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Most Health Centers Provide Some Behavioral Health Services to Patients With Substance Use Disorder, Despite Facing Challenges That Limit Comprehensive Treatment

HHS Office of Inspector General

REPORT HIGHLIGHTS

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Most Health Centers Provide Some Behavioral Health Services to Patients With Substance Use Disorder, Despite Facing Challenges That Limit Comprehensive Treatment

Why OIG Did This Review

- HRSA-funded health centers play an important role in national efforts to address substance use disorder. For many communities, health centers serve as the first and primary access point for their health care needs.
- Health centers serve over 31 million people, and HRSA estimates that 1 in 6 health center patients could benefit from substance use disorder services.
- Effective treatment for substance use disorder includes one or more types of behavioral health services:
  - ✓ **Mental health treatment** includes therapies and/or medication to address mental health disorders, such as bipolar disorder, that may co-occur with substance use disorder;
  - ✓ **Drug counseling** includes one-on-one, family, or group counseling or other therapies that address patients' specific drug use and misuse; and
  - ✓ **Medication for opioid use disorder (MOUD)** includes three FDA-approved drugs—methadone, buprenorphine, and naltrexone—to treat opioid use disorder.

What OIG Found

In 2022, 90 percent of health centers provided at least one type of behavioral health service to patients with substance use disorder, while 56 percent offered comprehensive treatment. Specifically, 88 percent provided mental health treatment, 69 percent provided drug counseling, and 72 percent provided at least one type of MOUD.

More than one-third of health centers experienced challenges with providing behavioral health services through external providers.

Health centers used a variety of professional types and delivery models to provide behavioral health services but reported that workforce and financial challenges impeded their efforts.

What OIG Recommends

To improve access to behavioral health services for people with substance use disorder, we recommend that HRSA take additional steps to help health centers overcome barriers that impede provision of both drug counseling and MOUD. HRSA stated that it agrees with the spirit of OIG's recommendation and outlined its efforts to expand access to behavioral health services, including drug counseling and MOUD at health centers.

TABLE OF CONTENTS

BACKGROUND

OBJECTIVES

1. Determine the extent to which Health Resources and Services Administration (HRSA)-funded health centers provide behavioral health services to patients with substance use disorder.
2. Identify barriers to health centers' provision of behavioral health services to patients with substance use disorder as well as strategies health centers adopted to address those barriers.

Access to behavioral health care is a vital component in addressing high rates of substance use disorder in the United States. After years of sustained public health efforts, provisional 2024 data suggest a recent decline in drug overdose deaths—the first decrease since 2018.[1] Recent efforts include the repeal of the requirement that providers, including those in primary care, be granted special permission through a waiver to prescribe buprenorphine,[2] and the expansion of the behavioral health services covered by Medicare and Medicaid.[3, 4, 5] However, continued efforts are required to maintain this progress. In March 2025, the Secretary of the U.S. Department of Health and Human Services (HHS) renewed the Public Health Emergency declaration, originally announced in 2017 to address the national opioid crisis, recognizing the ongoing consequences of substance use disorder nationwide.

As safety net providers, HRSA-funded health centers are well-placed to improve access to behavioral health services, including treatment for substance use disorder. HRSA estimates that 1 in 6 health center patients could benefit from substance use disorder services. Yet, HRSA has reported gaps in provision of this care, noting that in 2022, health centers met just 6 and 27 percent of their patients' estimated need for substance use disorder and mental health treatment, respectively.[6]

Behavioral Health Services for Patients With Substance Use Disorder

Substance use disorder is characterized by impairment (such as health problems and failure to meet major responsibilities) caused by the recurrent use of substances, including legal or illegal drugs.[7] According to the National Institute on Drug Abuse (NIDA) and the Substance Abuse and Mental Health Services Administration (SAMHSA), treatment for substance use disorder is often a long-term process involving multiple types of interventions and regular monitoring. Effective treatment should address all of a patient's needs, including other mental health disorders that

can affect a person's symptoms and treatment outcomes. Treatment includes one or more of the following behavioral health services[8] (see Exhibit 1):

- **Mental health treatment** includes therapies, medication, or a combination of both to address any mental health disorders (e.g., depression, bipolar disorder) that co-occur with the patient's substance use disorder.
- **Drug counseling** is a type of drug addiction treatment that may include one-on-one, family, or group counseling or other therapies that address patients' specific drug use and misuse. For example, drug counseling may include behavioral therapies to help patients cope with drug cravings, promote behaviors to avoid relapse, and improve interpersonal relationships.
- **Medication for opioid use disorder (MOUD)** is a type of drug addiction treatment that includes one of three drugs—methadone, buprenorphine, and naltrexone—that are approved by the Food and Drug Administration (FDA) to treat opioid use disorder.[9] MOUD is effective at blunting or blocking the effects of opioids and relieving cravings. Methadone can be provided only by a certified opioid treatment program (OTP);[10] buprenorphine and naltrexone can be administered or prescribed by providers who meet licensing and training requirements.[11, 12]

For patients with opioid use disorder, treatment guidelines recommend MOUD in conjunction with behavioral therapies (e.g., drug counseling) as the standard of care. However, either treatment may be offered alone, depending on individual patient circumstances.[13]

Exhibit 1: Types of behavioral health services to treat patients with substance use disorder

Source: Based on Guidelines released by NIDA and SAMHSA.

Behavioral health services may be provided by a variety of professionals, including physicians, advanced practice providers,[14] licensed clinical social workers, licensed counselors,[15] paraprofessionals,[16] and others. Professionals are required to obtain additional certifications or licenses to provide certain behavioral health services. Some of these requirements vary by State.

HRSA's Health Center Program

The HRSA Health Center Program was established to provide primary care to medically underserved patients. To meet this goal, HRSA awards Health Center Program grants to support health center operations.[17] In 2023, nearly 1,400 health centers with more than 15,000 sites served over 31 million patients. A single recipient organization may operate multiple sites within its service area. For the purposes of this report, the term "health center" refers to the recipient organization (i.e., not an individual site).

Health Center Program Requirements

As a condition of their grant funding, health centers must provide a core set of required primary health care services and may also choose to provide additional services.[18] (See Appendix A for a complete list of these service categories.) Each health center has a governing board that determines its "scope of project." The governing board determines the level and intensity of required and additional services,[19] and the method for delivering these services, based on factors such as the needs of the population served, unmet need in the community, provider staffing, and collaborative agreements.[20] Health centers are required to provide in-scope services to all patients regardless of their ability to pay and must discount services in accordance with the health center's sliding fee discount program.[21, 22]

Health centers may provide services directly (either onsite or through telehealth) or through external providers with whom the health centers have established a formal written contract/agreement or a formal, written referral arrangement (hereinafter referred to as a referral).[23] For all direct and contracted services, the health center is responsible for obtaining reimbursement from the patient and their insurance.[24] Payment for referred services is managed by the external provider, but the health center making the referral must ensure that (a) the referred service is made available equally to all health center patients, regardless of ability to pay, and (b) the referral provider's fee schedule meets Health Center Program requirements.[25]

HRSA oversees health centers' provision of both required primary health care services and additional services, which are defined by statute.[26] For required primary health care services, HRSA provides information on what elements (i.e., service options), at a minimum, are included for each service. For additional services, HRSA provides information on what elements "may" be included, as part of the provision of that service.[27] Further, a health center may remove an additional service from its scope of

project. HRSA provides health centers with technical assistance in understanding these classifications and reporting service data.

Health Center Provision of Behavioral Health Services

Behavioral health services—comprising substance use disorder and mental health treatments— are not a required primary health care service for recipients of most Health Center Program grants.[28] HRSA's FY 2024 and 2025 budget proposals included a provision to reclassify behavioral health as a required primary health care service, along with a commensurate funding increase for the program.[29] However, the final enacted budgets did not include this requirement.

In the meantime, to expand access to behavioral health services in health centers, HRSA awarded approximately $848 million in supplemental grants for this purpose between 2016 and 2020, with additional funding made available in 2024.[30] In addition, regardless of whether it receives supplemental funding, any health center may choose to include behavioral health services as an additional service category in its scope of project. Furthermore, through its health workforce grant programs, HRSA offered educational loan repayments to a wide range of behavioral health professionals who provide treatment and support to patients with substance use disorder in exchange for full-time service commitments at facilities, such as health centers. HRSA also provides tools and resources to health centers, through its technical assistance activities on the integration of behavioral health services into primary care, on topics such as MOUD prescribing; behavioral health therapies; insurance coverage and billing; and strengthening community partnerships.

Related OIG Work

Prior OIG work found that in 2022, many counties lacked providers who prescribe or administer MOUD.[31] OIG also found in 2021 that few behavioral health providers in selected counties actively served Medicare and Medicaid enrollees, with less than 5 active behavioral health providers per 1,000 enrollees, and that despite demand, overall behavioral health treatment rates are low in both programs.[32] Furthermore, OIG found in 2023, with the special requirements to prescribe buprenorphine (buprenorphine waiver) repealed, that more providers ordered buprenorphine for Medicare. However, fewer than one in five enrollees received any medication to treat their opioid use disorder.[33, 34]

Methodology

We conducted a mixed methods review. We sent a web-based survey to a simple random sample of 450 health centers. We addressed the surveys to each health center's project director, the recommended point of contact provided by HRSA. We collected information from health centers on their provision of behavioral health services in calendar year 2022. We received responses from 308 health centers for a 68-percent response rate. We projected our sample of 450 health centers to the 1,366 health centers in our total health center population. We provided point

estimates and 95-percent confidence intervals for all projections (see Appendix B). Through the survey, we collected data about behavioral health services provided to patients with substance use disorder and asked open-ended questions about health centers' efforts to provide these services. We analyzed the survey responses to calculate the proportion of health centers that provided each type of service through various delivery methods and to identify common themes related to the challenges health centers experienced. Finally, we reviewed publicly available policy, procedural, and guidance documents and interviewed HRSA staff, including individuals from the Bureau of Primary Health Care and Bureau of Health Workforce, to identify processes and requirements for behavioral health service provision at health centers, as well as HRSA oversight of the Health Center Program.

Limitations

This study relies on self-reported 2022 data provided by health centers. We did not independently verify the survey responses. Our findings pertain only to health centers that received Health Center Program funding from HRSA and cannot be generalized to other types of health organizations that provide behavioral health services.

Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

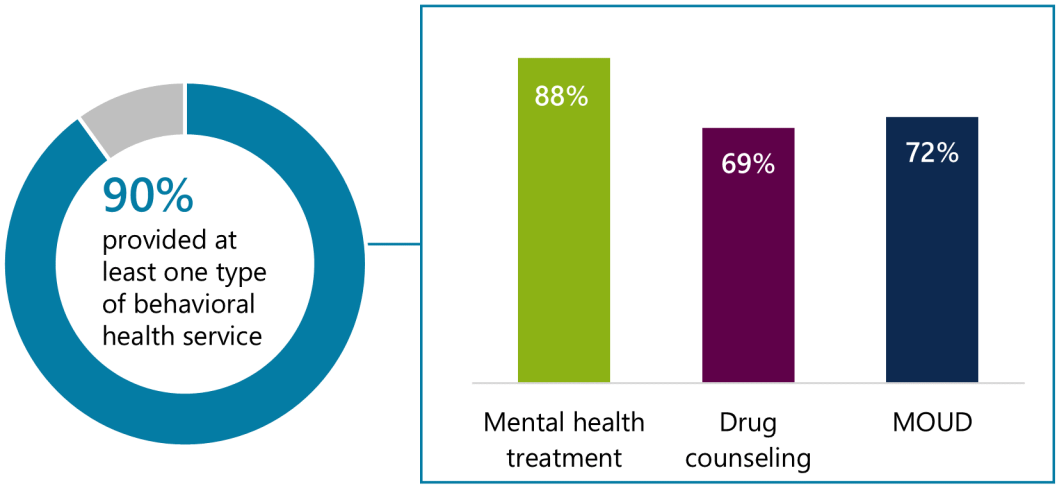
FINDINGS

Ninety percent of health centers provided at least one type of behavioral health service to patients with substance use disorder, while 56 percent offered comprehensive treatment

Clinical guidelines call for patients with substance use disorder to have access to all three behavioral health services: mental health treatment to address co-occurring mental health disorders (e.g., depression, bipolar disorder); drug counseling to address the patient's specific drug use or misuse; and MOUD to treat opioid use disorder. Every patient may not require all three services, but availability of all three options is necessary to ensure that each patient receives appropriate care based on their particular diagnoses and treatment needs.

Although most health center program grant recipients are not required to provide behavioral health services, OIG found that 90 percent of health centers provided at least one of these three types of behavioral health services to patients with substance use disorder (see Exhibit 2),[35] with appointments typically scheduled within 10 calendar days. However, fewer health centers (56 percent) offered all three types of services, which may hinder some patients' access to comprehensive treatment.

Exhibit 2: Most health centers provided at least one type of behavioral health service to their patients with substance use disorder



Source: OIG analysis of health center survey data, 2022.

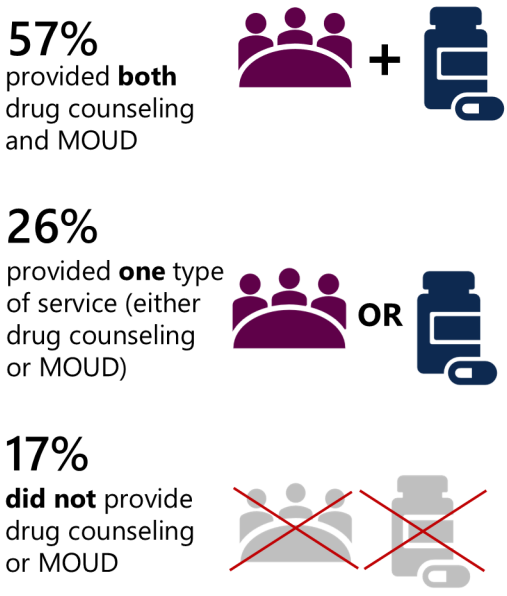
Eighty-eight percent of health centers provided mental health treatment

Overall, 88 percent of health centers provided mental health treatment to patients with co-occurring substance use disorder and other mental health disorders. Further, the relatively high rate of availability for these services was true for health centers that reported a high or very high need for behavioral health care in their service areas.

More than half of health centers provided both drug counseling and MOUD, but 43 percent lacked at least one of these treatments

Nationwide, 69 percent of health centers provided drug counseling, and 72 percent provided at least one type of MOUD. Fifty-seven percent of health centers provided both. However, 26 percent of health centers only provided one service type (either drug counseling or MOUD) and 17 percent did not provide either (see Exhibit 3). Depending on each patient's specific circumstances, they may require drug counseling, MOUD, or both. For example, a combination of drug counseling and MOUD is recommended to treat opioid use disorder,[36] but an individual with a stimulant use disorder may only require drug counseling. Health centers that do not provide both drug counseling and MOUD may be unable to meet patients' treatment needs specific to their addiction.

Exhibit 3: Overall, 43 percent of health centers lacked drug counseling, MOUD, or both



Source: OIG analysis of health center survey data, 2022.

Few health centers provided treatment with methadone

The majority of health centers provided MOUD treatment with buprenorphine and/or naltrexone, but only 6 percent of health centers provided methadone (see Exhibit 4). Methadone must be dispensed by a certified OTP. Approximately one-third of health centers reported working with OTPs to provide some form of behavioral health service, but these arrangements rarely included methadone. Further, prior OIG work found that more than three-quarters of counties nationwide did not have an OTP in 2022.[37] The American Society of Addiction Medicine practice guidelines for the treatment of opioid use disorder state that "[a]ll FDA approved medications for the treatment of opioid use disorder should be available to all patients."

Exhibit 4: Provision of MOUD varied by drug

Source: OIG analysis of health center survey data, 2022.

Most health centers that lacked drug counseling and MOUD operated in areas with a high need for behavioral health services

Of the health centers that did not provide both drug counseling and MOUD, 63 percent reported that there was a high or very high need for behavioral health services in their service areas. In addition, 72 percent of these health centers reported that availability of behavioral health care in their service area was fair, poor, or unavailable. Accordingly, expanding the range of drug addiction treatment options at these health centers would likely help them better meet the needs of patients in their service areas.

Health centers used a variety of professional types and delivery models to provide behavioral health services

Health centers employed a wide range of health care professionals to provide behavioral health services to patients with substance use disorder directly onsite at the health center. Health centers provided drug counseling and mental health care directly through various professional types, from licensed clinical social workers to physicians to paraprofessionals (e.g., peer support specialists[38] and case managers) (see Exhibit 5).[39] In addition, some health centers reported the benefits of establishing

multidisciplinary teams and integrated care models to provide the clinical, peer support, or case management services necessary for high-quality behavioral health care. For example, one health center described implementing "a dedicated team of case managers who work closely with each patient receiving medication for a [substance use disorder]," supporting patients' ongoing treatment.

Exhibit 5: Health centers that offered drug counseling and/or mental health treatment onsite employed various professional types to provide these services

Source: OIG analysis of health center survey data, 2022.

Health centers delivered behavioral health services through onsite care, telehealth, and arrangements with external providers

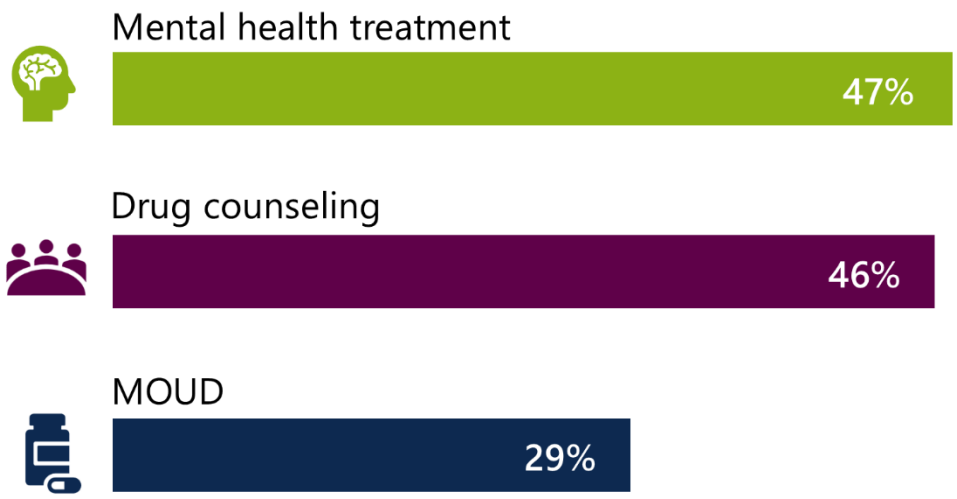
Health centers that provided behavioral health services typically offered multiple ways for patients with substance use disorder to access those services, including direct care onsite at the health center, via telehealth, or care from an external provider through contracts or referrals. Ninety percent of these health centers offered access to all their behavioral health services directly onsite. In addition, 86 percent of these health centers offered at least one type of behavioral health service through telehealth. Some health centers reported that the COVID-19 Public Health Emergency and the consequent expansion of telehealth flexibilities precipitated an increase in their use of telehealth for behavioral health services.[40]

In addition, approximately half of health centers that offered behavioral health services reported that they provided at least some services through referrals and/or contracts with external providers. For example, one health center noted that "[w]e have excellent community partner relationship[s] with shelters, schools, treatment

facilities[,] and other locations that support patients…who are in recovery or need [substance use disorder] services." Under referrals, the health center coordinates care, but the external provider is responsible for obtaining payment from patients and their insurance; under contracts, the health center reimburses the external provider. External providers who worked with health centers included outpatient providers (such as OTPs and certified community behavioral health clinics[41]) and inpatient providers (such as hospital inpatient[42] and residential treatment[43] programs). Overall, health centers provided these services more often through referrals than through contracts with external providers. Health centers' use of external providers varied by service type (see Exhibit 6). Specifically,

- 47 percent of health centers that provided mental health treatment delivered at least some of those services through external providers;
- 46 percent of health centers that provided drug counseling delivered at least some of those services through external providers; and
- 29 percent of health centers that provided MOUD delivered at least some of those services through external providers.

Exhibit 6: Health centers use of external providers varied by service type



Source: OIG analysis of health center survey data, 2022.

It is often challenging to find residential substance use disorder treatment providers in the community with openings to receive referrals in a timely basis. – Health center respondent

Health centers did not fully utilize local behavioral health provider networks

Over one-third of health centers reported struggling to access the external providers in their service areas. OIG's own analysis similarly found that many health centers may have established partnerships with only a fraction of the local provider network. For example, most health centers partnered with less than one-third of the outpatient behavioral health providers located within a 50-mile radius of their health centers. Some health centers faced additional barriers to partnering with inpatient providers, including a shortage of such providers in some service areas. For health centers that do not fully utilize their local provider network, increasing the number of these

partnerships could help them better meet their patients' behavioral health service needs.

Workforce and financial challenges impeded the provision of behavioral health services

Although most health centers provided some type of behavioral health care to patients with substance use disorder, health centers also reported staffing, payment, and other barriers that may limit their capacity to meet the full demand for these services. This is consistent with prior research identifying similar challenges,[44] as well as HRSA's own finding that health centers met only a fraction of the estimated need for these services among their patients.[45]

Many health centers faced challenges ensuring sufficient staffing for behavioral health services

Some health centers reported hiring additional providers to successfully provide behavioral health services to patients with substance use disorder. Others reported that they found success providing these services through their existing primary care staff by supporting them in obtaining training or certifications necessary to provide certain treatments. However, health centers reported challenges implementing each of these approaches.

[The health center] has had difficulty hiring…LCSW[s] and Certified Drug Counselors. We also need them to be Spanish speaking. Many…leave for more money or do not accept the job because of the same reason. – Health center respondent

Sixty-seven percent of health centers reported difficulty hiring and retaining staff to provide one or more type of behavioral health services to patients with substance use disorder. Some health centers attributed these challenges to provider shortages and a labor market in which the health centers could not offer the competitive salaries and work flexibilities available from other health organizations. Further, some health centers in rural areas noted that their location compounded these challenges. Additionally, 37 percent of health centers reported that a lack of external providers in their service areas or appointment availability at these providers impeded their ability to provide behavioral health services through referrals or contracts.

In addition, 31 percent of health centers reported difficulty providing behavioral health services through their existing primary care staff. Examples of these challenges included lack of provider time to integrate behavioral health services to their care portfolios, provider reluctance to obtain the additional training needed to provide certain treatments, and provider beliefs and misperceptions. Some health centers noted that negative provider and community perceptions of patients with substance use disorder and treatment clinics impeded efforts to offer behavioral health services.

Health centers reported varying strategies to mitigate staffing challenges. For example, one health center reported that it worked with a local college to increase access to drug counseling certification programs and offered internships, which created a path to employment at the health center. Another health center reported combating provider stigma with education, stating that, as a result of those efforts,

"we were able to bring most providers around…[which] increased our capacity" for behavioral health care.

Some health centers reported difficulty financing behavioral health services

We…have patients who do not qualify for Medicaid and cannot pay for insurance. They can usually afford outpatient counseling …with our slid[ing] fee option, but the cost of the medication is usually beyond their ability to afford. – Health center respondent

Thirty-four percent of health centers reported that difficulties financing the cost of behavioral health services hindered their ability to provide them. For example, some health centers reported that behavioral health appointments are longer and more complex, meaning the health center may have to schedule fewer appointments per provider for these services. In some cases, financing challenges were reported to be compounded by difficulties obtaining sufficient reimbursement for behavioral health services, due to a combination of low reimbursement rates and lack of insurance coverage. Finally, patients may also face financial barriers that prevent them from seeking or continuing treatment; some health centers reported that patients with low incomes or no insurance are unable to afford copayments and medications for their substance use disorder treatment. Examples of strategies that health centers reported using to address financial challenges include obtaining additional grant funding, assisting patients with obtaining insurance, and using 340B contract pharmacies to reduce the cost of drugs used for treatment with MOUD.

CONCLUSION AND RECOMMENDATION

Health centers play an important role in national efforts to address substance use disorder. For many communities, health centers serve as the first and primary access point for their health care needs: HRSA programmatic data indicate that in 2023, health centers provided non-MOUD substance use disorder services to 294,000 patients and MOUD services to 208,000 patients.[46] Although most health centers are not required to offer these services, we found that nearly all provided mental health care and the majority provided some type of care specific to drug use and misuse.

Despite these efforts, gaps in specific services may impede access to comprehensive treatment. For example, we found that 31 and 28 percent of health centers did not provide drug counseling and MOUD, respectively.[47] Further, we found that health centers rarely provided methadone, a key type of MOUD, even when health centers partnered with opioid treatment programs that have authority to prescribe this medication. Our findings are consistent with HRSA's own determination that many health centers cannot meet the estimated need for substance use disorder and mental health treatment among their patients.[48]

HRSA previously sought legislative action to reclassify behavioral health services (including substance use disorder treatment and mental health services) as "required primary health care services."[49] Currently, these services are classified as "additional services." For "required primary health care services," HRSA provides information on the minimum set of service options for each service category. However, HRSA does not provide minimum service options for "additional services." Therefore, health centers are able to decide what types of behavioral health services they provide and whether they provide services at all. Accordingly, Congressional action to reclassify behavioral health services as "required primary health care services" would be the most direct route to increasing access to this type of care in health centers. If this change occurs, HRSA should set minimum service option standards for behavioral health services that include both drug counseling and MOUD.

However, in the absence of statutory change, and in light of the Secretary's March 2025 renewal of the Public Health Emergency to address the national opioid crisis, action is needed to improve access to comprehensive behavioral health care. To address OIG's findings, we recommend that HRSA:

Take additional steps to help health centers overcome barriers that impede provision of both drug counseling and MOUD

Many health centers reported challenges that inhibit their ability to offer drug counseling and a full array of MOUD services. In March 2025, HHS announced the creation of the Administration for a Healthy America (AHA) combining functions currently performed by multiple agencies, including HRSA and the Substance Abuse

and Mental Health Services Administration (SAMHSA).[50] HRSA should work within the new framework to explore additional steps to better address the barriers our report identified. For example, HRSA could:

- Improve data collection regarding MOUD and drug counseling services to better identify and address gaps. For example, HRSA should consider including in required health center reporting the specific FDA-approved medications that each health center prescribed or administered and the types of non-MOUD substance use disorder services it provided.
- Leverage ongoing reorganization efforts to identify additional approaches to outreach, training, and technical assistance that would increase provision of MOUD prescribing and drug counseling. For example, the proposed realignment of HRSA and SAMHSA may offer new opportunities for external provider outreach on behalf of health centers to support contract and referral arrangements.

HRSA need not take any or all of these specific steps; we offer the actions above as examples. However, to implement this recommendation, HRSA should identify one or more actions to increase the number of health centers that offer both MOUD and drug counseling. Health centers have overcome many challenges to provide access to some types of behavioral health care. Additional Federal support is necessary and warranted to support their efforts, expand access to comprehensive treatment, and improve the health of Americans with substance use disorder.

AGENCY COMMENTS AND OIG RESPONSE

HRSA stated that it agrees with the spirit of OIG's recommendation and did not state whether it concurred with our recommendation. HRSA outlined its efforts to expand access to behavioral health services, including drug counseling and medication for opioid use disorder (MOUD) at health centers.

In response to our recommendation that HRSA take additional steps to help health centers overcome barriers that impede the provision of both drug counseling and MOUD, the agency stated that it has already taken additional steps to expand the provision of behavioral health services and believes it has already implemented OIG's recommendation.

HRSA explained that these efforts include a 2024 investment in Behavioral Health Service Expansion awards for health centers to start or increase the provision of substance use disorder services. Along with this funding, HRSA provides training and technical assistance to award recipients to overcome barriers related to the provision of drug counseling and MOUD. HRSA also cited its ongoing efforts to support the behavioral health workforce through its continued training, grant, and loan repayment programs for MOUD clinicians.

HRSA also stated that it has enhanced its partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA) to further integrate behavioral health services across health centers and external providers, with a scheduled technical expert panel in August 2025 to further identify strategies for increasing the provision of these services. Finally, HRSA explained that the agency has updated its health center program data collection and introduced two new Uniform Data System (UDS) measures to collect information on MOUD.

OIG recognizes HRSA's efforts and will work with HRSA to determine whether its ongoing and planned activities will implement our recommendation or whether further action is needed.

HRSA's efforts to enhance its partnership with SAMHSA is an important step to integrate behavioral health services across health centers and external providers; the agency should continue to leverage ongoing reorganization efforts to further support contract and referral arrangements. We ask that, in its final management decision, HRSA update us on its collaboration efforts with SAMHSA, including the outcome of the scheduled technical expert panel and any new strategies identified and adopted to integrate behavioral health services across health centers and external providers.

OIG also recognizes HRSA's efforts in updating its data collection measures. We also ask that, in its final management decision, HRSA more clearly specify how the new UDS measures will help to increase the number of health centers offering both drug counseling and MOUD.

For the full text of HRSA's comments, see Appendix C.

DETAILED METHODOLOGY

Scope

This report evaluated the extent to which health centers that received Health Resources and Services Administration (HRSA) Health Center Program funding in 2022 provided behavioral health services to patients with substance use disorder. We defined substance use disorder as meeting the DSM-5 definition of substance use disorder for one or more of the following drugs: marijuana; cocaine; heroin; hallucinogens; inhalants; methamphetamine; and prescription stimulants, tranquilizers, sedatives, and pain relievers. Services for alcohol use disorder were not included in this analysis. We evaluated the provision of three types of behavioral health services at health centers: mental health treatment, drug counseling, and MOUD. We defined "health center" as the recipient organization, regardless of the number of sites the health center operates. Health center look-alike data was not included in this analysis.

Data Sources

Our review was based primarily on a survey of health centers. In addition, we reviewed publicly available policy, procedural, and guidance documents and interviewed Bureau of Primary Health Care and Bureau of Health Workforce staff to identify processes and requirements on behavioral health service provision at health centers and HRSA program oversight.

Health Center Survey

We sent a web-based survey to a simple random sample of 450[51] health centers. We addressed the surveys to each health center's project director, the recommended point of contact provided by HRSA.[52] We received responses from 308, resulting in a 68-percent response rate. We selected our sample from a population of 1,366 health centers collected through HRSA's health center service delivery data. These data contained health centers' address, grant, and contact information. We removed any health centers that did not have 2021 Uniform Data System (UDS) service data from this analysis.

We collected the following information about behavioral health services provided in calendar year 2022 from health centers through a survey:

- provision of mental health treatment and drug counseling, and the administration and prescription of MOUD to patients with substance use disorder;
- delivery methods used for these services (e.g., directly onsite, telehealth, or through arrangements with external providers);

- wait times for appointments for these services;
- types of professionals employed to provide these services;
- need for behavioral health services in their service areas; and
- barriers that impeded the provision of behavioral health services at health centers and the strategies adopted to address those barriers.

Data Analysis

To determine the extent to which health centers provided behavioral health services to patients with substance use disorder, we calculated the proportion of health centers that provided mental health treatment, drug counseling, and MOUD (i.e., methadone, buprenorphine, or naltrexone) to their patients with substance use disorder. We compared these results with the survey data reported by health centers about the need for and availability of behavioral health care in their service areas. Furthermore, for each of these service types, we calculated the proportion of health centers that provided the service directly onsite, through telehealth, and through external providers (contracted or using formal written referrals). We also calculated the proportion of services with appointments offered within 10 days. Finally, we calculated the number and proportion of health centers that provided mental health treatment and drug counseling through different professional types (e.g., physicians, licensed clinical psychologists, licensed clinical social workers, etc.).

To further assess health centers' partnerships with external providers, we used publicly available data from SAMHSA's FindTreatment.gov locator tool to identify the number of outpatient and residential and hospital inpatient providers located within a 50-mile radius of each health center's primary address.[53] We also summed the number of outpatient and residential and hospital inpatient providers (i.e., external providers) each health center reported contracting or referring patients to in 2022.[54] Then, we calculated the ratio of external providers with which the health center contracted or referred patients in 2022 to the number of outpatient and residential and hospital inpatient providers in a 50-mile radius of their health center.

We projected our sample of 450 health centers to the 1,366 health centers in our total health center population. We provided point estimates and 95-percent confidence intervals for all projections (see Appendix B). To identify barriers to health centers' provision of behavioral health services to patients with substance use disorder, as well as strategies health centers adopted to address those barriers, we conducted a qualitative, thematic analysis of the open-ended responses to the health center survey.

APPENDICES

Appendix A: Health Center Program Required Primary Health Care and Additional Health Service Categories[55]

Required Primary Health Care Services	Additional Health Services
Health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology	***Behavioral and mental health and substance use disorder services***
Diagnostic laboratory and radiologic services	Recuperative care services
Preventive health services (including prenatal and perinatal services; appropriate cancer screening; well-child services; immunizations; screenings for elevated blood lead levels, communicable diseases, and cholesterol; pediatric eye, ear, and dental screenings; voluntary family planning services; preventive dental services)	In case of migrant health centers: • Screening for and control of infectious diseases; and • Injury prevention programs, including prevention of exposure to unsafe levels of agricultural chemicals including pesticides
Emergency medical services	Environmental health services, including: • Detection and alleviation of unhealthful conditions with water supply; chemical and pesticide exposures; air quality; or exposure to lead • Sewage treatment • Solid waste disposal • Rodent and parasitic infestation • Field sanitation • Housing
Pharmaceutical services as may be appropriate for particular centers	
Referrals to providers of medical services (including specialty referral when medically indicated and other health-related services—including substance use disorder and mental health services)	
Patient case management services (including counseling, referral, and follow-up services) and other services designed to assist health center patients in establishing eligibility for and gaining access to Federal, State, and local programs that provide or financially support the provision of medical, social, housing, educational, or other related services	
Services that enable individuals to use the services of the health center (including outreach and transportation services and English language translation)	
Education of patients and the general population served by the health center regarding, and availability and proper use of, health services	

Appendix B: Health Center Survey Responses: Statistical Estimates and Confidence Intervals

The tables below provide point estimates and confidence intervals for all projections included in the body of the report.

Table B-1: Health Center Survey Responses: Statistical Estimates and Confidence Intervals

Description	Sample Size	Point Estimate	95% Confidence Interval
Percentage of health centers that provided mental health treatment, drug counseling, or MOUD	308	90.3%	86.4-93.3%
Percentage of health centers that provided all three types of behavioral health services, which includes mental health treatment, drug counseling, and MOUD	308	56.2%	50.4-61.8%
Percentage of health centers that did not provide all three types of behavioral health services, which includes mental health treatment, drug counseling, and MOUD	308	43.8%	38.2-49.6%
Percentage of health centers that provided mental health treatment	308	87.7%	83.5-91.1%
Of health centers that reported high or very high need for behavioral health services, percentage that provided mental health treatment	229	89.1%	84.3-92.8%
Percentage of health centers that provided both drug counseling and MOUD	308	57.5%	51.7-63.1%
Percentage of health centers that did not provide both drug counseling and MOUD	308	42.5%	36.9-48.3%
Percentage of health centers that provided drug counseling	308	68.5%	63.0-73.7%
Percentage of health centers that provided MOUD	308	72.4%	67.0-77.3%
Percentage of health centers that only provided one service type (either drug counseling or MOUD)	308	26.0%	21.2-31.3%
Percentage of health centers that provided neither MOUD nor drug counseling	308	16.6%	12.6-21.2%
Percentage of health centers that provided buprenorphine or naltrexone	308	72.1%	66.7-77.0%
Percentage of health centers that provided buprenorphine	308	66.9%	61.3-72.1%

Percentage of health centers that provided naltrexone	308	52.9%	47.2-58.6%
Percentage of health centers that provided methadone	308	5.5%	3.2-8.7%
Percentage of health centers that worked with an OTP for behavioral health services	308	32.5%	27.3-38.0%
Of health centers that worked with an OTP, percentage that provided methadone	100	13.0%	7.1-21.2%
Of health centers that did not provide both drug counseling and MOUD, percentage that reported high or very high need for behavioral health services	131	62.6%	53.7-70.9%
Of health centers that did not provide both drug counseling and MOUD, percentage that reported availability of behavioral health care was fair, poor, or unavailable	131	71.8%	63.2-79.3%
Of health centers that provided mental health treatment and drug counseling directly, percentage that employed licensed clinical social workers	269	87.4%	82.8-91.1%
Of health centers that provided mental health treatment and drug counseling directly, percentage that employed advanced practice providers	269	69.5%	63.6-75.0%
Of health centers that provided mental health treatment and drug counseling directly, percentage that employed other licensed behavioral health professionals	269	67.3%	61.3-72.9%
Of health centers that provided mental health treatment and drug counseling directly, percentage that employed physicians	269	52.8%	46.6-58.9%
Of health centers that provided mental health treatment and drug counseling directly, percentage that employed paraprofessionals	269	46.1%	40.0-52.3%
Of health centers that provided mental health treatment and drug counseling directly, percentage that employed psychiatrists	269	40.1%	34.2-46.3%
Of health centers that provided mental health treatment and drug counseling directly, percentage that employed licensed clinical psychologists	269	25.7%	20.5-31.3%
Of health centers that provided behavioral health services, percentage of health centers that provided all behavioral health services directly onsite	278	89.6%	85.4-92.9%
Of health centers that provided behavioral health services, percentage of health centers that provided at least one type of behavioral health service through telehealth	278	86.3%	81.7-90.1%
Of health centers that provided behavioral health services, percentage that provided services through external providers	278	55.4%	49.3-61.3%

Of health centers that provided mental health treatment through external providers, percentage that provided services through contracts	127	35.4%	27.2-44.4%
Of health centers that provided mental health treatment through external providers, percentage that provided services through referrals	127	86.6%	79.4-92.0%
Of health centers that provided drug counseling through external providers, percentage that provided services through contracts	97	28.9%	20.1-39.0%
Of health centers that provided drug counseling through external providers, percentage that provided services through referrals	97	88.7%	80.6-94.2%
Of health centers that provided buprenorphine through external providers, percentage that provided services through contracts	53	18.9%	9.4-32.0%*
Of health centers that provided buprenorphine through external providers, percentage that provided services through referrals	53	92.5%	81.8-97.9%*
Of health centers that provided naltrexone through external providers, percentage that provided services through contracts	40	17.5%	7.3-32.8%*
Of health centers that provided naltrexone through external providers, percentage that provided services through referrals	40	90.0%	76.3-97.2%*
Of health centers that provided methadone through external providers, percentage that provided services through contracts	13	23.1%	5.0-53.8%*
Of health centers that provided methadone through external providers, percentage that provided services through referrals	13	92.3%	64.0-99.8%*
Of health centers that provided mental health treatment, percentage that provided services through external providers	270	47.0%	41.0-53.2%
Of health centers that provided drug counseling, percentage that provided services through external providers	211	46.0%	39.1-52.9%
Of health centers that provided MOUD, percentage that provided services through external providers	223	29.1%	23.3-35.6%
Percentage of health centers that reported struggling to access the external providers in their service areas	308	37.3%	31.9-43.0%
Percentage of health centers that reported difficulty hiring or retaining staff to provide one or more behavioral health services	308	66.6%	61.0-71.8%
Percentage of health centers that reported lack of external providers or appointment availability to provide behavioral health services through external providers	308	37.3%	31.9-43.0%
Percentage of health centers that did not provide access to drug counseling	308	31.5%	26.3-37.0%

Percentage of health centers that did not provide access to MOUD	308	27.6%	22.7-33.0%

*The 95% confidence intervals are wider than 10 percentage points from the point estimate.

Table B-2: Health Center Survey Responses for Appointment Wait Times: Statistical Estimates and Confidence Intervals

Description	Sample Size	Point Estimate	95% Confidence Interval
Percentage of mental health treatment services provided within 10 calendar days	419*	64.7%	59.1-69.9%
Percentage of drug counseling services provided within 10 calendar days	317**	72.2%	66.4-77.4%
Percentage of MOUD services provided within 10 calendar days	472***	82.2%	76.2-87.0%

*The sample size was calculated by combining the number of mental health treatment services health centers provided through direct, contract, and referral delivery methods.
**The sample size was calculated by combining the number of drug counseling services health centers provided through direct, contract, and referral delivery methods.
***The sample size was calculated by combining the number of buprenorphine, naltrexone, and methadone services health centers provided through direct, contract, and referral delivery methods.

Appendix C: Agency Comments

Following this page are the official comments from HRSA.

HRSA
Health Resources & Services Administration

5600 Fishers Lane
Rockville, MD 20857

DATE: July 16, 2025

TO: Ann Maxwell
Deputy Inspector General for Evaluation and Inspections
Office of the Inspector General
U.S. Department of Health and Human Services

FROM: Thomas J. Engels
Administrator

SUBJECT: Health Resources and Services Administration Response to OIG Draft Report: *Most Health Centers Provide Some Behavioral Health Services to Patients With Substance Use Disorder, Despite Facing Challenges that Limit Comprehensive Treatment*, OEI-BL-22-00520

The Health Resources and Services Administration (HRSA) appreciates the opportunity to review and comment on this report from the Office of the Inspector General (OIG).

OIG's draft report contains the following recommendation for HRSA:

To improve access to behavioral health services for people with substance use disorder, we recommend HRSA take additional steps to help health centers overcome barriers that impede provision of both drug counseling and medication for opioid use disorder (MOUD).

HRSA agrees with the spirit of OIG's recommendation, in that HRSA sees helping health centers meet the demand for behavioral health services as critically important. In recognition of this, HRSA has already taken additional steps since OIG's analysis, which was largely centered on 2022 data, to significantly expand the provision of behavioral health services, including drug counseling and MOUD treatment, such as:

1. Providing Behavioral Health Service Expansion awards and related technical assistance to health centers;
2. Enhancing HRSA's partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA);
3. Investing in the behavioral health workforce; and
4. Updating Health Center Program data collection measures specific to MOUD.

Based on these efforts, detailed below, HRSA believes we have already implemented OIG's recommendation.

Behavioral Health Service Expansion Awards and Technical Assistance
In 2024, HRSA invested $240 million in Behavioral Health Service Expansion (BHSE) awards to 403 health centers that serve more than 10 million people nationwide. More than half of the awardees used this funding to *start* providing and reporting services by substance use disorder (SUD) providers, including drug counseling and MOUD treatment, while other awardees are using it to increase the provision of these services in their communities. Examples of how health centers used/are using BHSE funding include:

- Hiring behavioral health specialists (e.g., a physician double board-certified in Internal Medicine and Addiction Medicine, licensed clinical professional counselors, SUD care navigators, and others);
- Enhancing screening practices for SUDs to increase referrals to addiction services;
- Beginning a street medicine clinic and providing community outreach to increase access to behavioral health services, including MOUD treatment; and
- Hosting clinical training for addiction medicine fellows to increase the number of primary care providers prepared to deliver addiction services.

HRSA provides ongoing technical assistance to BHSE awardees and all health centers it funds to help them meet the demand for these new or expanded services. Through HRSA's Behavioral Health and Substance Use Disorder Integration Technical Assistance Program, HRSA shares best practices and strategies for overcoming barriers related to the provision of both drug counseling and MOUD treatment through tailored webinars, site visits, and community-of-practice sessions.[1]

Enhanced Partnership with SAMHSA
An additional step that HRSA has taken to increase access to behavioral health services is through its enhanced partnership with SAMHSA in recent years. Through interagency collaboration, HRSA-supported health centers and SAMHSA-supported Certified Community Behavioral Health Clinics leverage expertise from one another in the delivery of primary care services to address the whole-person needs of patients with OUD.

HRSA is currently working with SAMHSA on a technical expert panel to further coordinate and integrate services across HRSA-supported health centers, Certified Community Behavioral Health Clinics, and Opioid Treatment Programs. HRSA and SAMHSA are identifying additional approaches for outreach, training, and technical assistance to increase the provision of drug counseling and MOUD. The technical expert panel is scheduled from August 6 to August 7, 2025.

Until the Consolidated Appropriations Act of 2023 removed the federal requirement for practitioners to have a waiver to prescribe medications (e.g., buprenorphine) for OUD, HRSA also provided scholarships to incentivize practitioners to acquire the training needed to provide

[1] Behavioral Health and Substance Use Disorder Integration Technical Assistance Program, Accessed at: https://bphc-ta.bizzellus.com/

buprenorphine. HRSA worked closely with SAMHSA to confirm that practitioners seeking to provide buprenorphine completed the training and were qualified to receive reimbursement for their training.

Investing in the Behavioral Health Workforce

HRSA also continues to support health centers' behavioral health workforce through ongoing training, grant, and loan repayment programs for MOUD clinicians, including:

- Addiction Medicine Fellowship Program, which expands the number of fellows trained at accredited addiction medicine and addiction psychiatry fellowship programs practicing in underserved areas;[2]
- Integrated Substance Use Disorder Training Program, which expands the number of health care professionals trained to provide mental health, SUD, and OUD services in underserved community-based settings that integrate primary care, mental health, and SUD services, including such settings that serve pediatric populations;[3]
- Opioid-Impacted Family Support Program, which increases the number of peer support specialists and other behavioral health-related paraprofessionals who provide services to children whose parents are impacted by OUD and SUD, and their family members;[4]
- Substance Use Disorder Treatment and Recovery Loan Repayment Program, which provides up to $250,000 to eligible SUD treatment clinicians and community health workers;[5]
- National Health Service Corps (NHSC) Substance Use Disorder Workforce Loan Repayment Program, which provides up to $75,000 to clinicians trained and licensed to provide SUD treatment serving in health professional shortage areas;[6] and
- NHSC Rural Community Loan Repayment Program, which provides up to $100,000 to clinicians trained and licensed to provide SUD treatment serving in rural health professional shortage areas.[7]

[2] Addiction Medicine Fellowship Program, Accessed at:
https://www.hrsa.gov/grants/find-funding/HRSA-25-069
[3] Integrated Substance Use Disorder Training Program, Accessed at:
https://www.hrsa.gov/grants/find-funding/HRSA-23-090
[4] Opioid-Impacted Family Support Program, Accessed at:
https://www.hrsa.gov/grants/find-funding/HRSA-24-016
[5] Substance Use Disorder Treatment and Recovery Loan Repayment Program, Accessed at:
https://bhw.hrsa.gov/funding/apply-loan-repayment/star-lrp
[6] NHSC Substance Use Disorder Workforce Loan Repayment Program, Accessed at:
https://nhsc.hrsa.gov/loan-repayment/nhsc-sud-workforce-loan-repayment-program
[7] NHSC Rural Community Loan Repayment Program, Accessed at:
https://nhsc.hrsa.gov/loan-repayment/nhsc-rural-community-loan-repayment-program

Updating Health Center Program Data Collection
Finally, HRSA updated its Uniform Data System (UDS) reporting requirements, which health centers implemented in calendar year 2025 reporting.[8] HRSA introduced two new UDS measures to collect the number of visits where MOUD was administered, as well as the percentage of patients who initiated and engaged in ongoing MOUD treatment.[9] Capturing these measures with electronic health record data will help identify patterns in patient care, diagnoses, and outcomes as well as areas where health centers are succeeding and where they may need additional technical assistance to improve quality performance.

In summary, HRSA has and continues to demonstrate its commitment to improving access to behavioral health services and considers OIG's recommendation implemented.

[8] Final UDS Changes for Calendar Year 2025, Accessed at: https://bphc.hrsa.gov/sites/default/files/bphc/compliance/pal-2025-03.pdf
[9] Federal Register Agency Information Collection Activities: Proposed Collection: Public Comment Request; HRSA UDS, Accessed at: https://www.federalregister.gov/documents/2024/11/22/2024-27394/agency-information-collection-activities-proposed-collection-public-comment-request-health-resources

ABOUT THE OFFICE OF INSPECTOR GENERAL

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The mission of the Office of Inspector General (OIG) is to provide objective oversight to promote the economy, efficiency, effectiveness, and integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of the people they serve. Established by Public Law No. 95-452, as amended, OIG carries out its mission through audits, investigations, and evaluations conducted by the following operating components:

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ENDNOTES

[1] Centers for Disease Control and Prevention (CDC), *National Vital Statistics System, Provisional Drug Overdose Death Counts, UPDATE 1/15/2025*, January 15, 2025. Accessed at https://www.cdc.gov/nchs/nvss/vsrr/drug-overdose-data.htm on February 3, 2025.

[2] The Consolidated Appropriations Act, 2023, repealed the buprenorphine waiver requirement on December 29, 2022. Waivered providers were limited to treating no more than 30 patients in the first year of prescribing but could then apply for an increase to a 100-patient maximum after one year. See 21 U.S.C. § 823(g)(2)(B)(iii)(I)-(II) (2018 supp. III). In subsequent years, a practitioner could treat up to 275 patients. See 42 CFR § 8.610 (2022).

[3] For example, effective January 1, 2024, Marriage and Family Therapists (MFTs) and Mental Health Counselors (MHCs) can bill Medicare independently for their services furnished for the diagnosis and treatment of mental illnesses.

[4] For example, beginning on or after January 1, 2020, opioid treatment programs (OTPs) may receive reimbursement from Medicare for substance use disorder services provided to Medicare enrollees. Section 2005 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT for Patients and Communities Act, Pub. L. 115-271, enacted October 24, 2018) amended the Social Security Act (SSA) by adding Sections 1861(s)(2)(HH), 1861(jjj), 1833(a)(1)(CC), and 1834(w).

[5] For example, effective October 2020, State Medicaid programs are generally required to cover all FDA-approved medications for opioid use disorder. See Section 1006(b) of the 2018 Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT for Patients and Communities Act) (P.L. 115-271) and Section 201, Subtitle B, Title I, Division G of the Consolidated Appropriations Act, 2024 (P.L. 118-42).

[6] HRSA's analysis of its health center program data. See HRSA, *Notice of Funding Opportunity: Fiscal Year 2024 Behavioral Health Service Expansion*. Accessed at https://grants.gov/search-results-detail/349049 on November 18, 2024.

[7] For the purposes of this study, substance use disorder is defined as meeting the DSM-5 definition of substance use disorder for one or more of the following drugs: marijuana, cocaine, heroin, hallucinogens, inhalants, and methamphetamine, as well as prescription stimulants, tranquilizers, sedatives, and pain relievers. Alcohol use disorder was not included in this definition.

[8] See:

- National Institutes of Health (NIH)/NIDA, *Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition)*, revised January 2018, accessed at https://nida.nih.gov/sites/default/files/podat-3rdEd-508.pdf on February 18, 2025;
- SAMHSA, *Treatment Improvement Protocol TIP 63: Medications for Opioid Use Disorder*, updated 2021, accessed at https://store.samhsa.gov/sites/default/files/pep21-02-01-002.pdf on November 18, 2024;
- SAMHSA, *Treatment of Stimulant Use Disorders*, accessed at https://library.samhsa.gov/sites/default/files/pep20-06-01-001.pdf on February 18, 2025; and

- ASAM (American Society of Addiction Medicine), *The ASAM National Practice Guideline For the Treatment of Opioid Use Disorder—2020 Focused Update*, 2020, accessed at https://www.asam.org/quality-care/clinical-guidelines/national-practice-guideline on February 18, 2025.

[9] Opioid use disorder is a specific type of substance use disorder that meets the DSM-5 definition of heroin use disorder and prescription pain reliever disorder (or both).

[10] OTPs must be certified by the Substance Abuse and Mental Health Services Administration (SAMHSA), licensed by the State in which they operate, and registered with the Drug Enforcement Administration. OTPs are the only provider type able to administer and dispense methadone to treat opioid use disorder. OTPs must also provide adequate medical; counseling; vocational; educational; and other assessment and treatment services either onsite or by referral to an outside agency or practitioner through a formal agreement. SAMHSA, *Treatment Improvement Protocol TIP 63: Medications for Opioid Use Disorder*, updated 2021. Accessed at https://store.samhsa.gov/sites/default/files/pep21-02-01-002.pdf on November 18, 2024.

[11] Providers can prescribe or administer buprenorphine if they have prescribing authority and appropriate Drug Enforcement Administration registration, and fulfill certain training requirements. See Section 1263 of the Consolidated Appropriations Act, 2023.

[12] Naltrexone can be prescribed by any provider licensed to prescribe medication. SAMHSA, *Naltrexone*, March 2024. Accessed at https://www.samhsa.gov/medications-substance-use-disorders/medications-counseling-related-conditions/naltrexone, November 18, 2024.

[13] ASAM (American Society of Addiction Medicine), *The ASAM National Practice Guideline For the Treatment of Opioid Use Disorder—2020 Focused Update*, 2020. Behavior change is an important part of recovery, and may be facilitated by behavioral therapies (e.g., drug counseling). However, these treatments take time to be effective. MOUD works quickly to reduce the risk of overdose and overdose death. Thus, the combination of MOUD and behavioral therapies, tailored to the individual's needs, is the recommended standard of care. However, there may be instances in which pharmacotherapy alone results in positive outcomes. A patient's decision to decline behavioral therapies or the absence of available treatment should not preclude or delay MOUD treatment of opioid use disorder, with appropriate medication management.

[14] Advanced practice providers include the professional titles of Nurse Practitioner, Physician Assistant, Certified Nurse Midwife, and Certified Registered Nurse Anesthetist (CRNA).

[15] Other licensed behavioral health professionals (e.g., licensed counselors) include, but are not limited to, the professional titles of Master Level Social Worker, Registered Nurse, Marriage and Family Therapist (MFT), Licensed Professional Counselor (LPC), and Substance Use Disorder Counselor.

[16] Behavioral health-related paraprofessionals (i.e., paraprofessionals) include, but are not limited to, the professional titles of Behavioral Health Paraprofessional, Health Educator, Peer Support Specialist, Recovery Coach, and Community Health Worker.

[17] 42 U.S.C. § 254b. HHS may make grants for the costs, planning, and delivery of services to medically underserved or special medically underserved populations. The Health Center Program has four population-based grants for community health; homeless population; migratory and seasonal agricultural workers; and residents of public housing.

[18] 42 U.S.C. § 254b.

[19] For example, health centers determine the level and intensity of substance use disorder services, which may include detoxification to manage withdrawal symptoms associated with substance use disorder; treatment/rehabilitation, to include individual and/or group treatment, counseling, and case management; and/or MOUD (e.g., buprenorphine, methadone, naltrexone). Health centers may also determine whether treatment should occur in outpatient or residential and hospital inpatient settings.

[20] HRSA, *Health Center Program Compliance Manual*, August 20, 2018.

[21] 42 U.S.C. § 254b.

[22] HRSA, *Health Center Program Compliance Manual*, August 20, 2018. A health center must prepare a schedule of fees or payment for the provision of its services consistent with locally prevailing rates or charge and designed to cover its reasonable costs of operation and must prepare a corresponding schedule of discounts (sliding fee discount schedule) to be applied to the payment of such fees or payments, by which discounts are adjusted on the basis of the patient's ability to pay.

[23] HRSA, *Health Center Program Compliance Manual*, August 20, 2018.

[24] Ibid.

[25] Ibid.

[26] 42 U.S.C. § 254b.

[27] HRSA, *Health Center Program Service Descriptors for Form 5A: Services Provided*. Accessed at https://bphc.hrsa.gov/sites/default/files/bphc/compliance/form-5a-service-descriptors.pdf on November 18, 2024.

[28] 42 U.S.C. § 254b. Exceptions apply to health centers that receive Healthcare for the Homeless awards, which require that they provide substance use disorder services.

[29] HHS, *HRSA Fiscal Year 2025 Justification of Estimates for Appropriations Committees*. Accessed at https://web.archive.org/web/20250308124649/https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2025.pdf on November 18, 2024.

[30] HRSA, *Notice of Funding Opportunity: Fiscal Year 2024 Behavioral Health Service Expansion*. Accessed at https://grants.gov/search-results-detail/349049 on November 18, 2024.

[31] OIG, *Medicare and Medicaid Enrollees in Many High-Need Areas May Lack Access to Medications for Opioid Use Disorder* (OEI-BL-23-00160), published in September 2024.

[32] OIG, *Data Brief: A Lack of Behavioral Health Providers in Medicare and Medicaid Impedes Enrollees' Access to Care* (OEI-02-22-00050), published in March 2024.

[33] OIG, *OIG Final Data Brief: Fewer than One in Five Medicare Enrollees Received Medication to Treat Their Opioid Use Disorder* (OEI-02-24-00430), published in April 2025. This proportion is similar to those for past years and may indicate that enrollees are facing ongoing challenges accessing treatment, despite the waiver repeal.

[34] Additional analyses similarly found that the repeal of the buprenorphine waiver requirement led to an increase in the number of providers prescribing buprenorphine. However, its removal has had limited impact on patient access to the drug. The number of patients receiving buprenorphine was minimally affected, leading to

the conclusion that addressing the other systemic barriers to substance use disorder treatment (including those is this report) may be more effective at increasing access. See:

- Chua K, Bohnert A, Nguyen, TD, "Buprenorphine Dispensing after Elimination of the Waiver Requirement," *The New England Journal of Medicine*, 390(16), 2024, 1530-1532.
- Ali MM, Chen J, Novak, PJ, "Utilization of Buprenorphine for Opioid Use Disorder After the Practitioner Waiver Removal," *American Journal of Preventive Medicine*, 68(1), 2025, 207-209.

[35] Includes all in-scope services provided directly at the health center and/or through referrals or contracts with external providers.

[36] ASAM (American Society of Addiction Medicine), *The ASAM National Practice Guideline For the Treatment of Opioid Use Disorder—2020 Focused Update*, 2020. Each treatment may be offered alone depending on individual patient circumstances.

[37] OIG, *Medicare and Medicaid Enrollees in Many High-Need Areas May Lack Access to Medications for Opioid Use Disorder* (OEI-BL-23-00160), published in September 2024.

[38] Peer support uses peer support specialists to provide non-clinical (i.e., not requiring training in diagnosis or treatment) recovery support services to individuals in recovery and to their families. Peer support specialists are people in recovery who have lived experiences in addiction plus skills learned in formal training. Additional professional titles may include peer recovery coaches, peer support specialists, and/or peer navigators.

[39] Since MOUD can be provided only by providers with the authority to prescribe and/or administer each specific medication, we did not collect information about the professional types providing MOUD at health centers.

[40] Consolidated Appropriations Act of 2021 – P.L. 116-260. During the COVID-19 public health emergency (PHE), CMS used emergency waivers to expand Medicare Part B's telehealth regulations. The flexibilities that allowed enrollees to receive behavioral health services from their homes through audio-only technology and allowed all federally qualified health centers (FQHCs) (e.g., health centers) and rural health centers (RHCs) to serve as telehealth providers were made permanent. However, other flexibilities are set to expire on December 31, 2025, such as the waiver of the provision whereby enrollees must have an in-person visit with their behavioral health provider within six months of their initial telehealth visit, and then make one in-person visit annually, thereafter.

[41] Certified Community Behavioral Health Clinics (CCBHCs) are centers that provide coordinated, comprehensive behavioral health care. These centers must provide services to anyone seeking help for mental health or substance use disorder regardless of their age, place of residence, or ability to pay. See SAMHSA, *Certified Community Behavioral Health Clinics*. Accessed at https://www.samhsa.gov/certified-community-behavioral-health-clinics on November 18, 2024.

[42] Hospital inpatient treatment programs provide 24-hour-a-day inpatient hospital treatment. The level of clinical care intensity can vary from medically monitored (i.e., 24-hour nursing care) to medically managed care (24-hour nursing and daily physician care). They may provide a variety of substance use disorder detoxification and behavioral health services.

[43] Residential treatment programs provide 24-hour-a-day long-term (greater than 30-day stays) or short-term (less than 30-day stays) treatment where patients stay at a non-hospital facility. The level of clinical care intensity can vary from less intense to highly intense, and these programs may provide a variety of behavioral health services.

[44] For example, see:

- Pourat N, O'Masta B, Chen X, Lu C, Zhou W, Daniel M, Hoang H, Sripipatana A, "Examining trends in substance use disorder capacity and service delivery by Health Resources and Services Administration-funded health centers: A time series regression analysis," *PLoS One*, 15(11), 2020, e0242407.
- Haffajee RL, Bohnert A, Lagisetty PA, "Policy Pathways to Address Provider Workforce Barriers to Buprenorphine Treatment," *American Journal of Preventive Medicine*, 54(6 Suppl 3), 2017, S230-S242.

[45] HRSA's analysis of its health center program data. See HRSA, *Notice of Funding Opportunity: Fiscal Year 2024 Behavioral Health Service Expansion*. Accessed at https://grants.gov/search-results-detail/349049 on November 18, 2024.

[46] HRSA, *Impact of the Health Center Program*. Accessed at https://bphc.hrsa.gov/about-health-center-program/impact-health-center-program on December 19, 2024.

[47] Our study used survey data collected in 2022, prior to the repeal of the buprenorphine waiver requirement. However, more recent HRSA programmatic data suggest that these service gaps continued to persist in 2023: Specifically, HRSA reported to OIG that 23 percent of health centers lacked MOUD services, and 48 percent lacked other non-MOUD substance use disorder services.

[48] HRSA's analysis of its health center program data. See HRSA, *Notice of Funding Opportunity: Fiscal Year 2024 Behavioral Health Service Expansion*. Accessed at https://grants.gov/search-results-detail/349049 on November 18, 2024.

[49] HHS, *HRSA Fiscal Year 2025 Justification of Estimates for Appropriations Committees*. Accessed at https://web.archive.org/web/20250308124649/https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2025.pdf on November 18, 2024.

[50] The Administration for a Healthy America (AHA) plans to combine the Office of the Assistant Secretary for Health (OASH), HRSA, SAMHSA, the Agency for Toxic Substances and Disease Registry (ATSDR), and the National Institute for Occupational Safety and Health (NIOSH).

[51] We did not distribute the survey to one health center, as they were involved in ongoing work by OIG's Office of Investigations.

[52] We pretested our survey with HRSA's Bureau of Primary Health Care staff, one primary care organization, and three health centers to obtain technical feedback. We contacted the health centers in our sample about the survey through multiple modes of communication including email, phone, and fax.

[53] We did not verify the accuracy of the provider information in SAMHSA's FindTreatment.gov locator tool. We removed duplicates on the basis of provider name and location matches but did not verify additional data elements for accuracy.

[54] We did not collect additional identifying information, such as provider names and address information, of the external providers health centers reported contracting or referring patients to in 2022.

[55] 42 U.S.C. § 254b.

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