "Home Buprenorphine/ Naloxone Induction in Primary Care," *Journal of General Internal Medicine* 24, no. 2 (February 2009), doi:10.1007/s11606-008-0866-8.
9. *Case Rate Toolkit*, Natl. Council for Behavioral Health, 2013, [www.thenationalcouncil.org](http://www.thenationalcouncil.org) (PDF).
10. Maria P. Carrieri et al., "Buprenorphine Use: The International Experience." *Clinical Infectious Diseases* 43, Suppl. 4 (Dec. 15, 2006): S197–S215, doi:10.1086/508184.
11. J. Bachman, personal interview, August 3, 2018.
12. *Addiction Recovery with Medical Home — Alternative Payment Model: Incentivizing Recovery. Not Relapse.*, Leavitt Partners and Facing Addiction with NCADD, 2018, [www.incentivizerecovery.org](http://www.incentivizerecovery.org) (PDF).
13. *Patient-Centered Opioid Addiction Treatment (P-COAT): Alternative Payment Model (APM)*, American Society of Addiction Medicine, 2018, [www.asam.org](http://www.asam.org) (PDF).
14. *Medication Assisted Treatment*, policy no. 404-1731, Central California Alliance for Health (CCAH), March 24, 2017, [www.ccah-alliance.org](http://www.ccah-alliance.org) (PDF).
15. *Provider Manual, 2018*, CCAH, July 1, 2018, [www.ccah-alliance.org](http://www.ccah-alliance.org) (PDF).
16. Frances L. Lynch et al., "Costs of Care for Persons with Opioid Dependence in Commercial Integrated Health Systems," *Addiction Science and Clinical Practice* 9, no. 1 (August 14, 2014): 16, doi:0.1186/1940-0640-9-16.
17. "County Plans & Contracts: Counties Participating in DMC-ODS," DHCS, last modified December 12, 2018, [www.dhcs.ca.gov](http://www.dhcs.ca.gov).
18. *Medication Assisted Treatment for Substance Use Disorders and the Drug Medi-Cal Organized Delivery System: Frequently Asked Questions*, DHCS, June 2018, [www.dhcs.ca.gov](http://www.dhcs.ca.gov) (PDF).
19. "Frequently Asked Questions about Medication Assisted Treatment within Community Clinics and Health Centers," California Primary Care Association.
20. "Audits and Investigations — Financial Audits: Branch Cost Report Forms and Documents," DHCS, last modified September 28, 2018, [www.dhcs.ca.gov](http://www.dhcs.ca.gov).
21. *Leveraging Federally Qualified Health Centers in California's Behavioral Health Care Continuum*, California Primary Care Association, November 6, 2017, [www.cPCA.org](http://www.cPCA.org).
22. "The California MAT Expansion Project," DHCS, last modified October 19, 2018, [www.dhcs.ca.gov](http://www.dhcs.ca.gov).
23. Meryl Schulman et al., "Exploring Value-Based Payment to Encourage Substance Use Disorder Treatment in Primary Care," Center for Health Care Strategies, June 2018, [www.chcs.org](http://www.chcs.org).
24. *State-by-State Health Home State Plan Amendment Matrix*, Centers for Medicare & Medicaid Services, September 2018, [www.medicaid.gov](http://www.medicaid.gov) (PDF).