Pennsylvania House Human Services Committee
Informational Meeting on Opioid Use Disorder Centers of Excellence

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I want to thank the members of the House Human Services Committee for hosting this hearing and inviting me to testify before you today.

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 SUD Treatment Services Policy Director. RCPA represents approximately 400 licensed addiction treatment facilities. 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, having served as special assistant to the secretary of the Pennsylvania Department of Human Services (DHS) and communications director for the Pennsylvania Department of Drug and Alcohol Programs (DDAP).

In 2016, I had the great opportunity to watch and participate in the launch of Pennsylvania's Opioid Use Disorder (OUD) Centers of Excellence (COEs). In fact, my role at the Department of Human Services (DHS) as special assistant to the secretary was exclusively to support the implementation and operation of the COEs. Today, with a changed vantage point but still close to the COEs, it is clear to me that the integrity and sustainability of a program that has expanded access to evidence-based treatment for OUD, kept people engaged in treatment longer, integrated physical and behavioral health care, and provided community-based care management and peer support services to address other health-related social needs, is in serious jeopardy.

What's at Issue? Variability, Inconsistency, Inefficiency, Redundancy, and Inadequacy

For six years, COEs have operated against one set of requirements, submitted data to one entity, and received consistent reimbursement for services, regardless of which MCO provided coverage for a COE client, all under the direction of DHS. That is no longer the case. Today, COEs are under extreme administrative burden resulting from inconsistency, redundancy, inadequacy, and inefficiency as each of Pennsylvania's behavioral health managed care organizations (BH-MCOs) implement: 1) new requirements beyond those already in existence; 2) new and additional data reporting policies; and 3) new payment models. Although providers of COE services bear the brunt of this burden, ultimately it is Pennsylvania's most vulnerable citizens seeking recovery from OUD who are most affected when

providers are forced to focus more on documentation compliance with various sets of policies and processes than clinical care.

At the heart of the issue today is DHS' — and more specifically its Office of Mental Health and Substance Abuse Services' (OMHSAS) — unwillingness to take a more proactive and direct approach with the Commonwealth's 24 primary contractors and five BH-MCOs to ensure an effective, consistent COE program. The result is the carte blanche given to BH-MCOs in interpreting, increasing, and enforcing compliance with COE requirements that were established by DHS seven years ago.

Why Were COEs Created?

In 2016, Pennsylvania was on course for 4,540 drug overdose deaths. In 2017, we saw a record number of 5,425 overdose deaths in Pennsylvania. The Commonwealth found itself in the midst of a crisis of historic portions. Fifteen Pennsylvanians were dying every day from a drug overdose.

We also knew that at that time, less than half (48 percent) of the Medicaid population diagnosed with an OUD were receiving treatment — and of those who were receiving treatment, only 33 percent remained engaged in treatment for more than 30 days. Simply put, Pennsylvania was not getting enough people into effective addiction treatment and those who were getting treatment were not staying in treatment long enough. The Commonwealth needed a solution to get more people into evidence-based treatment and keep them there longer, knowing that the greater the length of stay in the continuum of care, the greater the chance for sustained recovery.

Pennsylvania responded with the COEs, which were at the time the Commonwealth's single largest investment to address an opioid overdose death epidemic that was and still is out of control. It was a significant part of Pennsylvania's strategy to address the epidemic, and, for Medicaid patients, it aimed to: 1) expand access to evidence-based treatment, especially medication to treat OUD; 2) create community-based care management teams that would help individuals access treatment faster and remain engaged in the continuum longer; and 3) create a hub-and-spoke, no-wrong-door model that enabled greater integration of physical and behavioral health care in an effort to treat the whole person through community-based partnerships.

Forty-five behavioral and physical health providers, including primary care practices, hospitals, federally qualified health centers and Department of Drug and Alcohol program-licensed substance use disorder (SUD) treatment providers, each initially received a $500,000 grant to carry out this work. The funding was to be used mostly to hire a community-based care management team, including certified recovery specialists and care managers, because there was little to no reimbursement broadly available for behavioral or physical health providers to provide the care management support services envisioned for the COEs. The grant funding and, later, the DHS-directed per-member per-month payment (PMPM) acknowledged that for COEs to provide the services necessary to retain clients in treatment, keep them on a path of sustained recovery, and address other mental and physical health needs, flexible and alternative funding would have to be made available.

COEs: A Successful Program

Since their inception, COEs have proven to be successful.

Two years after the program launched, according to data collected by the University of Pittsburgh's Program Evaluation and Research Unit (PERU) and published in a paper on the COE program's results, more than 70 percent of the Medicaid population diagnosed with an opioid disorder was now receiving treatment, and of that group, 62 percent remained in treatment for more than 30 days. As previously described in this testimony, in the days before COEs, just 48 percent were receiving treatment and, of

that group, only 33 percent remained engaged in treatment for more than 30 days. In addition, follow-up within seven days after an OUD-related emergency department visit increased 51 percent and the number of primary care visits increased 46 percent.

For the first quarter of 2023, according to data collected by Pitt PERU, 65 percent of new clients enrolled in COEs statewide returned within one calendar month after the last face-to-face care management service they received for ongoing recovery and care management support. Top-performing COEs have a return rate of over 80 percent. Why does retention matter? Because the longer someone stays engaged with the system, the greater the chance of long-term recovery.

In assessing COE effectiveness, one BH-MCO correlated increased access to medication to treat opioid use disorder (MOUD) to increased retention in treatment, finding that some COEs, including those in rural areas, had retained nearly 50 percent of their patients one year later.

DHS found the program so worthwhile that in 2020 it expanded the program, resulting in an increase to more than 250 COEs across the state. And that number is likely higher today.

From One Payment Model and Set of Requirements to Wide Variation

Then, in 2021, DHS began transitioning COEs from a directed payment model into managed care through Pennsylvania's Medicaid State Plan and Medical Assistance Program Fee Schedule. In Pennsylvania, five BH-MCOs are charged with managing quality while reducing costs of care for those with Medicaid. What this has meant for providers of COE services is a disjointed, inconsistent set of multiple guidelines, requirements, policies, processes and payment models. What had been one set of requirements and one payment model has become splintered.

This transition has been fraught with immense challenges for providers of COE services, which ultimately negatively affects their ability to provide life-saving services to Pennsylvania's most vulnerable citizens.

The result of the transition thus far has resulted in:

1. Inconsistency and inefficiency: As one example, COEs are required to provide screening and assessment services to identify a client's health-related social needs, most appropriate level of OUD treatment, and risk for suicide. But MCO expectations and requirements of screening and assessment services – along with essentially all other requirements – vary and go beyond what DHS requires. Because of that, documentation requirements also vary. What this means is that one COE that is in network with, for example, three different BH-MCOs will have to follow three different sets of requirements and document three different ways to comply with three different MCOs.
2. Redundancy: Since the COEs began operating in 2016, they have been required to submit large amounts of data to demonstrate the work they are doing. Pitt PERU has done most of that data collection, which is contracted by DHS to provide technical assistance and data collection and analysis. Pitt PERU has collected stacks of data in seven years, yet in conversations with MCOs, they indicate that DHS has refused to allow them access to provider-specific, de-identified data that could help them better manage the COE program. As a result, MCOs are requiring COEs to submit data that they are already submitting to Pitt PERU.
3. Inadequacy: In 2019, when the COE program changed from a grant-funded program to DHS-directed payment by the Commonwealth's MCOs, DHS' actuary developed a PMPM rate based on the requirements that COEs must fulfill and the staffing level/mix needed to fulfill those requirements – essentially what is considered an actuarially sound rate. Then on Jan. 1, 2023, the DHS-directed payment expired and MCOs were no longer required to pay the actuarially sound PMPM. Although some MCOs continue to pay the original PMPM while indicating that a

move to value-based payment is on the horizon, others have stopped paying it. In one instance, providers are required to submit a claim for each patient encounter, and each encounter is paid separately rather than under a PMPM at a significantly reduced rate. At the same time, the administrative and clinical requirements have increased for COEs and the behavioral health field is in a workforce crisis, meaning what was actuarially sound in 2022 is now inadequate.

Significantly different expectations among and directives from BH-MCOs of what the COEs are to do creates confusion and unnecessary administrative burden, especially for those who contract with multiple MCOs, and risks program integrity and sustainability.

Some BH-MCOs are modifying and expanding requirements in such a way as to introduce processes that weren't required for seven years. Some BH-MCOs are signaling a relegation of the hallmarks of care management and recovery support while emphasizing clinical focus. Yet, only months ago, DHS re-asserted that care management is, in fact, the foundational element of the COEs.

These changes have forced COEs that have operated one way for six years to now suddenly become different programs operating under the COE umbrella. Providers that operate multiple COEs in Pennsylvania and contract with multiple BH-MCOs are even more burdened. There simply is no way to efficiently and effectively serve five different BH-MCOs with five different sets of requirements as a COE.

Strengthen Rather Than Dismantle an Existing Model of Integration.

In October 2023, Governor Shapiro signed an executive order establishing a Behavioral Health Council in Pennsylvania. In addition to addressing how to break down silos and deliver timely and quality mental health and addiction care services, the council will also address how to best integrate mental health and substance use disorder services with a patient's primary care provider by working hand-in-hand with state and local agencies, commissions, or organizations already engaged in the delivery of these services.

In January 2024, the Centers for Medicare & Medicaid Services announced a plan to launch a new integrated behavioral health model in eight states to test a no-wrong-door approach to providing behavioral and physical health as well as health-related social needs. This approach is intended to close gaps between behavioral health and physical health, allowing for care continuation regardless of where an individual accesses care.

What Governor Shapiro and CMS want exists in Pennsylvania with approximately 300 COEs. Integrated care is clearly the direction behavioral health and, in fact, health care in general is headed. Seven years ago, Pennsylvania had a vision for improving OUD treatment with an integrated, hub-and-spoke model that also worked toward a no wrong-door approach.

Why not continue to sharpen and expand this model through a more coordinated effort, rather than allow it to be dismantled by the extreme variance being introduced today?

We can debate the merits and components of the COEs. The same can be done for any program. There absolutely are areas for improvement and continued refinement. DHS has said it would expect the program to evolve over time. The providers agree — evolve. Not devolve.

Guide rails are one thing. Five varied sets of guidelines for one program is another.

DHS established very specific guide rails in July 2020 when it expanded the program to all Medicaid providers and announced the process for enrolling as a COE. These are the same services outlined in Appendix G of the Program Standards and Requirements contract DHS holds with the Commonwealth's

primary contractors to provide behavioral health services. That is and should remain the COE program. A COE cannot be defined, managed, and reimbursed five different ways.

RCPA, on behalf of its SUD treatment provider members, has repeatedly asked DHS to enforce consistency in the COE program from MCO to MCO, but it has not happened.

Our ask, then, of the House Human Services Committee, the House of Representatives, and ultimately the General Assembly, is to step in and address this inconsistency. COE operators should be held accountable to one set of requirements – no more and no less – across five BH-MCOs. Across five BH-MCOs, they should be assessed against those requirements with one audit tool that very specifically describes how a COE will document and demonstrate compliance with those requirements, all while recognizing that DHS has established and publicly communicated an actuarially sound per-member per-month rate that enables the COEs to meet the requirements set forth by the department.