pennsylvania
DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS

House Resolution 590 of 2015

Adopted May, 2016

Report of the Task Force Regarding Barriers to Accessing Substance Use Disorder Treatment and Benefits

September 2017

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COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS

Sept. 1, 2017

Dear Members of the General Assembly of Pennsylvania:

House Resolution 590 of 2015 directed the Department of Drug and Alcohol Programs (DDAP) to establish a task force to study access to substance use disorder treatment through health plans and other resources. As part of its work, the task force held public hearings across the commonwealth, asked for public comment through the DDAP website, and reviewed applicable state laws and regulations to assist individuals in accessing treatment.

The *Report of the Task Force Regarding Barriers to Accessing Substance Use Disorder Treatment and Benefits* presents an overview of the treatment system, some essential factors in understanding substance use disorder, and some challenges identified by individuals, families, stakeholders, insurers, and others. The report includes recommendations for the legislature to help remove barriers to treatment, and some recommendations for state departments with oversight of specific issues.

The comprehensive report is posted at: http://www.ddap.pa.gov/treatment/Pages/HR-590_Access_to_Treatment.aspx.

Thank you for the opportunity to provide information about access to treatment for substance use disorders (SUDs). We will continue working with the General Assembly, Governor Tom Wolf, and other state departments to combat the opioid epidemic. Our shared goal is clear – to provide proper access to treatment for Pennsylvanians suffering from SUDs.

Sincerely,

Jennifer S Smith

Jennifer S. Smith
Acting Secretary, Department of Drug and Alcohol Programs

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The Department of Drug and Alcohol Programs would like to expressly thank Congressman Patrick Kennedy for lending credence to this process with his participation in the inaugural hearing in Philadelphia.

Additionally, thank you to the Lieutenant Governor, members of the Pennsylvania legislature, district attorneys, and county commissioners who served as guest panelists or gave introductory remarks at the hearings.

Note: The Task Force was formed in accordance with HR 590 with representatives from the Department of Drug and Alcohol Programs, Department of Human Services, Department of Health, and the Pennsylvania Insurance Department. Through the course of the work, it was realized that there were other agencies that have input and duties related to the delivery of substance use disorder services. Although HR 590 did not require participation from the Department of Corrections, there was consultation with them when developing the document. If the Task Force is requested to continue work as recommended in this report, it would be important to add such agencies as the Department of Corrections, Department of Aging, Department of Transportation, and the Office of Attorney General to complete the ongoing efforts of the Task Force.

Executive Summary

Priority Recommendations for the Legislature

House Resolution 590 of 2015 (HR 590) charged the Pennsylvania Department of Drug and Alcohol Programs (DDAP) to establish and administer a task force to examine access to addiction treatment through health plans and other resources. This task force, hereafter referred to as the "Task Force", was to review public comment and testimony from hearings, including testimony from those who have lost their loved ones. Furthermore, the Task Force was directed to:

1. Review compliance with relevant laws,
2. Review tools used to evaluate and enforce access to care; and,
3. Report on the findings, including potential legislative remedies as appropriate.

Based on the findings of the Task Force, there were three key areas of concern: funding, regulatory compliance, and infrastructure capacity, all of which impact access. While DDAP coordinated the Task Force, the recommendations contained within are comprised of recommendations of the Task Force deliberations based on public comment and testimony.

Key recommendations are summarized below:

1. **Funding:** In Pennsylvania, funding has been limited, inhibiting provider reimbursement and workforce salary. The National Association of State Alcohol and Drug Abuse Directors (NASADAD) describes funding for the Substance Abuse Prevention and Treatment (SAPT) Block Grant over the past decade and emphasizes that when accounting for health care inflation, the Block Grant has lost 29% of its purchasing power. For Fiscal Year (FY) 2017, the SAPT Block Grant is level-funded at $1.854 billion. The program would need an increase of $542 million in FY 2018 in order to restore it to FY 2006 purchasing power. While the Block Grant and state allocations have historically gone to fund those services, which are foundational for the initiation of care and recovery, generally, these have not been sustained in a manner that provides for the full range of services or for the appropriate length of time. In fact, while there has been additional funding for worthwhile special projects, cuts at the state level for traditional, foundational services have also occurred. Numerous concerns presented in the hearings indicated that the rate of program funding is not adequate to support the rich array of needs in the treatment setting. A Substance Abuse and Mental Health Services Administration's (SAMHSA) workforce study found substance use disorder (SUD) counselors in Pennsylvania are paid lower than other disciplines and less than all other states in our region except West Virginia.[5] To begin to address these issues, the Task Force recommends that:

    a. The legislature should ensure maximum fiscal support for the full continuum of care in Pennsylvania including: prevention, intervention , hospital and non-hospital

[i] *Intervention is a professionally directed, education process resulting in a face to face meeting of family members, friends and/or employer with the person experiencing difficulty with his or her substance use. Those who have a substance use disorder are often in denial about their situation and may not see a need to seek treatment because of this inherent symptom of the condition. They may not recognize the negative effects their behavior has had on themselves and others. Intervention helps the person make the connection between their use of alcohol and drugs and the problems in their life.*

detoxification, hospital and non-hospital (short-term and long-term) residential rehabilitation, halfway house, medication assisted treatment, partial hospitalization, intensive outpatient, outpatient and ongoing recovery maintenance.

b. Provide the funding necessary to support the administrative recommendations to be accomplished by state agencies and stakeholders as identified throughout this document.

c. Fund the mandates of Act 50 of 2010 at levels reflective of existing treatment needs and the rapidly escalating opioid epidemic.

d. Fund workforce incentives such as new employee, counselor longevity or loan forgiveness incentives.

2. **Access to Services through Health Plans:** Testimony at public hearings and written comments submitted as part of the HR 590 process indicated that individuals, family members, and providers often have difficulty determining the benefits that are available through a health plan, including how to access substance use treatment services or what services are covered. Pennsylvanians receive coverage from a variety of sources, and therefore methods of access to necessary services, the affordability of those services, and the ability of the Commonwealth to assist with access to services also varies. Further, because of this inconsistency, Single County Authorities (SCAs) may be using their limited financial resources to pay for services for individuals enrolled in other health plans, an outcome which should be avoided whenever possible to preserve these essential resources for those most in need. To assist individuals and family members in understanding what benefits are available and how to access substance use treatment, it is recommended that the following occur:

   a. Due to the ongoing heroin use and opioid abuse epidemic, consumers must be given better information about the benefits available under their health plan.

      I. In response to the opioid epidemic, health plans should immediately provide information to beneficiaries about the SUD benefits covered under their plan and the process to access those benefits. Such information should be provided in a clear, concise, and consumer-focused manner. The notice to beneficiaries should also include information on the Insurance Department's consumer complaint process and on assistance available through the SCAs.

      II. Further, plans subject to Act 106, the Pennsylvania law that mandates many health plans provided by employers to cover substance use disorder treatment, should identify that they are in fact subject to Act 106 on an individual's insurance card to assist consumers and providers in efficiently accessing those services. The information provided to Pennsylvanians covered by Act 106 plans should delineate all services available including family and intervention services.

   b. Consumers should be given information on where they can go to seek help if their health plan becomes a barrier to access or if they do not have coverage.

The goal of intervention is to present the alcohol or drug using individual with a structured opportunity to accept help and to make changes before things get even worse. (National Council Alcohol and Drug Dependence).

I. Specifically, efforts should be undertaken to ensure consumers are aware of the SCAs available to help them access treatment and of the Insurance Department's consumer complaint process than can help them address issues with most private insurance coverage.

c. There should be increased awareness about the availability of coverage for critical services.

I. As an example, Task Force members identified a lack of awareness that Act 106 mandates that health plans governed by the law also include coverage for family counseling and intervention services, as well as substance use treatment services, services the Task Force believes would have a significant impact if utilized more frequently and effectively.

d. Health plans should be transparent about and accountable for the access they provide to SUD benefits, and information on measures of access should be made publicly available, and updated regularly, on DDAP's website.

I. Such information should include, at minimum, the number of individuals served in each level of care, the average length of stay in each level of care, the number of appeals related to access for these services, and the resolution of those appeals.

II. Insurance companies should be required to perform annual compliance audits on the use of plain language in consumer materials.

3. **Strengthening the SUD Service System:** The powers and duties of the Pennsylvania Drug and Alcohol Advisory Council should be enhanced to more actively advocate for, recommend, and affect necessary improvements to impact the delivery of and access to care over an extended period of time to develop and sustain long term recovery. The structure should be expanded to include partner state agencies and key stakeholders (i.e. parent, provider, recovery organizations). Additional committees should be added as appropriate, to include people and families with lived experiences.

4. **Infrastructure:** Through the HR 590 Task Force process, consistent testimony indicated that needed services were not available or that funding and reimbursement levels across the system fall below the level required to provide necessary care. This was particularly true in rural communities. The Task Force recommends that:

a. The legislature should encourage infrastructure development and expansion using vacant state buildings for use by substance use treatment and service providers.

b. Provide tax incentives to providers and/or communities willing to support the expansion of services, thereby reducing the "not in my backyard (NIMBY)" mentality.

c. Health plans should report their reviews of network adequacy to the Department of Drug and Alcohol Programs in compliance with the coordination of care requirements of Act 50 of 2010.

d. SCAs should be utilized to identify delivery gaps in their local area, in collaboration with partner county agencies and key stakeholders (i.e. parent, provider, and recovery organizations).

5. **Combating Stigma:** It is known that "compared to many other medical and psychiatric illnesses, Substance Use Disorder is a good prognosis disorder. It is estimated that between 42%-66% of people with substance use disorder achieve full remission, although it can take time to do so."[2] These conditions are highly stigmatized, yet research shows that portraying them as treatable helps change public perceptions in a positive manner.[3]

    a. It is recommended that a campaign occur, educating that recovery from SUD is a reality, just like other medical conditions. This should use recovery affirming language to reduce the use of stigmatizing language such as "clean" or "dirty"; to use person first, recovery affirming language such as "person with a substance use disorder";[4] and further consider using such recovery affirming language in bills, proclamations and public policy documents across state government.

6. **Moving Forward:** The HR 590 Task Force was able to obtain a significant amount of citizen and stakeholder input. Fifty-six scheduled testimonies along with additional open testimony was provided through seven public hearings. In addition, 207 comments were received during a month-long open comment period via DDAP's webpage. As well as gathering public input, the Task Force examined laws, regulations, compliance and audit tools in a systemic fashion. However, review of these laws, regulations, and audit and compliance tools could not be done in a comprehensive manner due to the relatively short duration and magnitude of the charge. Therefore, the Task Force respectfully makes the following additional priority recommendations:

    a. The legislature should mandate the creation of a workgroup to identify data needs and other gaps for critical objectives of the Task Force. The workgroup should consider meeting with the Mental Health Parity project that is underway at the Insurance Department to see if similar data needs could be better met by both groups working cooperatively.

    b. That a task force comprised of current members of the HR 590 Task Force and others to be added as appropriate should be required to continue to meet quarterly to assess the ongoing progress of the recommendations noted throughout this document and conduct a comprehensive analysis of compliance and audit tools to determine their degree of effectiveness.

Note: While the priority recommendations to the legislature are noted above, additional recommendations for legislative and administrative consideration are included throughout this document.

Background of the Report

House Resolution 590 of 2015 (HR 590) charged the Pennsylvania Department of Drug and Alcohol Programs (DDAP) to establish and administer a task force to examine access to addiction treatment through health plans and other resources. The Task Force was directed to evaluate Pennsylvanians' access to services for addiction treatment which was to be achieved through a review of public comment and testimony from hearings, including testimony from those who have lost their loved ones. Furthermore, the Task Force was directed to:

1. Review access to treatment under relevant laws;
2. Review tools available to evaluate and enforce compliance and access to treatment;
3. Report on the findings, including potential legislative remedies as appropriate.

During the month of August 2016, as announced through its web and announcement pages, DDAP received 207 comments via an open input and comment opportunity using Survey Monkey. Formal testimony was heard from at least 56 scheduled testifiers and additional unscheduled testifiers at seven formal public hearings held regionally across the commonwealth in the following locations:

- Philadelphia (2 hearing dates) – September 7, 2016 and December 6, 2016
- Wilkes Barre – September 21, 2016
- Pittsburgh – October 14, 2016
- Harrisburg – October 18, 2016
- Williamsport – October 27, 2016
- Erie – November 29, 2016

A full review of the hearing dates, locations and published testimony can be found at http://www.ddap.pa.gov/treatment/Pages/HR-590_Access_to_Treatment.aspx.

INTRODUCTION TO SUBSTANCE USE DISORDER (SUD) AND THE SUD TREATMENT SYSTEM IN PENNSYLVANIA

a. According to the American Society of Addiction Medicine, "addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social, and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. Addiction is characterized by inability to consistently abstain, impairment in behavior control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction can involve cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death."[5]

   Because of the impact of the SUD on the brain and its circuitry, along with physical withdrawal symptoms, denial and craving to use despite problems associated with use is a predominant factor of the illness. Therefore, the window of willingness or opportunity to engage an individual with an SUD into treatment is critical and often short. Funding, capacity or other limitations of the system are deterrents to care and recovery. Although treatment may not have been available during a person's readiness for help, it is the individual who is blamed and further stigmatized for continued use. Stigma further perpetuates the SUD, thereby contributing to a vicious cycle.

Furthermore, while medical science lends credence to the disease of SUD, it is not treated similarly to other chronic illnesses such as diabetes, high blood pressure, asthma, etc. As a society, those with cardiac conditions are treated with respect and dignity rather than shamed or regarded with disgust for smoking, overeating or other behaviors that may have contributed to the condition. Neither are cancer patients given only an insignificant portion of necessary care to eradicate and successfully treat their illness, only to be blamed for a reoccurrence of cancer cells or a tumor. It would not be permissible if individuals dealing with a carcinoma would be treated in this manner and yet it has been, and continues to be, the status quo of public opinion regarding individuals with a SUD. The same widespread awareness efforts to educate and inform the public regarding the disease of SUD as these other chronic illnesses is lacking and further contributes to the challenges of providing appropriate and accessible care to those suffering with SUD, as well as their family members.

b. It is estimated that there are currently 1.28 million Pennsylvanians who are currently in recovery.[6] Recovery from SUD can be achieved through multiple pathways and recovery support services (RSS) are an integral part of the process to wellness. RSS can be used to engage a person's initiation into treatment and can provide ongoing support to treatment services. RSS open up new opportunities to extend the effects of professionally-delivered services and provide sustained care and intervention that cannot be delivered in an ongoing manner in the formal, licensed, clinical setting. Studies demonstrate that when an individual with an SUD is able to maintain abstinence and engage in recovery efforts for five consecutive years, there is greater likelihood for sustained, long-term recovery.[7] [8] "RSS can often be provided at little cost, reducing the burden on professional health services" while decreasing SUD remission rates.[9] With less remission and repeat use of treatment by the same individuals, the treatment system is then free to serve those individuals with unmet needs or who have never before received clinical services.

   Examples of peer-based recovery support services can include, but are not limited to, assisting individuals in developing a recovery plan in collaboration with providers, goal setting and task completion, time management, provision of recovery-oriented social activities, etc. These and other recovery supports such as housing, transportation, childcare, etc. strengthen an individual's capacity and resources for maintaining recovery. Through the combined access to treatment and RSS, the overall probability of recovery is strengthened.

c. The current opioid addiction and overdose crisis has brought to the forefront issues that strain the SUD service system. While this crisis has resulted in a greater demand for treatment services and an increased burden on the system, it should be noted that the barriers and issues noted within this document do not specifically result from the opioid crisis and have broad application regardless of the substance of abuse or need for treatment. There are systemic issues that affect SUD across a range of substance and polysubstance use. Alcohol, cocaine, and marijuana remain common primary substances of use. There tends to be an historical trending of substance use crises which indicates that the overall focus of care needs to be for SUD treatment and recovery in general, rather than entirely focusing on the current opioid crisis. This document is meant to apply to both the current crisis as well as the overarching needs within the system.

While this report will identify systemic challenges and suggest potential remedies for addressing them, various policies currently being debated on the national level such as changes to the federal Affordable Care Act (ACA) and the Centers for Medicare and Medicaid Services' Final Medicaid Managed Care Rule (and specifically the Institution for Mental Disease (IMD) change included within the final rule) have the potential to shape this discussion.

Key Findings of the Task Force

The open public comment period, along with information presented in the seven public hearings garnered common themes and key barriers including, but not limited to: issues related to treatment capacity; accessibility, including the need for services that address specialized needs; insurance or funding issues; client-related concerns including the impact of stigma; under-funding of the treatment system in general; and, lack of support services for recovery maintenance. Recommendations for addressing each of these findings are included below.

CAPACITY

As previously indicated, at the time of this writing, Pennsylvania has 785 licensed facilities that, together, provide a rich array of services that cover the full continuum of care including:

- Outpatient
- Intensive Outpatient
- Partial Hospitalization
- Halfway House
- Medically Monitored Inpatient Detox
- Medically Monitored Short Term Residential
- Medically Monitored Long Term Residential
- Medically Managed Inpatient Detox
- Medically Managed Inpatient Residential

There was an increase in capacity to serve individuals created as part of Governor Wolf's decision to expand access to Medicaid to individuals below 138 percent of the Federal Poverty Level (FPL). However, during the hearing process, it became apparent that there is a general lack of capacity to meet the growing demand.

Pennsylvania has a significant number of quality treatment providers across the continuum of care, but, as noted anecdotally during the hearings, there is not enough capacity to meet the demand of those individuals who are currently in need of treatment. It is estimated that approximately 2,591,000 people in the United States are impacted by an opioid use disorder alone.[10] When individuals with other SUDs are factored in, it appears that the demand for treatment far exceeds the capability to provide the service.

As an example, in a survey conducted by DDAP in May 2016, 68% of all available detox facilities reported operating at full capacity 6-7 days per week. There are currently 67 inpatient detoxification facilities located in 33 counties in Pennsylvania (which means there are 34 counties in which there is no detox facility).

While the present crisis provides a good rationale for treatment providers to expand their services by adding beds to existing facilities or opening new facilities, various factors have inhibited this provider growth. DDAP has been rapidly approving expansions and new facilities, over 81 new facilities have opened in the past year, but many programs have already fully expanded to the capacity that can be safely managed in their physical location, as defined by regulation. Some testimony indicated that licensing regulations which have not been updated for some time may sometimes contribute to provider hardships regarding program expansion (e.g., difficulties in obtaining licenses and PROMISe numbers). Since its inception, DDAP has been engaged in an extensive process to update regulations which have been in existence for decades, while ensuring client safety is not compromised. In the field, difficulties with professional recruitment or retention of staff due to inequitable or insufficient salaries are often in direct correlation to inadequate and low reimbursement rates paid to providers for services rendered. Providers reported either not receiving rate increases for several years or indicated that the rates received do not adequately cover the cost of doing business. In addition to lack of financial resources for bricks and mortar or to support adequate staffing, expansion to new or additional facilities is often hindered by stigma and a community's resistance to having a treatment program in their neighborhood; this is often referred to as "NIMBY", i.e. "not in my backyard." Program expansion would need to be matched with workforce expansion to correspond with this growth.[11]

For those providers that can afford expansion or for new providers opening for business, there may be circumstances where such efforts are stifled because that particular geographic area has been deemed by an insurance provider as meeting network adequacy. Network adequacy is the ability of a health plan to provide enrollees with timely access to a sufficient number of in-network providers, including primary care and specialty physicians, as well as other health care services to be included in the benefit contract. In such cases where an insurer/health plan has determined network adequacy has been met, it is possible that the new or expanding provider can be excluded as a network provider, thus eliminating eligibility for reimbursement by a particular insurer/health plan.

Further impacting the expansion of services is the potential effect of circumstances and actions that may occur around health care with regard to insurance and programming on a federal level, such as the overhaul of the federal Medicaid Managed Care Rule including the Institutes for Mental Disease (IMD) exclusion, which puts limitations on the number of residential treatment days eligible for Medicaid reimbursement, as well as the possible changes to the Affordable Care Act.

A lack of treatment capacity for any reason contributes to excessive waits for admission to detox and all levels of treatment. Given the need to optimize on a crisis or an individual's window of readiness to seek help, when someone must wait for days or weeks it frequently negatively impacts a person's motivation and can result in a reoccurrence of use, ongoing illness, and loss of life.

Identified Barriers

1. Need for Additional Facilities/Additional assessment and treatment slots.

Recommended Legislative Action:

1. Work with the Department of Community and Economic Development (DCED) and the Pennsylvania Housing and Finance Authority (PHFA) to prioritize community development funding toward substance use treatment.

2. Appropriate new and recurring revenue to support expansion of inpatient treatment facilities, outpatient treatment slots, and staff to provide licensure oversight based on need as identified by DDAP, DHS, and DOH.
3. Prioritize the development of legislation and appropriate resources to support a statewide awareness and education campaign in order to support expansion or creation of treatment availability in communities across the commonwealth and combat stigma/reduce NIMBY.
4. Work with state agencies to identify vacant state office buildings that could be repurposed/rezoned as substance use treatment facilities.
5. Mandate transparency in how "network adequacy" is determined for each type of coverage, so that potential providers can determine geographical areas where expansion is needed and better understand the process for becoming a network provider.
6. As a means of determining insurer accountability require a report be submitted annually by coverage source to the General Assembly and/or related oversight entities that provides a summary of:
    - Annual number of requests for drug and alcohol (D&A) service
    - Type of service required
    - Type of service received
    - Wait time for receipt of service
    - Number of denials for SUD specialists and/or recommended level of care
    - Number of appeals submitted to the insurer
    - Average response time for appeal resolution
7. Urge the Centers for Medicare & Medicaid Services (CMS) to reconsider the IMD limitations as outlined in the Medicaid Managed Care Final Rule, or to create a mechanism for states to waive this restriction as this limitation to service provision directly impacts not only adequate individual care, but provider sustainability and expansion.

Recommended Departmental/Agency Action:

1. DDAP should continue its work on the rate setting process that would increase SCA reimbursements to providers.
2. DHS should consider review of Medical Assistance (MA) rates and possible ways to increase reimbursements to providers.
3. DDAP should continue to work with the Governor's office and prioritize anti-stigma campaigns that include Public Service Announcements via television, radio, and print.
4. DHS and DDAP should collaborate on increased outreach around DHS's Medical Assistance (MA) Provider Enrollment website, which assists providers with enrolling as Medicaid providers and obtaining PROMISe numbers, resulting in expediency for reimbursement and ultimately faster service provision for individuals with SUD.

ACCESS AND AVAILABILITY OF SERVICES

Despite the incidence of overdose being at an all-time high, many individuals remain unaware of SUD as a treatable disease or of existing treatment services and how to access them. Individuals present in various health care settings with complex needs and different levels of motivation, so their first point of engagement can be a wide range of professionals, with varying degrees of expertise in conducting appropriate assessments. In Pennsylvania, SCAs are the conduit for

public funding for the continuum of services funded through the Department of Drug and Alcohol Programs and other state agencies funding the uninsured and underinsured. SCAs work with Behavioral Health-Managed Care Organizations (BH-MCOs) and private insurers to provide access to services that is seamless regardless of ability to pay. In many communities, this is an expanded role for the SCA - and the organization is not always well known as a resource, despite being the local entry point to the continuum of care. Throughout the public hearings, it was noted that a more consistent and appropriate naming of the SCA in each county may increase recognition, and ultimately provision of services to those most in need.

In many instances, standardized placement tools are utilized to determine the level of care needed by each individual. The two most currently utilized criteria in the commonwealth are the Pennsylvania Client Placement Criteria (PCPC) and the American Society of Addiction Medicine (ASAM) Criteria. Often times these tools are used in conjunction with the clinical expertise of the treating physician or SUD specialist. However, impediments to ensuring that proper placement occurs include the potential lack of fidelity to the placement tool/criteria or inconsistent application of the criteria due to client choice, criminal justice override, program availability, assessor training, payers requiring failure at a lower level of care prior to receiving the service determined by the PCPC or ASAM criteria or, funding limitations that may impact the receipt of the proper level of care.

Testimony revealed that there are times when individuals have been told that they are "not sick enough" to qualify for detox services, yet they cannot enter another level of care without having completed detox. Denying a person services or providing an improper level of care or length of care can have a direct and significant impact on the effectiveness of the treatment outcome. In such cases, the individual is often blamed for failure to comply with treatment, when in fact, the care that was needed for positive outcomes was not provided in the first place. In addition, treatment providers may be identified as providing poor quality care, when in fact if they were funded to treat individuals for an appropriate length of stay, outcomes would likely be significantly improved.

When an individual does receive the recommended level of care for the appropriate length of stay, the necessary supports for maintaining the abstinence and recovery that was initiated in treatment once discharged can often times be absent. Case management services were once widely available through providers and the SCAs. However, years of funding cuts have limited the availability of case management services as well as recovery support services located in the communities in which individuals reside. This is likely to have a significant impact on the continuity of services and use of the full continuum of care – from pre-engagement to recovery maintenance. Similarly, such support services may exist in a given region, but may not be covered by an individual's insurance plan.

Identified Barriers

1. Individuals/families do not know how to access services; the system is difficult to navigate.
2. There are few providers that deliver early intervention Strategies/Services to assist in motivating individuals and families to seek out necessary services and treatment including education, training and skill building.
3. There is a need for Quality Assurance & Improvement in applying placement criteria.
4. Assessors do not have access to real-time bed availability.

Recommended Legislative Action

1. Appropriate additional funding to the SCAs, through DDAP, to support increased case

management services and other services listed in barrier 2 above.
2. Legislatively mandate that DDAP and the SCAs (in collaboration with partner county agencies and key stakeholders i.e. parent, provider, and recovery community organizations) be involved in decision-making related to SUD service provision and allocation of funds.
3. Appropriate additional funding to DDAP and DHS to increase the availability of recovery support services, including Certified Recovery Specialists.
4. Prioritize legislation that requires all licensed SUD providers in the commonwealth, rather than only those that receive public funding, to submit bed/slot availability data to DDAP in real-time.

Recommended Departmental/Agency Action

1. DDAP should work with SCAs to increase the amount and quality of case management services that prioritize system navigation.
2. DDAP and DHS should collaborate to develop strategies for increasing the utilization of Certified Recovery Specialists.
3. DDAP and other state agencies should identify new ways to increase awareness of the SUD Hotline – 1-800-662-4357 (HELP) and awareness of county SUD entities (SCA's) in order to increase access to services.
4. DDAP should develop and implement evidence-based training programs for providers on the intervention process in order to increase the number of individuals engaging in treatment.
5. DDAP should develop an inventory of providers that currently provide intervention-related services and make that inventory publicly available to increase utilization of these services.
6. DDAP should work with the SCAs to increase the number of available intervention providers by utilizing the contractual relationship to prioritize resources/funding.
7. DDAP should ensure regular, statewide availability of training opportunities in the use of PCPC/ASAM placement criteria.
8. DDAP, DHS and PID should more stringently monitor compliance and application of the placement criteria.
9. DDAP should ensure that the full continuum of care is available in all geographic locations.
10. DDAP should ensure provider adherence to follow-up and aftercare requirements.

SPECIAL POPULATIONS

Pennsylvania has a number of specialty services for adolescents, pregnant women suffering from SUD, parents with children, programs specifically for criminal justice-involved populations, seniors, mental health concerns and more. Specialty services can include inpatient and/or outpatient treatment, Medication Assisted Treatment (MAT), or any combination of the three. While there are providers who engage in regular training to meet the unique needs of certain individuals, there remains a wide range of specialty population needs. These include specialized services for families, adolescents, seniors, criminal justice-involved individuals, or other culturally diverse or disparaged populations (including individuals falling under Megan's Law who sometimes cannot obtain services based upon restrictions of that law). In order to

address these health and population-specific disparities, interagency and external collaboration are key to enhancing cultural responsiveness.

Specialty Populations – Adolescent Services

Identified Barriers

1. Over the years, there has been a decrease in adolescent service providers across the commonwealth, particularly for the provision of residential rehabilitation services. From a public health perspective, this population should have a special focus.

Recommended Departmental/Agency Actions

1. DDAP should conduct a Needs Assessment to determine the gaps in the system of care at all levels of care, if and why they exist, and how to improve the gaps that are identified.
2. The needs assessment should pay particular attention to the prevention, early intervention and family service resources for this population.

Specialty Populations – Family Services

Identified Barriers

1. Family members may find it difficult to identify and access SUD services specifically tailored to families.

Recommended Departmental/Agency Actions

1. DDAP, DHS, and other family-serving agencies should increase public awareness that SUD is a "family disease" and that services are available for family members, as well as available funding such as block grant funding for uninsured individuals and families.
2. Through a Needs Assessment, DDAP should determine the availability of family services specific to SUD and create and publish a directory of providers.
3. PID should increase awareness of Act 106's mandate for the payment of family services to Act 106-covered insurers, providers, and policy holders.

Specialty Populations – Culturally Diverse Services

Identified Barrier

1. As various religious, ethnic, and cultural populations grow all over the commonwealth, it appears there is a lack of capacity for providers that can meet the specific needs of these populations. In addition, providers may not be representative of the individuals they serve and/or may not have the language skills needed to effectively communicate around specific needs.

Recommended Departmental/Agency Action

1. DDAP should ensure regular, statewide availability of training opportunities in cultural competency and responsiveness.
2. DDAP should explore opportunities to increase service delivery in the primary language of service recipients through increased use of interpreter services and recruitment of specific language-speaking employees.

Specialty Populations – Seniors

Identified Barrier

1. There is extremely limited access to specialized SUD treatment services for senior citizens.

Recommended Legislative Action

1. Urge the Centers for Medicare and Medicaid Services (CMS) to increase SUD benefit coverage and number of participating providers for Medicare recipients.

Recommended Departmental/Agency Action

1. DDAP and DHS should collaborate with the Department of Aging to increase awareness of SUD and SUD treatment services among seniors and caregivers.
2. DDAP should ensure regular, statewide availability of training opportunities relevant to addressing the needs of our aging population.

Specialty Populations – Individuals Involved in the Criminal Justice System

Identified Barrier

1. With many different agencies providing services to individuals involved in or exiting the criminal justice system (i.e., Department of Corrections (DOC), Pennsylvania Commission on Crime and Delinquency (PCCD), Probation and Parole, DHS, DDAP, DOH, etc.), there are many opportunities for services to become fragmented just due the number of agencies involved in a particular case.
2. DUI and other offenders are not consistently accessing treatment as required by the law, as identified by the Pennsylvania's Treatment Compliance Oversight Committee led by DDAP. This includes timely expert assessment, and referral to licensed SUD treatment at the appropriate level as determined by placement assessment.

Recommended Legislative Action

1. Increase funding and capacity for evidence based county and state programs that provide justice-involved individuals the opportunity to receive total or partial community based treatment, such as, county intermediate punishment, state intermediate punishment, and drug courts. Review and implement the Justice Reinvestment Initiative (JRI) 2 policy recommendations that expand these options and increase funding.

Recommended Departmental/Agency Action

1. DDAP should collaborate with criminal justice agencies to ensure those individuals be considered for total or partial community based treatment as identified above, including assessment and referral to treatment, whenever possible, as well as cross training of professionals in the CJ system regarding SUD.
2. DDAP should engage in close planning with criminal justice agencies to enhance resource development and planning related to better meeting the SUD needs of criminal justice-involved populations.
3. DDAP should continue to provide technical assistance to counties to obtain greater compliance with the Pennsylvania's DWI statute Act 24 of 2003.

4. DDAP and PID should educate professionals in the CJ and SCA system that health plans cannot deny coverage for services delivered outside of the jail on the grounds of legal involvement and report such denials to PID.

Specialty Populations – Individuals with Co-Occurring Mental Health and SUD Needs

Identified Barrier

1. Current reimbursement rates frequently do not cover the cost of delivering services to individuals with more intense needs or with more significant impairment, including those with co-occurring mental health and SUD needs, as reported by public testimony.
2. A lack of a statewide directory clearly identifying providers offering co-occurring specialty services makes referral to and access of services challenging.

Recommended Legislative Action

1. Provide the necessary funding for co-occurring infrastructure development and support, to include clinical, case management, and Certified Recovery Specialist services.

Recommended Departmental/Agency Actions

1. PID and DHS should work with public and private payers to ensure they consider the cost of delivering specialty services when making rate adjustments.
2. DDAP should continue its efforts in reviewing and updating the rate setting process.
3. DDAP and DHS should implement a state level needs assessment to identify location of and need for programs with specialties in co-occurring treatment of SUD and mental health. This should also explore ways to identify providers that specialize in trauma treatment.
4. DDAP and DHS should collaborate regarding the strengthening of co-occurring services in the system.

Specialty Populations – Individuals in Need of or Utilizing MAT

Identified Barrier

1. Inadequate or lack of engagement in counseling in conjunction with the use of medications use may contribute to increased risk of diversion and treatment failure.
2. Methadone and other FDA-approved medications such as buprenorphine, Vivitrol may not be covered by private insurance.
3. There are continued challenges in the effective and appropriate implementation of MAT in accordance with evidence based practices, which causes and contributes to related stigmatization.

Recommended Legislative Action

1. Work with DDAP and stakeholders to develop minimum standards for Office Based Opioid Treatment (OBOT) providers and codify them into law.

Recommended Departmental/Agency Actions

1. DDAP should work with other commonwealth agencies to consider recommending an increase in the amount of clinical sessions an individual should receive when receiving MAT services as well as ensure coordination with recovery support services.

2. Working with the legislature and a group of stakeholders, DDAP should implement minimal clinical standards for OBOTs through regulation.
3. PID should continue their work to better understand coverage provided for MAT by fully-insured commercial plans.
4. PID should evaluate the extent to which existing law could require coverage for MAT, and look for potential legislative strategies to fill any gaps.
5. Ongoing dialogue and education is needed regarding MAT in the continuum of care.

UNDERFUNDING

Historically, the SUD field has been drastically underfunded and with the passage of time and shrinking budgets has meant even greater cuts to funding by local, state and federal governments. As stated, reimbursement rates have often remained lower than the cost of providing services and can lead to situations where treatment facilities hold beds for individuals with commercial insurance for whom reimbursement for services can often be paid at a higher rate. This helps to offset the costs of publicly funded clients; however, it further limits the availability of treatment beds or slots for publicly funded individuals including those on Medicaid and those who are uninsured. Underfunding also impacts workforce recruitment, retention, and development.

With the passage of the Affordable Care Act and Medicaid expansion, many individuals who have otherwise been unable to access services are now able to receive them. However, many commercial insurance plans have high co-pays and deductibles that require individuals to pay exorbitant out-of-pocket costs upfront, which is cost prohibitive to seeking care. Additionally, adequate funding for infrastructure development in establishing improvements to capacity, access, and recovery support have been absent or limited. Case management services assist with access to resources and recovery support services; however, these services have had insufficient attention since the focus of expenditures has been on the provision of treatment which is also underfunded and continues to be further impacted by high deductibles and a number of other factors. While our own state legislature has recognized the far-reaching impact that SUD has on the economic, social, personal, and other demands of the commonwealth overall, DDAP, the agency that statutorily via Act 50 of 2010 has oversight of all regulations related to drug or alcohol abuse, has been consistently underfunded.

Identified Barriers

1. Providers indicate disparity in rates between commercial and public insurance that do not adequately cover the cost of providing services.
2. The IMD Exclusion as revised in the CMS final Medicaid Managed Care Rule limits federal financial participation for inpatient settings to only 15-day episodes, which shifts a significant financial burden for payment of services to the commonwealth.

Recommended Legislative Action

1. The legislature should continue engaging with DHS to support their work with CMS to modify the IMD provision of the final Medicaid Managed Care Rule to alleviate the cost burden for the commonwealth and ensure length of care is determined by a clinician.

Recommended Departmental/Agency Actions

1. DDAP should continue with its rate setting process to include engagement of BH-MCO's.

2. DHS should continue working with CMS on exploring an 1115 SUD Waiver that will enable the commonwealth to address the IMD exclusion in the final Medicaid Managed Care Rule.

INSURANCE AND PAYERS

As with any medical need, remediation and care cannot be obtained without resources to pay for those services. There are several reimbursement/payment sources that an individual might use when seeking SUD treatment. These include:

- Commercial insurance – fully-insured and self-insured plans, some of which are employer sponsored, others that are obtained via the marketplace or privately purchased otherwise;
- Federal plans including Tri-Care, Federal BlueCross and Medicare; Medicaid (also a federal plan, but with strong partnerships and cost sharing among states);
- State and federal funding from various agencies along with potential local allocations distributed at the local level through the SCAs; and,
- Self-pay, out-of-pocket.

Each category of payment has specific considerations that may likely contribute to the barriers which exist in accessing care, some more common across payment types and others unique to each payer. It is of interest to note that data from a survey of counselors conducted by the Pennsylvania Recovery Organizations Alliance (PRO-A) reflected similar concerns on this topic as were obtained from the HR 590 open comment period and hearings.[12]

Fully-Insured Group Insurance Plans

A fully-insured group health plan is the more traditional way to structure an employer-sponsored health plan. With a fully-insured health plan, the company pays a premium to the insurance carrier. The premium rates are fixed for a year, based on the number of employees enrolled in the plan each month. The Pennsylvania Insurance Department (PID) has regulatory oversight of these plans regarding compliance to insurance law, consumer service and protection, receipt of complaints, and more.

While the coverage of every group plan can be independently negotiated regarding premiums, deductibles and co-pays, and benefit coverage, most of these plans must comply with at least the minimum SUD coverage as outlined in Pennsylvania's Act 106 of 1989. Small group and individual health plans must also comply with the Essential Health Benefits (EHB) requirements in the Affordable Care Act, which mandates coverage for mental health and substance use disorder services, including behavioral health treatment. The PID, along with the Office of the Attorney General, has made significant headway over the last several years in raising awareness with insurers that minimum provisions for SUD treatment exist and ensuring that insurance companies are compliant with these provisions.

A complicating factor of Act 106 is the public's lack of awareness of the law and whether it applies to their particular insurance plan. Many times, it is not readily clear to the consumer, or even to treatment providers who may advocate on behalf of their patients, what type of plan an individual has, or if Act 106 is applicable. This is not identified on a person's insurance card or in their benefit handbook. Many times, full details of one's policy benefits are not provided to the consumer in hardcopy or in language that is easily understood. Even for those plans that provide individual SUD treatment benefits in compliance with the Act, the entitlements for family benefits, intervention and treatment often are overlooked, unknown, or unutilized.

Insurance and Payers – Act 106 and Benefit Information

Identified Barriers

1. PA's Act 106 of 1989 establishes mandated minimum coverage for the full continuum of care for fully-insured, often employer-based, group plans. Under Act 106, the only lawful pre-requisite to obtain care is certification and referral by a licensed physician or licensed psychologist. Act 106 applies solely to fully-insured group plans. Many individuals and providers are unsure if it applies, and some insurance companies and providers may not be aware of its requirements.

Recommended Legislative Action

1. Prioritize legislation that requires insurance companies that fall under state regulatory authority to clearly identify on an insurance card if the plan is a "fully-insured group plan."
2. Prioritize legislation that requires insurance companies that fall under state regulatory authority to develop benefit books that include explanation of specific SUD benefits and ensure that in addition to electronic access to information, individuals receive regular written notification of these benefits.
3. Prioritize legislation that requires those insurance companies to issue an immediate notification advising subscribers of addiction treatment benefits and how to access them.

Recommended Departmental/Agency Action

1. PID should continue to make individuals covered by plans that are subject to the parameters of Act 106 aware of minimum benefits – including coverage for family and intervention services - in clear, understandable language.
2. DDAP and PID should work together to develop materials for licensed providers regarding the provisions of Act 106 and the expectation that they should advocate on behalf of individuals and their families in accessing these services.
3. DDAP should require SCAs to provide information about Act 106 benefits to individuals covered by the plans subject to the Act's requirements, including family benefits.

Self-Insured Group Insurance Plans

A self-insured group health plan (also known as a 'self-funded' plan) is one in which the employer assumes the financial risk for providing health care benefits to its employees. In practical terms, self-insured employers pay for each claim as they are incurred instead of paying a fixed premium to an insurance carrier that will then pay those claims, which is known as a fully-insured plan. Typically, a self-insured employer will set up a special trust fund to earmark money (corporate and employee contributions) to pay incurred claims. Self-insured group plans are not regulated by the Pennsylvania Insurance Department; instead, they are regulated under federal law through the Employee Retirement Income Security Act (ERISA) and oversight is provided by the United States Department of Labor. States are pre-empted by ERISA from imposing their own requirements or regulation on these plans. Currently, nearly all plans must cover SUD under the ACA and the Mental Health Parity and Addiction Equity Act (MHPAEA).

Those plans that do include SUD treatment benefits as part of their plan frequently come at a high purchase price, have excessive deductibles and co-pays, and often provide coverage in a limited fashion. Frequently, these plans do not make known the criteria used for admission to treatment, if criteria are used at all. Pre-authorization and continued authorization may be a lengthy and cumbersome process resulting in several days wait for confirmation for admission to care or authorization of payment. Authorizations are often denied or issued for only a short duration, requiring repeated requests from the treatment provider to justify ongoing care, taking clinical time away from patients to perform this administrative task. Numerous testimonies attested to individuals being required to fail at a lower, less expensive level of care to receive those services that would be most appropriate. Treatment stays were often reported as significantly inadequate by providers or the patients themselves. There is also sometimes a lack of benefit coverage for MAT and services for family members.

As a result of the many nuances of self-insured plans, there is a lack of a clearly defined pathway for enforcing them.

Insurers and Payers – Self Insured Group Insurance Plans

Identified Barriers

1. There are significant differences in requirements and regulations for benefit coverage depending on the type of insurance plan (among non-Act 106 plans) as well as differences in oversight, appeals process, and other administrative processes.
2. Individuals are often unclear about what their insurance benefits are because they may not receive specific information on SUD benefits in writing/hardcopy that is clearly stated and easily understood.

Recommended Departmental/Agency Actions

1. DDAP and PID should explore ways to collaborate with consumer advocacy groups to educate consumers on appeals procedures including parity in simple layman's terms.
2. PID and its partner agencies should increase awareness regarding its soon to be available consumer information packet.

Federally Managed Insurance Plans

A significant number of Pennsylvanians are covered for medical services by federally underwritten plans such as Federal Blue Cross, Tri-Care, and Medicare. Due to the federal management and oversight of these plans, the state does not have the authority to apply additional requirements or regulate these plans. Often access to treatment and benefits under these plans are limited and restrictive which often leads to a shortage of available participating providers.

Medical Assistance (Medicaid or MA) Coverage

Medicaid is a federal and state program providing health coverage to low-income individuals who meet certain eligibility requirements.

Testimony from stakeholders receiving substance use services reimbursed through the Medicaid program identified the following concerns: Medical necessity should be determined by the treating physician or SUD clinician, utilizing established placement criteria. Despite the commonwealth mandate that care provided under MA must be determined using the Pennsylvania Client Placement Criteria (PCPC) for adults or the American Society for

Addiction Medicine (ASAM) Criteria for adolescents, admission approvals or utilization reviews for continued stay may be denied or delayed per testimony. The HealthChoices program, Pennsylvania's Medicaid managed care program, requires that only a physician may deny SUD treatment and that a written denial notice be provided to the individual with information on how to file a grievance. For services previously authorized, the behavioral health managed care organization (BH-MCO) is required to pay for the services throughout the grievance process when the grievance has been filed within the established timeframes as part of the continuation rights. Some of the reasons given for the denials or delays in authorizations for services include failure on the part of the clinician to provide a well-prepared substantiation for medical necessity which is a federal requirement for payment of services utilizing Medicaid. Yet, experienced clinicians testified to giving information that should have been considered satisfactory and complete only to be required to provide additional information. The request for additional information has the potential to result in delays in admission for detox, denials for appropriate levels of care, and lack of appropriate lengths of stay.

Providers that accept MA indicated that the low reimbursement rates under this coverage do not cover the cost of providing services. MA sets the rates for the substance use services that are provided as part of the State Plan which include outpatient services such as individual, family, and group psychotherapy, medication management, psychiatric evaluation, psychological evaluation, medical examination, or methadone maintenance, and medically managed detoxification and rehabilitation services. Rates for supplemental services are negotiated by each BH-MCO with the network providers. Not all treatment providers accept MA which may limit the capacity and access for individuals with this type of coverage. Those providers that do take MA may reserve a greater number of admission slots for commercially insured or private pay individuals over those with MA. While it is understood that this practice may be necessary for a provider to sustain its business plan and viability, it limits access for individuals in need. Additionally, billing for more than one service delivered on the same day under the Medicaid Fee-for-Service program was also noted as being problematic.

While various concerns have been identified related to MA, anecdotally or by way of testimony, it is important to note that modifications to service provision and payment for service may be limited by federal mandates for this program.

ADDITIONAL INSURANCE/PAYER CONCERNS

Regardless of the type of insurance plan, there are other difficulties that may inhibit access to SUD treatment. The cost of purchasing a plan may be prohibitive, regardless of the current federal mandate for all persons to be insured. Frequently, the costs of deductibles and co-pays are so high that individuals cannot afford the insurance they have purchased or that is provided to them through their employer. Billing complexities add to difficulties for providers who may encounter requests for payment refunds long after an individual has been discharged from treatment. When an individual's funding source changes, such as from having group insurance to qualifying for MA due to job loss, there may be a lack of continuity in care because the same provider or clinician cannot be utilized under the new payer.

The Mental Health Parity and Addiction Equity Act (MHPAEA is the federal law that generally prevents large group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits. However, similar to Pennsylvania's Act 106, the provisions that individuals are entitled to under the law are not widely known or understood by the public who have this or other types of coverage. The Pennsylvania DHS is currently in the process of determining how the execution of parity applies to Medicaid and the Children's Health Insurance Program (CHIP) and has until October 2017 to implement this.

Insurance and Payers – Parity Issues

Identified Barriers

1. Similar to Act 106, there is a lack of awareness about the particulars of MHPAEA and to whom it applies.
2. MHPAEA excludes various plans, including those which cover large sectors of the population, such as retiree-only plans, TriCare, and Medicare. Self-insured group plans can opt out and in such instances MH/SUD benefits are not required.

Recommended Legislative Actions

1. Work with the Pennsylvania federal delegation to advocate for inclusion of SUD benefits in federally managed insurance plans.

Recommended Departmental/Agency Actions

1. With assistance from other state agencies and stakeholder groups, PID should continue its efforts to ensure compliance with MHPAEA.
2. PID, DDAP, and stakeholders should work to increase consumer awareness of parity and PID's complaint hotline.

Insurers and Payers – Level of Care Determination and Authorization for Services

Identified Barriers

1. It is often unclear how non-Act 106 covered insurers determine and approve level of care for SUD services and/or what if any standardized criteria for placement are utilized.
2. Authorizations for SUD treatment can often be delayed, resulting in client disengagement in entry to treatment (this results in a "non-denial, denial" by the insurance company).
3. Insurance companies not regulated by the state often fail to authorize the appropriate level of care placement determined by the treating physician or SUD specialist.
4. Frequently, very short units of authorization are issued for treatment resulting in unreasonable, time consuming clinical justification for additional treatment.
5. The overall length of stay paid for by insurance companies can be short and contrary to the treating SUD clinician's recommendation.

Recommended Legislative Action

1. Establish a funding pool through DDAP, administered by the SCAs, to support treatment of a patient in the event of appeals procedures not being completed in a timely manner, or denied.

Recommended Departmental/Agency Action

1. DDAP should work with partner agencies and the SCAs to educate consumers and treatment providers about their rights to be notified by the insurer of level of care placement, including modifications to any standard criteria (e.g. ASAM).
2. With assistance from other state agencies and stakeholder groups, including the Office of Attorney General, PID should continue to evaluate the extent to which these practices are occurring and whether they are in compliance with MHPAEA and other relevant laws.

3. PID, DOH, and DDAP should collect and publish an overview of trends in denials for review in collaboration with the interagency parity workgroup (led by the PID) and consumer organizations.
4. DDAP and provider organizations should ensure adequate training in the provision of medical necessity.

Insurers and Payers – Denials and Appeals

Identified Barriers

1. Approvals for admission to treatment, level of care, or continued stay are frequently delayed by the insurance company thereby impacting client entry into care or retention in services.
2. The appeals process is often unclear and time consuming, resulting in discontinuation or disruption in services.
3. There is a wide range of improper justifications for denial of services (e.g. failure to receive timely authorizations, lack of clear criteria, requirements of failure in a lower level of care, etc.), which prohibits individuals from receiving care and can lead to dramatic cost shifting to public funding.
4. In contrast to other medical illnesses, care is parsed out (e.g., limited/repeated authorizations) rather than provided in alignment with the nature of the illness.

Recommended Departmental/Agency Actions

1. DDAP should work with partner agencies to educate consumers and providers on the timeframes of appeals under Act 68 of 1998 and Medicaid.
2. DDAP, provider associations, and other stakeholders should provide regular informational bulletins about continued stay and payment provisions that exist in the event of an appeal. For example, under HealthChoices, MA continues to pay for services until an appeal determination has been made, thereby allowing for continuation of services during the appeal process.
3. PID should continue to monitor compliance among regulated insurance companies to ensure consumers are being given proper notice and appeal timelines are being complied with, including expedited appeals.
4. PID and DDAP should work together to ensure appeals letters should be tailored to specifically list the next steps in appeals procedures for a specific type of plan.

Insurers and Payers – Compliance and Utilization Monitoring

Identified Barriers

1. There are instances in which compliance and/or utilization data is not collected, or collected but not analyzed in the aggregate, or used to inform decision-making around utilization.

Recommended Legislative Actions

1. As a means of determining insurer accountability and provision of network adequacy, require a report be submitted by insurers, including MA, to the General Assembly and or related oversight entities, that provides a summary of annual:
    - Number of Requests for D & A service
    - Type of Service Required

- Type of Service Received
- Wait time for Receipt of Service
- Number of Denials for SUD Specialists recommended level of care
- Number of Appeals submitted to the insurer
- Average response time for appeal resolution

SINGLE COUNTY AUTHORITY (SCA) FUNDING

As has been previously discussed regarding underfunding of the SUD service delivery system, when funding cuts occur at the federal and state level, this has a direct impact on what can be allocated for use by the SCAs, either for administrative functions or for the provision of direct services to individuals.

SCAs are engaged in a process to determine rate setting for reimbursement for those providers with whom they contract for treatment services. This method and process has been in place for a number of years and may need revision. DDAP has been holding workgroup meetings to consider ways in which insufficient rates can be remediated in the current fiscal climate and moving forward. Work continues with this initiative.

Other Systemic Concerns

To date, the SUD service delivery system is slowly embracing the philosophy and transformation to a recovery oriented system of care (ROSC). As defined by SAMHSA, "the central focus of a ROSC is to create an infrastructure or system of care with the resources to effectively address the full range of substance use problems within communities. The specialty substance use disorder field provides the full continuum of care (prevention, early intervention, treatment, continuing care and recovery) in partnership with other disciplines, such as mental health and primary care, in a ROSC. A ROSC encompasses a menu of individualized, person-centered, and strength-based services within a self-defined network."[13] Such a system recognizes the chronic nature of SUD, treats and provides interventions across the lifespan, and acknowledges many pathways to recovery.

Identified Barriers

1. The Pennsylvania Drug and Alcohol Advisory Council, as enacted by Act 63 of 1972, has not been fully utilized as necessary to strengthen the SUD service system.
2. Due to retirement and a shrinking ability to recruit or maintain SUD professionals because of low rate/insufficient pay scales, staffing shortages are likely to become increasingly problematic in all levels of treatment/care.
3. The system could be strengthened by increasing the number of providers that embrace the already existing ROSC philosophy and practice.
4. Stigma and discrimination unnecessarily negatively prevents individuals from seeking help and produces negative opinions and lack of support for those individuals with an SUD or the SUD service system.
5. Time constraints and the magnitude of the task did not permit a conclusive effort towards the completion of the HR 590 Mandates.

Recommended Legislative Actions

1. The structure of the HR590 taskforce as established, should be expanded to include partner state agencies and key stakeholders (i.e. parent, provider, recovery organizations). Additional committees should be added as appropriate, to include people and families with lived experiences. Legislation should also require the task force to meet quarterly and track and monitor the recommendations noted in this report.
2. Establish a loan forgiveness program for individuals working in the SUD treatment field.

Recommended Departmental/Agency Actions

1. DDAP, DHS, SCAs, and Recovery Organizations should prioritize the mobilization and engagement of individuals in recovery in both the policy and decision-making processes for the treatment and recovery system.
2. DDAP, its partner agencies, and stakeholders should address stigma and discrimination by:
   - Providing education about the essential nature of SUD, stressing that treatment and recovery supports help sustain remission, and that most people make full recoveries.
   - Support personal witness and provide opportunities to highlight individuals in recovery.

- Changing language to be consistent with the nature of the condition and include such language changes in all relevant policies and procedures.

3. DDAP, other state agencies, and stakeholder groups should continue the work of the Task Force to more fully address the mandates of HR 590 and to consider and implement the recommendations noted in this report.
4. DDAP should enhance the functions of the Pennsylvania Drug and Alcohol Advisory Council to more actively advocate for, recommend, and affect necessary improvements to impact the delivery of and access to care over an extended period of time to develop and sustain long term recovery.

Summary

of State and Federal Laws and Regulations Reviewed by HR 590 Task Force

HR 590 resolved that the Task Force "review compliance with all relevant current laws, regulations, agreements and other legal requirements and review tools that are available to evaluate, monitor, report and audit or otherwise assist consumers in accessing addiction treatment through current laws." To accomplish this task, each state government agency represented on the Task Force was asked to identify those relevant laws and regulations falling under its purview with a direct impact on access to SUD treatment and benefits and to identify any mechanisms in place to audit or ensure compliance with the law or regulation.

It is important to note that some of the laws promulgated have created significant advances in overcoming access barriers that have existed in the field over time. For example, Act 106 of 1989 has greatly assisted individuals in obtaining treatment through fully-insured group insurance plans. Act 152 of 1988 has helped Medical Assistance eligible individuals to receive treatment services across the continuum of care. Act 65 of 1993 has established specialized services for pregnant women. The chart below identifies those laws specifically identified and reviewed by the Task Force at large. The legislation and information is categorized by the agency under which implementation or compliance is monitored.

In addition to state and federal law, the Task Force also considered monitoring and auditing tools, as applicable, some of which are also noted on the chart below. Some of the auditing tools were provided to all Task Force members for review and consideration. In those instances in which an agency was represented on the Task Force with expertise to attest to compliance, that Task Force member's input and information was relied upon for assurance of appropriate application of these tools and adherence to the requirement. However, some areas of implementation and compliance that are reflective of regulation or contractual agreements to provide services are not represented on the chart.

Finally, the information presented in the chart below is also reflective of reports or websites from which information regarding compliance can be obtained, when such a report is available.

Department of Drug and Alcohol Programs				
Act 50 of 2010		Creation of DDAP, oversight and development of D & A system, training, licensure.	Advisory council; Licensing regulations and monitoring tools; SCA Monitoring Tools; Minimum Provider Monitoring Tool; Training Management System; Publications Awareness Clearinghouse. The Task Force (TF) reviewed D&A Licensing Regulations, SCA Monitoring Tools	State Plan; Block Grant (BG) Plan, Assessment & Report; Licensing citations are published on website; SCA performance audited annually, although not published; Fiscal Reports are noted in State Plan and BG Report, including county expenditures; Training expenditures noted in BG report.
Act 65 of 1993		Specialized inpatient treatment for Pregnant & Parenting Women.	Fiscal Reporting; SCA monitoring.	Block Grant Report; State Plan/Annual Report.
Act 1 of 2010		Gambling funds for non-hospital detox & rehab & halfway house SUD services.	Fiscal Reporting.	Annual Gambling Report.
Act 53 of 1997		Involuntary commitment of minors.	No mechanism for courts to track occurrence.	There is no annual report.
4 Pa. Code §255.5		State confidentiality regulation.	Licensing Monitoring SCA Monitoring.	No annual report per se. Licensing citations related to confidentiality violations noted on website.
	42 CFR, Part 2	Federal confidentiality regulation.	Licensing/SCA Monitoring.	No annual report. Licensing citations related to confidentiality violations noted on website.
	42 CFR, Part 8	Opiate/NTP regulation.	Licensing/SCA Monitoring.	No annual report. Licensing citations noted on website.
	Alcohol, Drug Abuse, and MH Admin. Reorg. Act of 1992	A Guide for Allotment Calculations for Federal BG formulas grants was derived from the Act, indicating how appropriations are made to the states.	BG Report.	BG Report.
	45 CFR 96	Expenditure Requirements for federal BG for D & A Treatment.	BG Report.	BG Report.
	Title II,Part B of XIX –Public Health Services Act	Block Grants- federal funding for SUD.	Licensing/SCA Monitoring/Training.	BG Report.

Department of Human Services				
Act 78 of 1994		Human Services Development Fund (HSDF)- funds to meet local social service needs as determined by county officials. Can be used for individuals with a SUD diagnosis.		
Act 152 of 1988		Act 152 of 1988 provides, on behalf of persons eligible for medical assistance, a continuum of alcohol and drug detoxification and rehabilitation services. Facilities serving as appropriate treatment settings include hospital and nonhospital drug detoxification and rehabilitation facilities, hospital and nonhospital alcohol detoxification and rehabilitation facilities, and hospital and nonhospital drug and alcohol detoxification and rehabilitation facilities and outpatient services licensed by DDAP. The type, level and length of care or treatment is based upon the use of criteria developed by DDAP.	Funds are appropriated by the legislature annually. Funds are allocated to the counties. Counties complete an Income and Expenditure (I&E) Report and submit to DHS Bureau of Financial Operations annually. Bureau of Financial Operations (BFO) reviews and certifies all I&E Reports by county.	The I&E reports are not published or posted by county.
Act 35 of 1996		The Behavioral Health Special Initiative (BHSI) was established to provide persons with mental health and the most severe substance use disorders with state funding for an array of MH and SUD services to avoid cost shifting to other systems. BHSI provides a full array of treatment and support services to individuals in need of SUD services with no other funding source.	Funds are appropriated by legislature annually. Funds are allocated to the counties to provide services. Counties must complete an I&E report and submit to DHS BFO annually. BFO reviews and certifies the I&E report annually.	The I&E reports by county are not published or posted by county.
Act 80 of 2012 & Act 55 of 2013		Human Services Block Grant (HSBG) program allocates funds to county governments to provide county-based human services to meet the needs of county residents (includes HSDF, Act 152, BHSI as part of the funding) Currently 30 counties are part of the	Bureau of Financial Operations reviews and certifies all I&E reports and appropriations for each HSBG county.	An annual report of the HSBG program must be submitted to the General Assembly. The report is posted on the DHS website and can be accessed at: http://www.dhs.pa.gov/publications/budgetinformation/humanservicesblockgrant/index.htm

		HSBG program. This may be expanding to any interested county.		
Act 126 of 1998		Act 126 allows the release of SUD treatment and other records regarding a child who is alleged to be or adjudicated dependent or delinquent from the child's parents under the federal rules.	DDAP licensing review of SUD providers – release of information consents and copy of adjudication order.	
	42 CFR, Parts 431, 433, 438, 440, 457, and 495	Establishes managed care rules for the delivery of MA health care to manage cost, utilization and quality.	Compliance with the Federal Managed Care rules including independent Review and Evaluation.	
	XIX Soc Security Act 1915 (b)	Medicaid Coverage – Fee for Service (FFS) and HealthChoices (BH) Medicaid Managed Care waiver.	Payment for Medicaid OP SUD services under FFS must comply with 55 Pa. Code, Chapter 1223. The Balanced Budget Act (BBA) of 1997 requires DHS to contract with an External Quality Review Organization to conduct an annual external quality review of the services provided by the Medicaid Managed Care Organizations (MCO) including compliance with the structure and operation standards established by the state (42 CFR § 438.358). The T.F. reviewed auditing/quality assurance tools from the following HC providers: Community Care, PerformCare, Value Behavioral Health as well as provider rate sheets.	Link to payment regulations: http://www.pacode.com/secure/data/055/chapter1223/chap1223toc.html Link to HealthChoices Program Standards and Requirements (PS&R) and compliance reports: www.dhs.pa.gov/publications/healthchoicesbehavioralhealthpublications
	Soc. Sec. Act	Children's Health Insurance Program (CHIP).		http://www.chipcoverspakids.com/chip-resources/Pages/AnnualReports.aspx

Department of Health				
Act 68 of 1998		Insurance (Ins) Company law requiring mgd care to assure availability and accessibility of adequate health care providers & timeliness.	Impact analysis Plan; Receipt of Complaints.	The annual report templates, which contain the summary data and tables, are scanned by the Bureau and can be emailed to a requestor. Requests can be made to anyone at the Bureau.
Act 150 of 1998 (40 P.S. § 764g)		Requires coverage of 9 specified mental health conditions, establishing minimum standards for inpatient and outpatient services. Act 150 applies to policies issued to large groups (50 or more employees).		
Act 106 of 1989 (40 P.S. §§ 908-1—908-8)		Minimum benefits for D & A under group ins plans.	Annual Status Reports	
Act 14 of 2010		Parity (adopts fed law into PA law).		
Act 191 of 2014		Prescription Drug Monitoring Program (PDMP) – requiring referrals.		

Department of Insurance				
Act 68 of 1998		Accountability of gatekeeper PPOs and HMOs.	PID and DOH – joint oversight; PID forms review and market regulation tools.	
Act 14 of 2010		Parity (adopts federal law into PA law).	PID forms review and market regulation tools.	
	Affordable Care Act of 2010	Accessibility of Insurance (Ins); requires as an Essential Health Benefit – (EHB) D&A coverage for individual and small group plans.	PID forms review and market regulation tools.	
	MHPAEA of 2008	Parity – requires Behavioral Health services to be delivered with parity in comparison to Physical Health.	PID forms review and market regulation tools.	
Act 106 of 1989		Minimum benefits for D & A under group ins plans.	PID forms review and market regulation tools.	

Other Agencies				
Act 14 of 1987 LCB		LCB 2% funds to DDAP.	Currently in place. Annual LCB Report notes transfer amounts. Checks and balances through Dept of Revenue, Treasury, etc. SCA Invoices.	Annual LCB Report. DDAP's MOE; Budget reports.
Act 154 of 1994 Individual county		DUI fine money to SCAs.		
Act 198 of 2002 PCCD		DUI money to PCCD (SAEDR); 50% funds to county.	There is no mechanism to know how much money goes to PCCD and how much in turn goes to counties.	PCCD grants are published on their website.
Act 211 of 1990 PDE		Requires schools to do SAP and education.	Unfunded mandate; Unsure whether schools must provide a report of this activity.	
Act 80 of 2015 DOC		Prison MAT Pilots.	Quarterly reports to PCCD, also an Annual report - (early in the project, no info yet).	Quarterly reports to PCCD, also an Annual report - (early in the project, no info yet).
Act 122 of 2012, the Criminal Justice Reform Act. DOC		Expands the eligibility of intermediate punishment for an offense involving drugs and alcohol.	Contract requirements with providers, provider monitoring, invoicing, etc.	While the info is available by request from Bureau of Community Corrections, it is not published in a report.

Conclusions

Moving Forward

Pennsylvania has a robust system of care with a full continuum of services from prevention and client engagement, to treatment and recovery management. Treatment providers provide a full array of services and are constantly seeking quality improvement opportunities. SCAs assist in client navigation and payment of services for those individuals who are uninsured or underinsured and have a longstanding history of client advocacy and promotion of improved access to care. More than ever, state agencies are working together to ensure coordination of services and to collaborate regarding the best use of resources. Nonetheless, there is much work to be done.

As has been discussed throughout this report, there are a variety of systemic challenges impacting access to SUD treatment and benefits. The nature of the illness requires qualified professionals and families to have the tools to assist individuals and get them into care. While the system itself has difficulty accommodating some individuals due to lack of capacity, difficulty with access and navigation, and funding barriers, it is the individual suffering from the disease who is often blamed for his or her continued use. Society as a whole – be it government, the systems meant to serve individuals with a SUD, or the recovering community, must make it a priority to give credence to SUD as the verifiable, physical brain disorder that it is for it to be properly understood. Without this proper understanding and prioritization, access to treatment and benefits will likely continue to be problematic. Stigma can only begin to be truly addressed by improved awareness and education about SUD and by putting a voice and face to the condition. To this end, every effort to fully engage and mobilize the recovering community at every level of decision-making must be a priority.

Furthermore, given the far-reaching impact that SUD has on individuals, families, the economy, and our social service systems and institutions, unless SUD is recognized as a primary illness with overarching impact and is addressed appropriately and sufficiently as the priority issue that it is, attempts at resolving this health care crisis and achieving more positive treatment outcomes are likely to result in half-measures. It is with humility and expectation that the Task Force submits this report and recommendations for addressing the identified barriers to the General Assembly and to the representative State Agencies and stakeholders. It is hoped that through careful consideration and swift action by those involved, improvements to the system will be realized, fewer people will die and Pennsylvanians who suffer from SUD will have an improved opportunity to seek and obtain treatment and recovery.

The Pennsylvania Department of Drug and Alcohol Programs wishes to thank all those who provided input to this report through comment and public testimony, especially those family members whose loved ones currently remain in the grip of SUD or those who sadly and unnecessarily have lost loved ones to this insidious disease. The department wishes to thank Lieutenant Governor Mike Stack for co-chairing the HR 590 hearings.

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- Doyle Heffley (R-122nd district) – Carbon County
- Curtis Thomas (D-181st district) – Philadelphia (part)
- Harry Readshaw (D-36th district) – Allegheny Counties
- Gene DiGirolamo (R-18th district) – Bucks County (part)

- Donna Bullock (D-195th district) – Philadelphia County (part)
- Thaddeus Kirkland (D-159th district, retired) – Delaware County (part)
- Greg Rothman (R-87th district) – Cumberland County (part)
- Rosemary Brown (R-189th district) – Monroe / Pike Counties
- Mark Rozzi (D-126th district) – Berks County (part)
- Mike Vereb (R-150th district, retired) – Montgomery County (part)
- Daniel McNeill (D-133rd district) – Lehigh County (part)
- Dom Costa (D-21st district) – Allegheny County (part)

Various state legislators also provided testimony or comment at the hearings, served as guest hearing panelists, or attended the hearings. The giving of their time and attention to this issue demonstrated their ongoing commitment to addressing the issue of SUD and the opioid overdose crisis. Other state dignitaries including, but not limited to, District Attorneys, County Commissioners, and Judges also participated in this process and to them much gratitude is extended.

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Notes

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