REHABILITATION & COMMUNITY PROVIDERS ASSOCIATION

Center for Rural Pennsylvania
Public Hearing Testimony - New Developments in the Opioid and SUD Crisis in Rural Pennsylvania
Regulatory Solutions to a Workforce Crisis

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My name is Jason Snyder, and I am a director of the Behavioral Health Division of the Rehabilitation and Community Providers Association (RCPA), where I am also the Substance Use Disorder (SUD) Treatment Services Policy Director. RCPA represents approximately 400 licensed addiction treatment facilities in Pennsylvania. Prior to joining RCPA, I was director of strategic partnerships for Pinnacle Treatment Centers, a large addiction treatment provider with nearly 130 facilities across the country. I also worked for Pinnacle as regional director of operations, overseeing seven opioid treatment programs. I have significant experience working in state government as well. I served as special assistant to the secretary of the Pennsylvania Department of Human Services (DHS), where I oversaw implementation and operations of the Opioid Use Disorder Centers of Excellence. I also was communications director for the Pennsylvania Department of Drug and Alcohol Programs (DDAP). I am a lifelong Pennsylvanian, having grown up in rural Cambria County. I also am in long-term recovery from the disease of addiction, although I lost both of my siblings – my two brothers – to drug overdose deaths.

By now, no one should be surprised to hear about the crisis addiction treatment providers face in maintaining a workforce. In fact, in October 2021, the Center for Rural Pennsylvania commissioned a report on recruitment and retention of addiction treatment counselors in rural Pennsylvania, so I recognize this board is very familiar with the issue.

What is surprising, frankly, is that providers have managed to hold onto to enough staff to keep their doors open and to enable a network of providers across Pennsylvania. Beyond those issues the Center for Rural Pennsylvania's report identified, we know the system asks more and more and more of our providers and our clinicians, and little of it objectively improves the quality of treatment. In fact, it can be argued that much of what our providers are forced to do by regulators and payers hinders access to quality treatment. Rather, it can be summed up as increasing administrative burden.

Decades-old regulations that have long outlived their utility have gone beyond burdensome to become significant barriers to accessing addiction treatment for many of Pennsylvania's most vulnerable people. Addiction treatment providers' current inability to fill open positions as a result of an unprecedented workforce crisis and the ill-timed

mandate by DDAP to implement a new treatment system framework have not only weakened the treatment system's ability to meet demand for services, but worse, have forced providers to turn patients away despite having capacity to treat them.

When I first started working for DDAP in 2015, the Commonwealth was just beginning to realize the significance of the opioid epidemic. In fact, one year earlier, in 2014, the Center for Rural Pennsylvania helped advance our collective understanding of what was happening as it conducted four hearings across the Commonwealth on what we were then calling the heroin epidemic. As part of my role with DDAP, I traveled all over Pennsylvania with the governor and the DDAP secretary, and everywhere we went, one of the main topics of discussion was beds. We'd hear about the dearth of beds and the long wait lists. Every bed was full. You couldn't get anybody into residential treatment, so the story went.

Fast forward to 2023. We're in the third generation of this ever-worsening opioid epidemic. We've devolved from OxyContin, to heroin, to fentanyl. People are losing limbs and lives to "tranq dope," which is xylazine-laced fentanyl. We continue to hear about the rise in the use of methamphetamine, especially in rural Pennsylvania. Alcohol use disorder never went away, killing more than 140,000 people annually.

In other words, years later, the situation is no better. And although rural Pennsylvania still lacks adequate access to addiction treatment, today, the capacity that does exist there, like capacity across all of Pennsylvania, is going unused. Although beds are not the answer for everyone, there are beds available. Outpatient facilities operate at a fraction of their previous, or necessary, capacity. At our opioid treatment programs, where we provide evidence-based, FDA-approved medication that is proven by research and data to reduce overdose deaths, providers are expected to turn away those who seek help, even if the provider has capacity on its license, if the counselors currently employed there would have to take on a higher caseload than regulations allow, because the provider can't hire enough counselors in this workforce crisis.

And that is what I'm here to talk to you about today: decades old regulations that do little to ensure or enhance quality treatment and that, in fact, in an unprecedented workforce crisis, are one of the biggest barriers to treatment.

Our problem today is not capacity-related. Our problem is now two-fold: 1) our inability to hire counselors and nurses because reimbursement for services is inadequate to meet unprecedented salary demands and a subsequent dearth of qualified candidates; and 2) regulations that exacerbate this workforce crisis.

When we ask our provider members what regulations are most in need of revision, they will frustratingly grin and tell us they don't even know where to begin to answer that question.

So RCPA has convened a regulatory reform work group comprised of SUD treatment providers to attempt to prioritize where regulatory reform can have the biggest, most immediate impact.

Before the first meeting of the work group, we asked all of our provider members to provide us with their thoughts on which regulations we should focus. We received many responses, but the ones we received most often focused predominantly on three areas:

1. Staff-to-patient ratios;
2. Unnecessary administrative burden (i.e., treatment plan updates); and
3. Staff qualifications, supervision and training.

Staff-to-patient Ratios

There is no evidence or data supporting the safety or effectiveness of staff-to-client ratios in addiction treatment. In fact, the American Society of Addiction Medicine (ASAM) Criteria, the framework in which Pennsylvania providers treat addiction, makes no recommendations on ratios at any level of care. Rather, the ASAM Criteria recommends the *composition* of care teams, with a goal of delivering quality services by a knowledgeable multidisciplinary, credentialed team. (In 2021, DDAP mandated treatment providers to treat patients within the ASAM Criteria without making any changes to its regulations, meaning the ASAM Criteria have been layered on top of already existing regulations, essentially forcing providers to comply with outdated regulations and a separate comprehensive set of new criteria acting but not technically defined as regulations.)

Further, surrounding states which adopted ASAM Criteria well before Pennsylvania have either no ratio regulations or significantly larger ratios, choosing to allow providers that are required to staff with licensed and credentialed counselors—as Pennsylvania providers are – the flexibility to treat individual patients in the manner and through a combination of professionals that is best for them.

Right in our own Commonwealth, on the mental health side of behavioral health, there are no regulations governing staff-to-patient ratios.

As we work toward integration of not only physical and behavioral health, but mental health and substance use disorder, Pennsylvania's dually-licensed facilities often are conflicted with contradictory regulations, beholden to both DDAP and the Office of Mental Health and Substance Abuse Services, while treating patients with mental health issues and SUD.

Two stark examples illustrate how outdated regulations are exacerbating the current workforce crisis and forcing open treatment slots offline because of providers' inability to meet regulatory ratios.

First, so far in 2023, Gaudenzia, the commonwealth's largest nonprofit addiction treatment provider with approximately 60 residential facilities within its organization, has had to reduce its bed capacity by more than 10 percent because of counselor shortages. In other words, the capacity is there, but patients are turned away from a safe rehabilitative environment back to the street. Those who may seek treatment at a lower level of care as an alternative may well find the same situation – no ability by the outpatient provider to accept them, either. In fact, at any level of care, the same thing can be said. In Gaudenzia's case, increasing the client-counselor ratio to be more in line with today's reality would immediately bring these beds back online and allow the agency to treat at least 100 more individuals monthly while still prioritizing high-quality, effective clinical care.

Second, many of our opioid treatment programs, which provide medication that has been proven to lower opioid overdose death rates, have been forced to stop taking patients, not because their license capacity is full, but because of citations for non-compliance with counselor-to-patient ratios. Because a counselor may carry a caseload beyond what is allowed by regulations or a patient may not get the number of hours of therapy in a given month required by regulation, providers are forced to turn away a patient or face citations and the threat of provisional licenses.

What this amounts to at any level of care – residential or outpatient – is a willingness by the regulator to risk the death of an individual in need of treatment over allowing that individual to access life-saving treatment if it means noncompliance with an unfounded regulation.

Administrative Paperwork

We cannot have a discussion about reforming unfounded ratios without discussing how to reduce the already-overburdening paperwork that comes with the provision of addiction treatment, not only through regulation but a multitude of other requirements by other overseers (i.e., payers) of providers.

One of the most egregious of these is the treatment plan update.

In early treatment, rarely do our patients make the kind of progress that requires the need for a treatment plan update every 30 days. The smallest of treatment goals are sometimes major hurdles for our clients, and at the residential level of care, they have relatively little time to make changes from a lifetime of maladaptive behaviors. This frequency not only is illogical relative to our patients' rehabilitation efforts, it puts added pressure on counseling staff to create goals that might not be relevant to the recovery of the clients, let alone the unnecessary added burden.

Conversely, at the outpatient level of care, in particular at our opioid treatment programs, treatment plan updates are mandated by regulation every 60 days. Many of our patients remain engaged in treatment for years, achieving stability and productivity. For these patients, a treatment plan update every 60 days is unnecessary and burdensome.

Lastly, inherent in Pennsylvania's addiction treatment system is the multiple sets of requirements enforced by five behavioral health MCOs, 47 single county authorities, DDAP and OMHSAS. These varying oversight bodies, each of which conducts its own annual audit of providers, require differing documentation, adding significant administrative burden to providers, forcing providers to focus on paper over clinical work. It is not uncommon for an addiction treatment provider to undergo five to 10 or more audits every year. Streamlining the audit process will lessen the paperwork burden and enable currently employed staff to focus more on clinical treatment. We need a mandate to enforce consistency in the system.

Additional Barriers to Access

Several other regulatory issues are creating barriers to treatment access. Under the ASAM Criteria, providers are required to hire licensed or credentialed counselors, as well as comply with regulations that limit who can be a counselor depending on degree and experience. In a workforce crisis, this greatly limits the candidate pool. Additionally, current counselor supervision ratios also limit the number of counselors a provider can employ at any given time, and the scope of training, especially for new staff, is burdensome and disincentivizes new staff to stay through the orientation period. Although training new staff is a must, a recalibration of regulations governing supervision and training can significantly and positively affect the workforce crisis.

Solutions

Recognizing that regulatory reform takes time – in most instances at least two years – RCPA on behalf of its addiction treatment providers is asking the Center for Rural Pennsylvania and the legislators and other influencers on its board to help not only rural Pennsylvanians but all Pennsylvanians in need of addiction treatment get access to it through immediate emergency measures while on a parallel track focusing on substantive, meaningful regulatory reform.

The DDAP secretary has the ability to grant a blanket exception to state regulations in furtherance of sound program implementation. Although we recognize *individual* facility exceptions can and are occasionally granted through a waiver process, they are time limited and themselves a burden to submit, especially for our largest providers that need them for many. We encourage the Center for Rural Pennsylvania and any legislator who is on

this board to compel the secretary, through a combination of meetings, additional committee hearings, legislation and request to the Independent Regulatory Review Commission to immediately address the concerns outlined in this testimony in the short-term while reviewing and amending these and other regulations to improve over the long-term access to addiction treatment in Pennsylvania.