

**PENNSYLVANIA SUBSTANCE USE DISORDER (SUD)
1115 DEMONSTRATION**

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Section I: Background

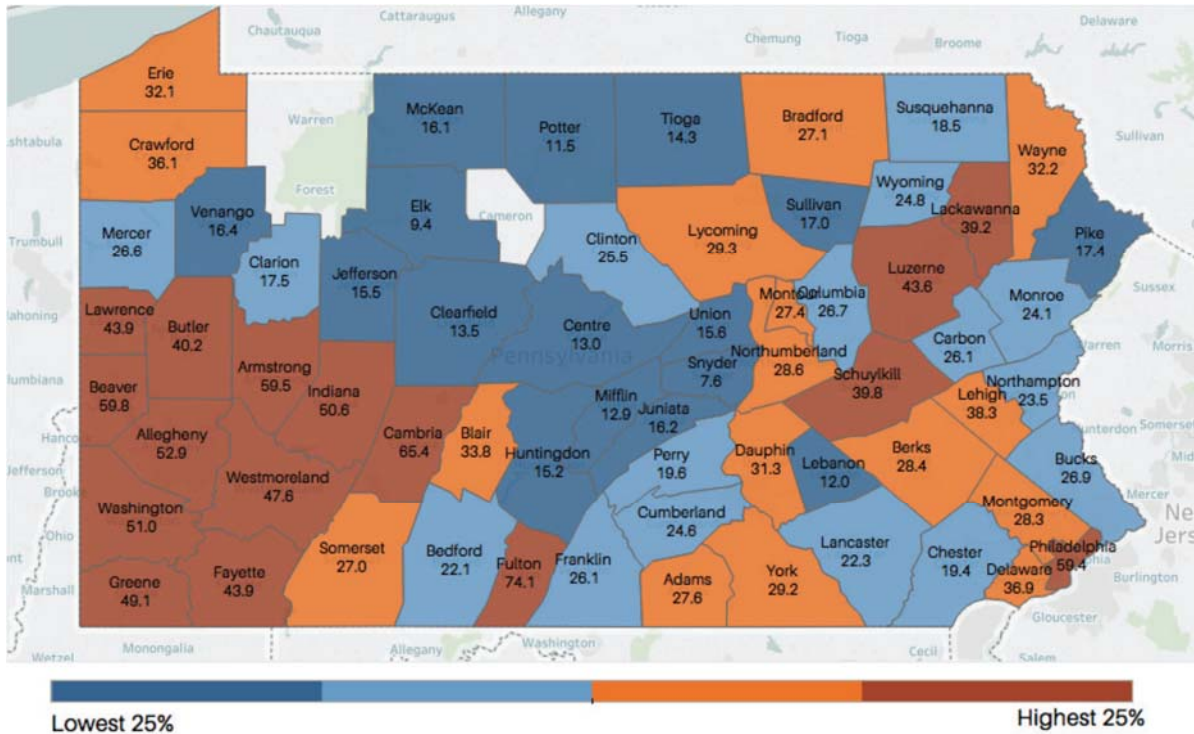
Pennsylvania is in the midst of a public health crisis affecting both the well-being of its residents and the economic health of the commonwealth. On January 10, 2018, Governor Tom Wolf, in order to further bolster the fight against heroin and opioid addiction, signed a statewide disaster declaration to enhance state response, increase access to treatment, and save lives. The declaration is the first-of-its-kind for a public health emergency in Pennsylvania and will utilize a command center at the Pennsylvania Emergency Management Agency to track progress and enhance coordination of health and public safety agencies¹.

In 2016, more than 4600 Pennsylvanians² lost their lives to drug-related overdose which averages to 13 drug-related deaths each day. This is a significant increase from the approximately 3500 overdose fatalities in 2015, and almost double from the nearly 2500 deaths in 2014. The Pennsylvania drug-related overdose death rate in 2016 was 36.5 per 100,000 people, a substantial increase from the death rate of 2015². This death rate is significantly higher than the national average of 16.3 per 100,000. Pennsylvania's Prescription Drug Monitoring Program reports that the number of emergency department visits related to an opioid overdose have increased by 82% from the third quarter of 2016 to the third quarter of 2017. While Pennsylvania is a very large and diverse state, there is no area of the commonwealth that is not affected by this epidemic.

The map below shows the rate of Drug-Related Overdose Deaths per 100,000 people in Pennsylvania Counties in 2016:

¹ Governor Wolf Declares Heroin and Opioid Epidemic a Statewide Disaster Emergency. Available at: <https://www.governor.pa.gov/governor-wolf-declares-heroin-and-opioid-epidemic-a-statewide-disaster-emergency/>

² "Analysis of Overdose Deaths in Pennsylvania, 2016." Available at: <https://www.dea.gov/docs/DEA-PHL-DIR-034-17%20Analysis%20of%20Overdose%20Deaths%20in%20Pennsylvania%202016.pdf>



Source: Pennsylvania Coroner/Medical Examiner Data

The Pennsylvania Health Care Cost Containment Council (PHC4), which is an independent state agency charged with collecting, analyzing, and reporting on health care in the state, examined hospital admissions between 2000 and 2014 for Pennsylvania residents ages 15 and older (excluding overdoses treated in emergency departments or overdose deaths that occurred outside the hospital setting). The findings showed a 225% increase in the number of hospitalizations for overdose of pain medication and a 162% increase in the number of hospitalizations for overdose of heroin during that period. While there were higher numbers of hospital admissions for these types of overdoses among urban county residents, the percentage increases were larger for rural county residents. For rural county residents, there was a 285% increase between 2000 and 2014 in the number of hospitalizations for pain medication and a 315% increase for heroin, whereas for urban counties the percentage increases were 208% and 143%, respectively. More information on the findings is available at: http://www.phc4.org/reports/researchbriefs/overdoses/012616/docs/researchbrief_overdose2000-2014.pdf.

In 2016, PHC4 released their updated findings for 2016 that contained the following highlights:

Heroin:

- There were 1524 hospital admissions for heroin overdose in 2016.
- The in-Hospital mortality rate for these patients was 9.4% (nearly 1 in 10) – up from 7.5% in 2014.
- About 70% of the hospital admissions were for patients between the ages of 20 and 39.
- Between 2014 and 2016, the number of hospital admissions for heroin overdose increased 66% (from 919 to 1524) and almost doubled since 2013 (from 786 to 1524).

Pain Medicine:

- There were 1775 hospital admissions for overdose of pain medication in 2016.
- The in-hospital mortality rate for these patients was 2.8%.
- About 3% of the patients hospitalized for overdose of pain medication in 2016 had at least one additional admission for pain medication overdose in that year.
- The average age of patients admitted for pain medication overdose was 54. About 60% of the pain medication overdose admissions were for patients aged 50 and older. (Not included in the analysis were 28 admissions for patients younger than 15 years old.)

The complete 2016 report is available at:

http://www.phc4.org/reports/researchbriefs/overdoses/16/docs/researchbrief_overdose2016.pdf.

Alcohol-attributable deaths have also been a major concern for the commonwealth, with 3522 deaths reported for the period 2006-2010. The following table shows the data by age groups, categorized into chronic causes and acute causes³:

Alcohol –Attributable Deaths 2006-2010						
	Age Groups					
	Overall	0-19	20-34	25-49	50-64	65+
Chronic Causes	1363	7	16	227	525	588
Acute Causes	2159	125	597	557	383	497
Total	3522	132	613	784	908	1085

In 2015, 199,372 individuals enrolled in Pennsylvania’s Medicaid program had a substance use disorder (SUD) diagnosis. Of these individuals, 89,952 had some form of an opiate addiction either as the primary diagnosis or in combination with another drug addiction. Between 2011 and 2015, there was a 27% increase in persons enrolled in the Medicaid program with an SUD diagnosis. The percentage increase is due, in part, to Medicaid expansion implemented in 2015. The numbers of individuals receiving Medicaid-funded treatment continue to grow in Pennsylvania. Complete claims data have not been received for 2016, but preliminary data show 215,861 individuals with an SUD diagnosis. In fiscal year (FY) 2015-16, 118,716 individuals (unduplicated) received SUD services funded by Pennsylvania’s Medicaid program; 37,804 of those individuals received SUD residential services, which was a substantial increase from FY 2014-15, when 30,421 individuals received residential services.

Additionally, according to the Bureau of Labor Statistics, Pennsylvania has an unemployment rate of 5.1%, which is one of the highest in the country.⁴ Pennsylvania also has a poverty rate of 12.9%, which increases to 26.4%⁵ in Philadelphia, the

³ “Alcohol and Public Health: Alcohol-Related Disease Impact (ARDI),” 2006-2010. Available at: https://nccd.cdc.gov/DPH_ARDI/Default/Report.aspx?T=AAM&P=1c5610ca-1f39-446c-b495-bebc10f98949&R=d7a9b303-48e9-4440-bf47-070a4827e1fd&M=E59635B9-9F19-40F3-B4FD-AC7D4EE2375C&L=&F=AAMCauseAgeGroupAllNew&D=H

⁴ Bureau of Labor Statistics, August 2017. Available at: <https://data.bls.gov/map/MapToolServlet?survey=la&map=state&seasonal=u>

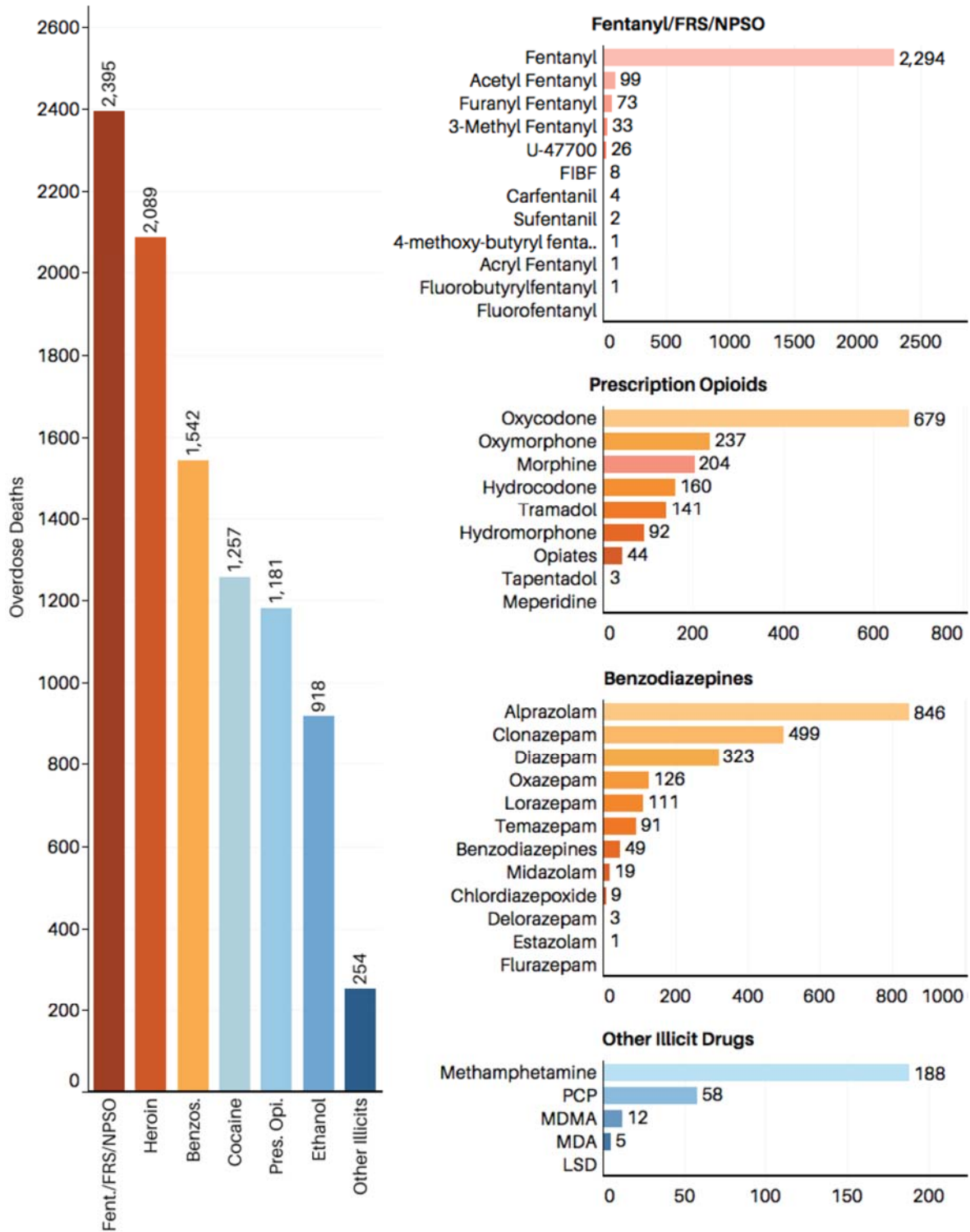
⁵ United States Census. Available at: <https://www.census.gov/quickfacts/fact/table/PA/PST045216>

country's poorest large city, which has endured a spike in opioid overdoses in recent years.⁶ These socio-economic factors, combined with the growing number of individuals with SUDs, present a challenge for the Medicaid program to provide a continuum of care for beneficiaries in need of the full array of substance use treatment services.

The chart on the following page shows the number of drug-related overdose deaths in Pennsylvania in 2016 by drug presence:

⁶ "The Epidemic of Overdoses from Opioids in Philadelphia." June 2016. Philadelphia Department of Public Health. Available at: <http://www.phila.gov/health/pdfs/chartv1e1.pdf>

Source: Pennsylvania Coroner/Medical Examiner Data



Section II: Demonstration Purpose and Goals

The purpose of the Section 1115 Demonstration waiver is to afford continued access to high quality, medically necessary treatment for opioid use disorder (OUD) and other SUDs. Pennsylvania recognizes the importance of a full continuum of treatment services, including residential services that are provided in a cost-effective manner and for a length of stay that is governed by appropriate clinical guidelines. This Demonstration is critical to continue the federal funding needed to support the continuation of medically necessary services and SUD treatment in residential facilities that meet the definition of Institution for Mental Diseases (IMDs), for individuals 21-64 years of age, regardless of the length of stay. The Commonwealth is not proposing any changes to Medicaid cost-sharing under the demonstration, standard Medicaid state plan cost-sharing rules would apply.

Until recently, CMS has approved these residential services as cost-effective alternatives to state plan Services (in lieu of services) in HealthChoices, Pennsylvania's Medicaid mandatory managed care program. However, the recent requirements in the Medicaid Managed Care rule allow states to receive federal funding, for individuals 21-64 years old, in a residential facility that is an IMD only if the length of stay is no longer than 15 days. Pennsylvania has estimated that this rule change would impact nearly 160 SUD service providers encompassed within the definition of IMD, affecting about 12,240 individuals statewide. Pennsylvania recognizes the importance of these services in the continuum of care, and believes that this Demonstration is critical in ensuring that we are able to sustain the availability of these services to the impacted population.

Residential treatment services provide a structured recovery environment in combination with high-intensity clinical services. Individuals in residential settings receive daily clinical services to stabilize symptoms; a range of cognitive, behavioral, and other therapies to develop recovery skills in a protected environment; and recovery support services to assist in developing a social network supportive of recovery. Dependence on substances is a complex disease that affects multiple brain circuits, and effective treatment must incorporate an array of clinical and psychosocial components

provided in a safe environment, as determined by appropriate clinical guidelines. Residential treatment is a core service in the continuum of care for many individuals with SUD.

The National Institute for Drug Abuse (NIDA) identified key principles for effective treatment which include the ability to remain in treatment services for an adequate period of time. The appropriate duration of treatment depends on the clinical needs of the individual. Research indicates that the majority of individuals need at least 90 days of treatment to significantly reduce or stop using substances⁷. Recovery is a long-term process, and the best outcomes occur with longer durations of treatment across the entire continuum of care based upon clinical needs.

Pennsylvania has provided residential treatment services to individuals based upon a comprehensive assessment and standardized level of care placement criteria to ensure appropriate treatment. Access to residential treatment services has not been based upon an arbitrary length of stay but upon the determination of clinical need and medical necessity for this level of care. The loss in federal matching dollars due to the current changes to the managed care rule places an enormous financial burden on the commonwealth, thereby impacting its ability to provide adequate and appropriate residential treatment services to individuals who have been assessed and determined to require the level of care the residential facility provides if it meets the definition of an IMD. This severely impacts an individual's ability to remain in an appropriate level of treatment for adequate lengths of time which may result in negative outcomes such as relapse, resulting in increased costs over time.

⁷ "Principles of Drug Addiction and Treatment – A Research-Base Guide", Third Edition (2012). Available at: https://www.drugabuse.gov/sites/default/files/podat_1.pdf

The goals of this Demonstration are:

1. Improve the overall population health outcomes for Medicaid beneficiaries diagnosed with a substance use disorder by:

- Reducing overdose deaths.
- Increasing the number of Medicaid beneficiaries who have access to substance use treatment.
- Increasing the rate of retention in treatment across all levels of care.

2. Decrease utilization of high-cost emergency department and hospital services by:

- Decreasing the number of emergency department visits and inpatient admissions.
- Decreasing the number of readmissions to the same level of care or higher levels of care for a primary SUD diagnosis.

3. Improve care transition across the continuum of substance use services by:

- Enhancing coordination of care with other behavioral and physical health services.
- Enhancing the process of transitions between levels of care.

Section III: Delivery System for SUD Services

Medicaid and Medicaid Managed Care

In the HealthChoices program, behavioral health services (mental health and substance use services) are “carved out” and administered separately from physical health managed care. The HealthChoices program, is administered by five behavioral health prepaid inpatient health plans (herein referred to as Behavioral Health Managed Care Organizations (BH-MCOs)) and eight Physical Health Managed Care Organizations (PH-MCOs) operating under the 1915(b) waiver authority. The Office of Mental Health and Substance Abuse Services (OMHSAS) in the Department of Human Services (DHS) oversees the HealthChoices Behavioral Health managed care program (HC-BH). With a few exceptions, Medicaid beneficiaries are automatically enrolled in the HC-BH program in the county of their residence. As of July 1, 2017, 2.6 million

individuals were enrolled in HC-BH, supported by projected total funding of \$3.7 billion in FY 2017-18.

Community HealthChoices (CHC)

Pennsylvania is currently in the process of implementing Community HealthChoices (CHC), its new mandatory managed care program for dually eligible (Medicaid and Medicare) individuals and beneficiaries with physical disabilities—serving more people in communities, giving them the opportunity to work and experience an overall better quality of life. When implemented, CHC will enhance service delivery to hundreds of thousands of Pennsylvanians. CHC will use managed care organizations (CHC-MCOs) to coordinate physical health and long-term services and supports (LTSS) for participants. CHC will: (1) enhance access to and improve coordination of medical care; and (2) create a person-driven, long term support system in which people have choice, control and access to a full array of quality services that provide independence, health and quality of life.

OMHSAS has partnered with our sister program office in DHS, the Office of Long Term Living, to ensure that behavioral health care needs will be met for all individuals enrolled in CHC. Behavioral health services will continue to be offered through the existing BH-MCO network. CHC-MCOs and BH-MCOs will work together to ensure that all participants receive the coordinated services they need. CHC will be rolled out in geographic zones, beginning in the southwest region of the commonwealth in January 2018.

Department of Drug and Alcohol Programs

While the Department of Drug and Alcohol Programs (DDAP) is not responsible for Medicaid in Pennsylvania, the below information outlines how this department functions as part of the SUD service delivery system in the commonwealth. Pennsylvania established DDAP in 2010. DDAP has the statutory authority to oversee substance use services, except for the responsibility for managing substance use services in Medicaid and HC-BH, which remain under OMHSAS. Both DHS and DDAP

are cabinet agencies under the Governor. DDAP maintains the responsibility for the development of the State Drug & Alcohol Plan and for the control, prevention, intervention, treatment, rehabilitation, research, education, and training aspects of substance use issues.

DDAP is responsible for the allocation of the federal Substance Abuse Prevention and Treatment Block Grant (SAPTBG) in combination with state appropriations to the Single County Authorities (SCAs). The SCA system provides the administrative oversight to local substance use programs that provide prevention, intervention, and treatment services. The SCA contracts with the local licensed treatment providers for a full continuum of care for individuals who qualify for substance use services within their geographical region.

DDAP requires the SCA to provide screening, assessment, and coordination of services as part of the case management function. Screening includes evaluating the individual's need for a referral to emergent care including detoxification, prenatal, perinatal, and psychiatric services. Assessment includes Level of Care (LOC) assessment and placement determination. All individuals who present for drug and alcohol treatment services must be screened and, if appropriate, referred for LOC assessment. Through coordination of services, the SCA ensures that the individual's treatment and non-treatment needs are addressed as well as ensuring the individual is enrolled in the appropriate health care coverage.

The SCA is responsible for ensuring the individual has access to available drug and alcohol treatment and treatment-related services, which is facilitated through the case management system. The provision of case management services will vary from county to county in terms of how these functions are organized and delivered. In some instances, the SCA may choose to contract for certain case management functions and activities while retaining others.

Behavioral Health HealthChoices contracts require BH-MCOs to have a letter of agreement with SCAs to coordinate service planning and delivery with. The letter of agreement includes

- A description of the role and responsibilities of the SCA;

- Procedures for coordination with the SCA for placement and payment for care provided to members in residential treatment facilities outside the HC Zone.

Treatment Service Array

Pennsylvania has developed a comprehensive set of SUD treatment benefits that provide a full continuum of care through its fee-for-service and managed care delivery systems, federal grants, and state funds. The continuum includes:

- Inpatient Drug & Alcohol (Detoxification and Rehabilitation Services)
- Outpatient Drug and Alcohol, including Methadone Maintenance Services
- Medication Assisted Treatment (MAT)
- Residential drug and alcohol detoxification and rehabilitation
- Certified Recovery Specialist services

Inpatient, Outpatient, and MAT services are covered services within Pennsylvania's Medicaid state plan. The last two services listed above are not available under the Medicaid state plan and are provided under Pennsylvania's 1915(b) HealthChoices Waiver as "in lieu of services" (IMD restrictions in Medicaid Managed Care apply to residential services). Federal grants and state funds can be utilized for all allowable services.

SCAs at the local level receive federal grants as well as state and local funds to support treatment needs of individuals who are uninsured or underinsured. In FY 2014-15 the SCAs reported providing treatment to 32,417 unique individuals.

For HealthChoices members, the continuum of care consists of an array of treatment interventions as well as additional ancillary services to support a recovery environment. Each BH-MCO contracts with a variety of providers to complete the the LOC assessment. This may include the SCA, licensed intake and evaluation providers, or licensed outpatient providers. Clinical services are determined based upon a comprehensive assessment process and the application of standardized placement criteria such as the *American Society of Addiction Medicine-Patient Placement criteria* (ASAM-PPC-2R) for children and adolescents under the age of 21. The *Pennsylvania*

Client Placement Criteria (PCPC)⁸ is currently being utilized for adults. These will be transitioned to ASAM starting July 2018.

OMHSAS-DDAP Coordination

While OMHSAS is responsible for the administration of HC-BH, DDAP is the entity that has the statutory authority for the licensing of SUD treatment programs. As discussed in other sections of this application, OMHSAS and DDAP collaborate closely at various levels to ensure synergy across systems and to maintain consistency in the application of program requirements.

Drug Addiction Treatment Act of 2000 and the SUD Delivery System

The Drug Addiction Treatment Act of 2000 (DATA 2000) expanded the clinical context of medication-assisted opioid dependency treatment by allowing qualified physicians to dispense or prescribe specifically approved Schedule III, IV, and V narcotic medications in settings other than an opioid treatment program (OTP) such as a methadone clinic. The legislation waives the requirement for obtaining a separate Drug Enforcement Administration (DEA) registration as a Narcotic Treatment Program (NTP) for qualified physicians administering, dispensing, and prescribing specific FDA approved controlled substances such as buprenorphine in settings beyond opioid treatment programs (OTPs). DATA 2000 increases options for treating opiate dependence and gives individuals the ability to coordinate both behavioral health and physical health care by the use of qualified physicians. Since the beginning of 2002, 3717 Pennsylvania physicians have been certified under DATA 2000, with 2725 of those certified to treat up to 30 patients and the remaining 992 certified to treat up to 100 patients⁹.

According to a survey conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), physicians and patients alike reported an average

⁸ "Pennsylvania's Client Placement Criteria," Third Edition (2014). Available at: [http://www.ddap.pa.gov/Manuals/PA%20Client%20Placement%20Criteria%20\(PCPC\)%20Edition%203%20Manual.pdf](http://www.ddap.pa.gov/Manuals/PA%20Client%20Placement%20Criteria%20(PCPC)%20Edition%203%20Manual.pdf)

⁹ SAMHSA - "Number of Data-Certified Physicians". Available at: https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/certified-physicians?field_bup_us_state_code_value=PA&=Apply

of an 80% reduction in opioid abuse when asked whether buprenorphine was effective in treating addiction. Additionally, responses to the survey indicated that buprenorphine and similar medications increase other indices of recovery.¹⁰

Section IV: Comprehensive Evidence-Based Benefit Design

Building and implementing a strong evidence-based prevention and intervention strategy for Pennsylvania, along with building and supporting our comprehensive treatment and recovery support system, requires the coordination among many entities¹¹. The strategy includes prevention and intervention, treatment and recovery support, quality assurance, and workforce development.

While the Commonwealth encourages innovative practices, a range of evidence-based programs and practices that have been replicated for positive outcomes for over 40 years remains a driving force in treatment approaches. Appropriate intensity, duration, and continuum of treatment services are prime examples of principles that have been validated as critical for effective outcomes. In contrast, *under-treatment* in these three areas (e.g. detox only, or outpatient when long-term residential treatment is indicated by the assessment) leads to poorer outcomes and contributes to the rates of fatal overdoses. Other examples of elements that have been found to be ineffective are fear-based tactics in prevention services, and simple drug education/information for those in need of treatment.

As discussed in the previous section, Pennsylvania has developed a comprehensive set of SUD treatment benefits that provide a full continuum of care in the Medicaid fee-for-service and managed care delivery systems and through other federal grants, and state funds. The following chart and subsequent subsections in this section showcase the levels of care and other services available in the continuum:

¹⁰ "MAT Legislation, Regulations, and Guidelines." Available at: <https://www.samhsa.gov/medication-assisted-treatment/legislation-regulations-guidelines>

¹¹ DDAP State Plan (2016-2017). Available at <https://www.samhsa.gov/medication-assisted-treatment/legislation-regulations-guidelines>

Available SUD Services

Service & PCPC Level of Care (LOC)	Corresponding Closest ASAM Level	Description of Service
Early Intervention (Level .5)	Level .5*	Early Intervention is an organized screening and Psycho-educational service designed to help individuals identify and reduce risky substance use behaviors. Services may be offered in non-specialty settings, such as hospital emergency departments or community clinics. Examples of Early Intervention may include impaired driving programs or SBIRT screenings.
Outpatient (Level 1A)	Level 1.0	Outpatient treatment is an organized, non-residential treatment service providing psychotherapy in which the individual resides outside the facility. These services are usually provided in regularly scheduled treatment sessions.
Intensive Outpatient (Level 1B)	Level 2.1	Intensive Outpatient treatment is an organized, non-residential treatment service in which the individual resides outside the facility. It provides structured psychotherapy and stability through increased periods of staff intervention. These services are provided according to a planned regimen consisting of regularly scheduled treatment sessions at least 3 days per week.
Partial Hospitalization (Level 2A)	Level 2.5	Partial Hospitalization treatment consists of psychiatric, psychological, and other types of therapies on a planned and regularly scheduled basis in which the individual resides outside of the facility. This service is designed for those individuals who do not require 24-hour residential care, but who would nonetheless benefit from more intensive treatments than are offered in outpatient treatment programs. Partial hospitalization services consist of regularly scheduled treatment sessions at least 3 days per week.
Halfway House (Level 2B)	Level 3.1	A Halfway House is a treatment facility located in the community that is state licensed, regulated, and professionally staffed. Programs focus on developing self-sufficiency through counseling, employment, and other services. Some of these programs staff medical and psychiatric personnel on site to assist individuals with their medical and/or co-occurring needs. This is a live in/work out environment.
Medically Monitored Inpatient Detoxification (Level 3A)	Level 3.7 WM	Medically Monitored Inpatient Detoxification is a treatment conducted in a residential facility that provides a 24-hour professionally directed evaluation and detoxification of addicted individuals. This type of care utilizes multi-disciplinary personnel for individuals whose withdrawal problems (with or without biomedical and/or emotional problems) are severe enough to require inpatient services, 24-hour observation, monitoring, and, usually, medication. However, the full resources of an acute care general hospital or a medically managed intensive inpatient treatment system are not necessary.

Service & PCPC Level of Care (LOC)	Corresponding Closest ASAM Level	Description of Service
Medically Monitored Short Term Residential (Level 3B)	Level 3.3 or 3.5	Medically Monitored Short Term Residential treatment includes 24-hour professionally directed evaluation, care, and treatment for addicted individuals in acute distress. These individuals' SUD symptomatology is demonstrated by moderate impairment of social, occupational, or school functioning. Rehabilitation is a key treatment goal.
Medically Monitored Long Term Residential (Level 3C)	Level 3.5 or 3.7 (separate unit of a free-standing level 3.5 residential facility) Variable Length of Stay	Medically Monitored Long Term Residential treatment 24-hour professionally directed evaluation, care, and treatment for addicted individuals in chronic distress, whose SUD symptomatology is demonstrated by severe impairment of social, occupational, or school functioning. Habilitation is the treatment goal. These programs serve individuals with chronic deficits in social, educational, and economic skills, impaired personality and interpersonal skills, and significant drug-abusing histories that often include criminal lifestyles and subcultures.
Medically Managed Inpatient Detoxification (Level 4A)	Level 4 WM	Medically Managed Inpatient Detoxification is a treatment that provides 24-hour medically directed evaluation and detoxification of individuals with SUDs in an acute care setting. The individuals who utilize this type of care have acute withdrawal problems (with or without biomedical and/or emotional/behavioral problems) that are severe enough to require primary medical and nursing care. 24-hour medical service is provided, and the full resources of the hospital facility are available.
Medically Managed Inpatient Residential (Level 4B)	Level 4	Medically Managed Inpatient Residential treatment provides 24-hour medically directed evaluation, care, and treatment for addicted individuals with coexisting biomedical, psychiatric, and/or behavioral conditions that require frequent care. Facilities for such services need to have, at a minimum, 24-hour nursing care, 24-hour access to specialized medical care and intensive medical care, and 24-hour access to physician care.
Other Services	Non-clinical	
Recovery Supports- Peer Services	Dimension 6 – Recovery Environment that encompasses external supports for recovery	Certified Recovery Specialists (CRS) provide peer support services to help others move into and through the recovery process. CRS services are available to individuals at all stages of the recovery process, including individuals not yet engaged in treatment. CRS services may include outreach, mentoring, peer support, as well as providing resource information and referrals for ancillary services in the community to support recovery.

The table below shows the services in the preceding chart that are covered under the Medicaid State Plan and services Pennsylvania is proposing to cover under the 1115 Demonstration waiver authority:

SUD Service	State Plan	Covered under the new 1115 Waiver
Early Intervention	No	No
Outpatient	Yes	No
Intensive Outpatient	Yes	No
Partial Hospitalization	No*	No
Halfway House	No**	Yes (for facilities that meet the definition of IMDs)
Medically Monitored Inpatient Detoxification	No**	Yes (for facilities that meet the definition of IMDs)
Medically Monitored Short Term Residential	No**	Yes (for facilities that meet the definition of IMDs)
Medically Monitored Long Term Residential	No**	Yes (for facilities that meet the definition of IMDs)
Medically Managed Inpatient Detoxification	Yes	No
Medically Managed Inpatient Residential	Yes	No
Recovery Supports-Peer Services	No*	No

* Currently provided under 1915(b) “in-lieu of” authority

** currently provided under the 1915(b) “in-lieu” of authority for all ages in non-IMD settings, and for permissible ages (under 21, and 65 and above years of age) in IMD settings.

Medication-assisted treatment (MAT)

MAT is the use of medications, in combination with counseling and behavioral therapies, to provide an integrated, person-centered approach to the treatment of SUD.

MAT is available in all LOCs. It is a comprehensive treatment approach requiring staff with identified prerequisite competencies and relevant programmatic licensure approved by federal and state agencies such as SAMHSA, the DEA, and DDAP. When treating SUDs, and specifically opioid dependence, developing a comprehensive and integrated healthcare approach that combines medication and behavioral therapies achieves the greatest success and treatment outcome⁸.

Medications that are currently approved and available for the treatment of opioid dependence are methadone, buprenorphine, and naltrexone. Methadone is a synthetic opioid that blocks the effects of heroin and other prescription drugs containing opiates and/or opioids. Used successfully for more than 40 years, methadone has been shown to eliminate withdrawal symptoms and relieve drug cravings from heroin and prescription opiate medications¹². Methadone must be dispensed and administered in licensed Opioid Treatment Programs that meet all state and federal requirements.

[DATA 2000 \(discussed in detail in the section “Delivery System for SUD Services”\)](#) expanded the clinical context of medication-assisted opioid dependence treatment by allowing qualified physicians to prescribe and/or dispense specifically approved Schedule III, IV, and V narcotic medications for the treatment of opioid dependence in treatment settings other than the traditional Opioid Treatment Programs (i.e., methadone maintenance programs). In October 2002, the FDA approved a buprenorphine monotherapy product, Subutex®, and a buprenorphine/naloxone combination product, Suboxone®, for use in treatment for opioid dependence. The combination product is designed to decrease the potential for use by injection. Subutex® and Suboxone® are currently the only Schedule III, IV, or V medications to have received FDA approval for opioid dependence in settings other than Opioid Treatment Programs.

Medications approved for the treatment of alcohol dependence include:

- Disulfiram, Antabuse®
- Naltrexone, Revia® (for oral administration)
- Naltrexone, Vivitrol® (for intramuscular injection)
- Acamprosate, Campral®

¹² Center for Substance Abuse Treatment [CSAT], 2005

These medications may be prescribed for the treatment of alcohol dependence and are on the department's Medicaid formulary. These medications may be prescribed to individuals in all LOCs.

The following chart shows the number of unique individuals who received MAT from 2011 through 2016, categorized by diagnosis:

	2011 # of Recipients	2012 # of Recipients	2013 # of Recipients	2014 # of Recipients	2015 # of Recipients	2016* # of Recipients
Alcohol	32,741	32,258	31,142	31,230	38,880	42,962
Alcohol, Opiate	1,987	2,329	2,635	2,777	4,035	5,322
Alcohol, Opiate, and Other	6,745	6,284	6,627	6,908	10,065	10,608
Alcohol and Other	17,031	15,205	14,149	13,297	16,601	15,770
Opiate	25,285	28,532	31,739	34,642	45,349	58,241
Opiate and Other	20,854	21,767	22,862	24,680	30,504	30,082
Other	47,850	47,099	45,698	45,851	49,624	47,781
Receiving MAT Treatment/No Diagnosis	4,592	4,939	5,113	5,156	4,314	5,095
Total Unique SUD	157,085	158,413	159,965	164,541	199,372	215,861

Seamless transition between LOCs

Services approved under the 1115 Demonstration Waiver authority will also be provided under HealthChoices in addition to the other SUD services provided under the authority of the 1915(b) waiver. Since the BH-MCOs will oversee the provision of all services across LOCs, transition between LOCs will be a seamless process that will not cause any disruption or delay in services, regardless of whether or not the services in the LOCs are covered by the Demonstration.

Section V: Appropriate Standards of Care

Licensure of Drug and Alcohol Facilities

DDAP is responsible for the licensure of any partnership, corporation, proprietorship, or other legal entity intending to provide drug and alcohol treatment services in Pennsylvania. DDAP has regulatory responsibility through its licensure authority over both public and private drug and alcohol treatment facilities. Once licensure is obtained, a certificate of licensure or certificate of compliance is issued to the owner for a specific location and for specific drug and alcohol activities. A facility may be licensed for more than one activity. Depending on the legal base under which the organization operates, and the services provided, different chapters of regulations would apply.

Level of Care Determination

Pennsylvania currently uses PCPC to determine the most appropriate level of care for adults. The PCPC is a set of guidelines designed to provide clinicians with a basis for determining the most appropriate care for individuals with SUDs. These guidelines were developed in response to legislative actions in 1988 and 1990. These guidelines, which have been modified to fit Pennsylvania's specific needs and circumstances, apply to admission and continued stay. The guidelines also give detailed guidance for special issues and populations that are important to ensuring that individuals receive optimal treatment placement. They have been formulated to promote a broad continuum of care, which places individuals in the most clinically appropriate setting, while providing the best opportunity to efficiently utilize SUD treatment, intervention, and other community resources. The PCPC plays a critical role in a Recovery Oriented System of Care (ROSC) by supporting two major ROSC elements: ensuring continuity of care and promoting access and engagement.

Information obtained from a comprehensive assessment is interpreted according to dimensional severity (using the PCPC dimensional matrix) in order to determine the most appropriate LOCs and TOSs (Types of Service). Each LOC, from outpatient to

medically managed residential, has its own dimensional specifications. Assessors are not to place individuals in the lowest LOC, but in the most appropriate LOC based on their need at the time of the assessment.

The individual is assessed by an SUD professional trained in the use of the PCPC employed by the SCA or its contracted provider, or a licensed intake evaluation facility. An LOC assessment is defined as a face-to-face interview with the individual to ascertain treatment needs based on the degree and severity of alcohol and other drug use through the development of a comprehensive confidential personal history, including significant medical, social, occupational, educational, and family information. The PCPC guidelines are used to assist the assessor in placing the individual in an appropriate LOC and TOS. Every assessor using the PCPC guidelines should carefully consider the DOs/DON'Ts and Special Population Consideration sections under each LOC, which describe ways the PCPC guidelines would need to be applied for determining placement and continued stay for special populations and issues. The assessor forwards the PCPC Summary Sheet to the BH-MCO for HealthChoices members or to the SCA for non-HealthChoices members and admitting provider.

The Commonwealth provides several services based on the PCPC. These standards can also be mapped to the LOCs established by the ASAM. The [chart](#) in the section “*Comprehensive Evidence-Based Benefit Design*” illustrates the PCPC LOCs, a brief description of the services, funding mechanism, and the closest corresponding ASAM level.

In addition, the following areas must be considered prior to placement in order to determine, and maximize retention in, a particular type of service:

Co-Occurring Disorders	Women with Dependent Children
Cultural/Ethnic/Language Considerations	Women’s Issues
Sexual Orientation and Gender Identity	Impairment (e.g. hearing, learning)
Medication-Assisted Treatment (e.g. methadone, buprenorphine)	Criminal Justice Involvement

Transition to ASAM

Beginning July 2018, Pennsylvania will adopt ASAM to replace PCPC as the guidelines in determining the level of care and all BH-HealthChoices agreements will be

amended to include this requirement. This decision by DDAP coincides with the federal requirement that all providers who will receive funding under the 1115 Demonstration Waiver utilize ASAM. Training on the use of ASAM will be provided to the SUD treatment field, including clinical staff and BH-MCO care managers prior to implementation. OMHSAS will work with DDAP on cross-walking ASAM and PCPC and in the training of SUD staff and care managers.

Section VI: Network Development Plan

Medicaid beneficiaries served through managed care will continue to receive all SUD services, including the delivery of residential treatment services authorized under the 1115 Demonstration Waiver, through the BH-MCO provider networks. BH-MCOs will contract with licensed providers that have the ability to deliver services consistent with the ASAM criteria (since the commonwealth is transitioning ASAM starting in July of 2018) in accordance with evidence-based SUD practices. BH-MCOs are also responsible for conducting provider recruitment and credentialing, and working with OMHSAS to maintain network adequacy. The current BH-MCOs have established a network of providers to deliver the full continuum of SUD services in the commonwealth. The assurance of federal financial participation in residential treatment through the 1115 Demonstration Waiver will play a critical role in continuing the use of appropriate LOCs and lengths of stay for the continuum of SUD treatment.

Service Access

The HealthChoices program has access standards for services in all of the MCO agreements. These access standards will apply to 1115 Demonstration Waiver services.

Upon the initial face-to-face intervention, the implementation of treatment services must adhere to the prescribed treatment plan, including the start date and frequency of treatment services. BH-MCOs must have a notification process in place with providers for the referral of a member to another provider, if a selected provider is not able to schedule the referred member within the access standard. BH-MCOs must maintain a provider network which is geographically accessible to members. All LOCs must be accessible in a timely manner.

The Provider network must provide face-to-face treatment intervention within one hour for emergencies, within twenty-four (24) hours for urgent situations, and within seven (7) days for routine appointments and for specialty referrals. Network Providers are not required to be located within the county in which the BH-MCO operates. Adherence to the time requirements can be facilitated by the inclusion of out-of-county behavioral health service providers in the BH-MCO's network.

Section VII: Care Coordination Design

Pennsylvania will continue to utilize existing BH-MCO care managers to ensure that beneficiaries successfully transition between levels of SUD care, SUD providers, settings and facilities (e.g., behavioral health, primary care, emergency department), and physical and behavioral health care systems. The current care managers will be trained on ASAM for the SUD services provided under the 1115 Demonstration Waiver to ensure a seamless transition between LOCs.

The BH-MCO care managers will coordinate with county case management units to ensure that an individual can access needed ancillary support services such as social, educational, vocational, housing or other services that will support recovery. Coordination of care services may include:

- Assessment and reassessment of individual needs to determine case management service needs.
- Level of care assessments for transition between levels of care and providers.
- Development of a service plan to access ancillary support services in the community.
- Monitoring treatment and services.
- Advocating for needed community resources, linkage with physical health or other behavioral health services, coordination of transportation to ensure access to treatment, or referrals for recovery support services.

The BH-MCO care managers will help to support transitions between levels of care by managing authorizations for services and facilitating communication with service providers to ensure coordination of care.

Coordination of Care in HealthChoices

The BH-MCOs must require through their Provider Agreements that, their providers interact and coordinate services with the PH-MCOs and their Primary Care Practitioners (PCPs). Both behavioral health clinicians and PCPs have the obligation to coordinate care of mutual patients. Consistent with state and federal confidentiality laws and regulations, both must:

- Ascertain that the beneficiary's PCP, and/or relevant physical health specialist, or behavioral health clinician and obtain applicable releases to share clinical information.
- Make referrals for social, vocational, education, or human services when a need for such service is identified through assessment.
- Provide health records to each other, as requested.
- Comply with the agreement between the BH-MCO and the PH- MCOs to coordinate behavioral and physical health care including resolution of any clinical dispute.
- Be available to each other for consultation.

Coordination of Services by SUD Case Managers

Coordination of care is further augmented by the DDAP requirement that SCAs utilize case management in coordinating service delivery in order to ensure the most comprehensive process for meeting an individual's treatment and non-treatment needs throughout the recovery process. Through coordination of services, the SCA ensures that individuals with multiple complex issues, receive the individualized services they need in a timely and appropriate fashion. Coordination of services is a collaborative process that includes the following activities: engagement, evaluation of needs, establishing linkages, arranging access to services, ensuring enrollment in the

appropriate healthcare coverage, advocacy, monitoring, and other activities to address the needs of individuals throughout the course of treatment.¹³

Section VIII: Integration of Physical Health and SUD

Pennsylvania has been emphasizing integration between the PH- MCOs and the BH-MCOs and has set forth integration efforts between the BH-MCOs and Community HealthChoices within the CHC-MCO and BH-MCO HealthChoices agreements.

The HealthChoices agreements require the PH-MCOs and the BH-MCOs to communicate and coordinate the delivery of services. The PH-MCOs and BH-MCOs have quarterly meetings to discuss and analyze coordination efforts, studies and initiatives and to deliberate over issues that arise. In addition, through the HealthChoices Pay-for-Performance (P4P) program, there is an Integrated Care Program (ICP) that focuses on the PH-MCOs and BH-MCOs working to ensure effective coordination, with an incentive attached to data collection and documentation to demonstrate the coordination occurring. The Department expects this ICP Program to improve the quality of health care and reduce Medicaid expenditures through enhanced coordination of care between the PH-MCOs, BH-MCO, and providers. DHS has Managed Care Delivery System meetings that bring together the MCOs, consumer, advocate and provider representation, the Office of Medical Assistance Programs and OMHSAS programs to identify and address issues related to coordination and effective service delivery.

Certified Community Behavioral Health Clinics (CCBHC) Implementation

Pennsylvania is committed to integrating physical and behavioral health services to improve health outcomes and reduce SUD costs. In December 2016, Pennsylvania won a Demonstration grant to receive an enhanced federal matching rate on payments to the CCBHCs. The CCBHC Demonstration grant will test the integration of physical and behavioral health services. CCBHCs will allow individuals to access a wide array of behavioral and physical health services at one location to remove barriers that often exist across the physical and behavioral health systems. For the adults and children

¹³ Department of Drug and Alcohol Programs, Treatment Manual (2015-2020). Available at: <http://www.ddap.pa.gov/Manuals/Treatment%20Manual.pdf>

with serious mental illnesses and SUDs who will primarily be served by these community clinics, the increase in coordination and individualized care has the potential to greatly improve the quality of life for those served and loved ones.

Pennsylvania began implementation of the CCBHCs in July 2017 as one of eight states selected to participate in the two-year Medicaid Demonstration grant. Under seven clinics, Pennsylvania will be implementing a comprehensive array of behavioral and physical health services under this grant. Service recipients will benefit from increased access and availability of high quality services resulting in improved health outcomes and quality of life. The seven clinics anticipate serving 24,800 individuals, 17,800 who are Medicaid beneficiaries. The clinics are located in Allegheny, Berks, Clearfield, Jefferson, McKean, Montgomery and Philadelphia counties. The clinics are paid a prospective payment encounter rate for all services provided. The selected clinics will gather and submit data to evaluate quality of services and individual consumer outcomes. The 21 quality measures collected through sources such as program records, Medicaid claims, managed care encounter data, and clinic cost reports will be utilized to evaluate the outcomes of the Demonstration. Pennsylvania plans to utilize information gained from the evaluation to inform broader quality improvements to the behavioral health services.

OUD Centers of Excellence (COE)

Pennsylvania leads the nation in the number of drug overdoses in men ages 12-25 and eighth among the general population. However, there are often waiting lists for persons seeking treatment. In 2015, Pennsylvania Governor Tom Wolf announced a new initiative using state behavioral health funds and Medicaid funding to create OUD COEs throughout the commonwealth. Pennsylvania currently has 45 COEs operating out of 51 locations statewide. These centers primarily focus on treatment of individuals eligible for Medicaid diagnosed with OUDs by integrating behavioral health with primary care.

Individuals served in an OUD COE:

- Have an OUD;
- May have a co-occurring behavioral and/or physical health condition;

- Need help to navigate the health care system;
- Need guidance to stay in treatment.

The COEs embrace every individual's unique treatment path and focus on a holistic treatment method, not just treating the addiction. Each patient at a COE receives integrated care and evidence-based medication assisted treatment and has health navigators to assist them in their journey to recovery. Health navigators help an individual engage in the health care system. Navigators find an individual the right health insurance and work with family members on after care. This link contains flowcharts that demonstrate how COEs improve provision of care:

http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_230390.pdf.

The COEs will also utilize CRSs who use their personal experience with addiction to encourage individuals throughout their recovery journey. With the implementation of these OUD Centers of Excellence, it is estimated that over 10,000 people suffering from OUD will now have access to treatment in Pennsylvania.

Section IX: Program Integrity Safeguards

Even prior to establishment of the stipulation in the final rule on Medicaid Managed Care issued by CMS on May 6, 2016 that all network providers in managed care be enrolled as Medicaid providers, OMHSAS had required that all BH-MCO network providers be enrolled in Medicaid. This requirement has been in place since the inception of Behavioral Health HealthChoices in Pennsylvania.

Section 6401(b) of the Patient Protection and Affordable Care Act (Pub. L. 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) (collectively known as the Affordable Care Act or ACA) amended Section 1902 of the Social Security Act (Act), to add paragraphs (a) (77) and (kk), that required states to comply with provider screening requirements. Consistent with these requirements and the implementing regulations at 42 CFR 455, Subpart E – *Provider Screening and Enrollment*, the Commonwealth required revalidation of all Medicaid providers initially by September 25, 2016 and at least every five (5) years thereafter. Consistent with the requirements outlined in the Affordable Care Act (ACA) and

implementing regulations, Pennsylvania requires revalidation of provider enrollment every five years. In accordance with the ACA and CMS guidance, all providers enrolled in the Pennsylvania Medical Assistance (MA) Program were required to complete the revalidation process by September 25, 2016. DHS issued two bulletins, namely 99-14-06¹⁴ and OMHSAS-14-03¹⁵ to address this requirement.

Additionally, the Department issued Medical Assistance Bulletin Number 99-16-07, titled “Enrollment of Ordering, Referring and Prescribing Providers”¹⁶ effective April 1, 2016, in which the providers were informed of the implementation of the federal requirement for enrollment of ordering or prescribing providers in the MA Program. This bulletin also advised providers that when a claim is submitted for payment, the Department would use the National Provider Identifier (NPI) of the ordering or prescribing provider included on the claim to validate the provider’s enrollment in the MA Program and if the NPI of the ordering, referring or prescribing provider was not enrolled in the MA program, the claim for payment would be denied.

DHS led a series of meetings that included face to face, webinar and conference calls, with BH-MCOs and providers to address the *Ordering, Referring and Prescribing* (ORP) requirements and allow for adequate discussion on what services require an ORP and what providers needed to be enrolled. OMHSAS and OMAP led a small workgroup that included counties, BH-MCOs, and providers to ensure that all possible avenues were covered in terms of communicating the requirements around ORP. The Department requires the BH-MCOs to develop a written compliance plan as stipulated in 42 CFR §438.608 that contains the following elements:

¹⁴ Bulletin 99-14-06 is available at http://www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/c_228794.pdf

¹⁵ Bulletin OMHSAS-14-03 is available at http://www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/c_093853.pdf

¹⁶ Bulletin 99-16-07 is available at http://www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/c_224393.pdf

- Written policies, procedures, and standards of conduct that articulate the BH-MCO's commitment to comply with all federal and state standards related to Medicaid MCOs;
- The designation of a compliance officer and a compliance committee that is accountable to senior management;
- Effective training and education for the compliance officer and MCO employees;
- Effective lines of communication between the compliance officer and MCO employees;
- Enforcement of standards through well-publicized disciplinary guidelines;
- Provisions for internal monitoring and auditing; and
- Provisions for prompt response to detected offenses and the development of corrective action initiatives.

The BH-MCOs must also comply with the Department's MA Bulletin #99-11-05 titled "Provider Screening of Employees and Contractors for Exclusion from Participation in Federal Health Care Programs and the Effect of Exclusion on Participation"¹⁷ to check providers against the National Plan and Provider Enumeration System (NPPES) (effective for rating periods starting on or after July 1, 2017), the System for Award Management (SAM) at www.sam.gov ; the Excluded Individuals and Entities (LEIE) and the Medicare databases for screening to determine exclusion status at the time of hire or contracting and thereafter on an ongoing monthly basis.

Effective for rating periods starting on or after July 1, 2017, the BH-MCOs must comply with the federal database check as per 42 CFR §455.436 which requires that the Social Security Death Master File (DMF) be checked monthly in addition to the databases described above. Providers who have enrolled or re-enrolled since the date of implementation must have their Social Security numbers compared to the DMF.

BH-MCOs must also designate a full-time Fraud Waste and Abuse Coordinator who is dedicated to preventing, detecting, investigating, and referring suspected Fraud,

¹⁷ Bulletin #99-11-05 available at http://www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/d_005732.pdf

Waste, and Abuse in the BH-HC to the Department. The Fraud, Waste, and Abuse Coordinator acts as a direct contact with the Department in matters relating to Fraud, Waste, and Abuse.

Section X: Benefit Management

General Requirements

BH-MCOs are required to adhere to Pennsylvania Department of Health (DOH) Regulation 28 Pa. Code Chapter 9, Subchapter G¹⁸ that pertains to Health Maintenance Organizations (HMOs). The inclusion of this requirement in the BH-MCO agreements is intended to ensure that consumer choices are offered to advance quality assurance, cost effectiveness, and access to health care services.

BH-MCOs must have written policies and procedures to monitor use of services by its members and to assure the quality, accessibility, and timely delivery of care being provided by its network providers. Such policies and procedures must:

- a) Conform to Medicaid State Plan Quality Management (QM) requirements.
- b) Assure a Utilization Management (UM)/QM committee meets on a regular basis.
- c) Provide for regular UM/QM reporting to the BH-MCO management and its provider network (including profiling of provider utilization patterns) as well as reports of joint UM/QM activities/studies conducted with the PHSS.
- d) Provide opportunity for consumer (including representation of consumers in Special Needs Populations), persons in recovery and family (including Parents/custodians of children and adolescents) participation in program monitoring.

Utilization Management (UM)

BH-MCOs are required to have OMHSAS-approved written UM policies and procedures that include protocols for prior approval, determination of medical necessity, concurrent review, denial of services, hospital discharge planning, provider profiling, and retrospective review of claims. As part of their UM function, the BH-MCOs must have processes to identify over, under, and type of service utilization problems and

¹⁸ The Pennsylvania Code, Subchapter G. HMOs. Available at:
<http://www.pacode.com/secure/data/028/chapter9/subchapGtoc.html>

undertake corrective action. In their UM practices, BH-MCOs focus on the evaluation of the medical necessity, level of care, appropriateness, and effectiveness of behavioral health services, procedures, and use of facilities.

Drug and alcohol reviews must be conducted in accordance with the PCPC⁸ for adults, issued by DDAP, discussed above. Drug and alcohol reviews for children and adolescents must be conducted in accordance with ASAM.

The BH-MCOs must distribute the review and UM criteria to all providers in its provider network and to any new provider. The criteria must also be provided to members upon request.

Mental Health Parity and Addiction Equity Act (MHPAEA) and UM

OMHSAS will ensure conformance with the requirements of MHPAEA and implementing regulations in all UM policies and processes.

Section XI: Community Integration

Medicaid beneficiaries who are receiving Home- and Community-Based Services (HCBS) will have access to all substance use treatment services through the HealthChoices Program and the 1115 Demonstration Waiver. BH-MCOs will ensure that all services provided under this Demonstration are based upon the identified individual needs of each member and documented in the person-centered treatment plan of the individual receiving HCBS. Licensing standards for the development of treatment plans require the involvement of the individual receiving services and should include the identification of needed supportive services.

The new HCBS requirements issued by CMS in 2014, contained the following requirements for all HCBS settings:

- Integrates in and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community - to the same degree of access as individuals not receiving Medicaid HCBS.

- Allows the individual to select from setting options, including non-disability specific settings, and an option for a private unit in a residential setting. The setting options are identified and documented in the person-centered service plan and are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.
- Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.
- Optimizes, but does not regiment, individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.
- Facilitates individual choice regarding services and supports, and who provides them.

In order to meet these requirements, Pennsylvania developed a statewide transition plan (STP)¹⁹. In this plan, which was published in August 2016, the commonwealth facilitated community integration in various ways. Pennsylvania created its STP through a series of forums, public outreach, and stakeholder meetings. Following these initiatives, the commonwealth looked to ensure that regulations, policy bulletins, and service definitions met the CMS requirements

Section XII: Strategies to Address Prescription Drug Abuse

Prescription Drug Monitoring Program (PDMP)

Pennsylvania PDMP system, which collects Schedule II-V controlled substances data and stores it in a secure database is available only to health care professionals and others as authorized by law. Previously, the PDMP required the reporting of Schedule II controlled substances only. The legislature passed a new law, Act 191 of 2014²⁰, which required monitoring Schedule II through Schedule V controlled substances.

¹⁹ Pennsylvania's Home and Community-Based Services (HCBS) Settings CMS Final Rule Statewide Transition Plan, 2016. Available at: http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/c_220667.pdf

²⁰ Act 191: Achieving Better Care by Monitoring All Prescriptions Program (ABC-MAP) Act. 2014. Available at: <http://www.legis.state.pa.us/cfdocs/legis/li/uconsCheck.cfm?yr=2014&sessInd=0&act=191>

The PDMP system has improved the quality of patient care in Pennsylvania by providing prescribers and dispensers access to information about all controlled substances dispensed to their patients. This system also assists prescribers in referring patients with the disease of addiction to appropriate treatment. Protected Health information in the PDMP system is protected as required by the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) and state confidentiality laws.

The PDMP provides data to health care professionals to enable them to make more informed decisions about prescribing and dispensing monitored prescription drugs to their patients. Health care professionals are encouraged to use the data available from the PDMP to improve their treatment of patients, including referring patients to substance use treatment²¹. Training is available for dispensers and prescribers to utilize the new system.

Pennsylvania's Opioid State Targeted Response (STR) funding will accelerate Pennsylvania's integration of the PDMP data at the point-of-care, promoting ease-of-use and greater adoption of the data for clinical decision-making. Increased access to a patient's controlled substance prescription data will support improvement of the health care provider's knowledge of the patient's needs and facilitate referral to treatment, when warranted. Objectives of STR include:

- Increase the number of licensed prescribers trained in the use of the PDMP.
- Increase the utilization of PDMP data before writing prescriptions for opioids, benzodiazepines, and all controlled substances (Schedule II-V).
- Decrease the rate of emergency department visits due to misuse or abuse of controlled substances (Schedule II-V).
- Reduce the average daily morphine milligram equivalent (MME/day) prescribed.

Additionally, the commonwealth has expanded the prescription drug take back program. DDAP, working in partnership with Pennsylvania Commission on Crime and Delinquency and the Pennsylvania District Attorneys Association, has continued to increase the availability of permanent prescription take back boxes across the

²¹ More information is available at: http://www.health.pa.gov/Your-Department-of-Health/Offices%20and%20Bureaus/PaPrescriptionDrugMonitoringProgram/Pages/home.aspx#.Wlu_L0xFzIW

commonwealth, with the goal of reducing the amount of prescription drugs available for potential misuse/abuse. Initially, 385 prescription drug take back boxes were installed in local law enforcement departments. Additional boxes funded through other sources are also accessible bringing the total number of boxes statewide to 584, with at least one box in all 67 counties. Since 2014, approximately 218,000 pounds of medications, including prescription drugs, have been collected and destroyed.

Electronically Transmitted Prescriptions.

An electronically transmitted prescription²² is the communication of an original prescription or refill authorization by electronic means, to include computer-to-computer, computer-to-facsimile machine or e-mail transmission which contains the same information it contained when the authorized prescriber transmitted it. The term does not include a prescription or refill authorization transmitted by telephone or facsimile machine.

A pharmacist may accept an electronically transmitted prescription from an authorized licensed prescriber or an authorized designated agent which has been sent directly to a pharmacy of the patient's choice meeting the requirements in the state regulations²².

The electronic transmission of a prescription for a Schedule II, III, IV or V controlled substance is considered a written prescription order on a prescription blank and may be accepted by a pharmacist provided that the transmission complies with the applicable federal and state rules.

Section XIII: Strategies to Address Opioid Use Disorder

As stated earlier, on January 10, 2018, Governor Wolf signed a statewide disaster declaration to enhance state response, increase access to treatment, and save lives - the first-of-its-kind for a public health emergency in Pennsylvania. Some of the key directives in this declaration include¹:

²² The Pennsylvania Code: Technology and Automation. Available at: <http://www.pacode.com/secure/data/049/chapter27/s27.201.html>

- Enabling Emergency Medical Services providers to leave behind naloxone by amending the current standing order to include dispensing by first responders, including Emergency Medical Technicians (EMTs).
- Allowing pharmacists to partner with other organizations to increase access to Naloxone by waiving regulations to allow pharmacists to partner with other organizations, including prisons and treatment programs to make naloxone available to at-risk individuals upon discharge from these facilities.
- Allowing for the immediate temporary rescheduling of all fentanyl derivatives to align with the federal DEA schedule while working toward permanent rescheduling.
- Waiving the face-to-face physician requirement for Narcotic Treatment Program (NTP) admissions to allow initial intake review by a Certified Registered Nurse Practitioner (CRNP) or Physician Assistant (PA) to expedite initial intakes and streamline coordination of care when an individual is most in need of immediate attention
- Expand access to medication-assisted treatment (MAT) by waiving the regulatory provision to permit dosing at satellite facilities even though counseling remains at the base NTP. This allows more people to receive necessary treatments at the same location, increasing their access to all the care and chances for recovery.
- Waive separate licensing requirements for hospitals and emergency departments to expand access to drug and alcohol treatment to allow physicians to administer short-term MAT consistent with DEA regulations without requiring separate notice to DDAP.

Other strategies to address OUD are manifold as outlined in the ensuing discussions.

Opioid Crisis STR grant

Pennsylvania will utilize SAMHSA's STR grant to address the opioid crisis by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose related deaths through the provision of prevention, treatment, and recovery activities for OUD. This grant will help Pennsylvania to expand funding for treatment services building upon our robust Medicaid program and state funding for treatment

services for the uninsured and underinsured. Supports to assure timely access to treatment and to maintain ongoing connection to long-term recovery services will be built upon state funding for the Pennsylvania OUDs COEs. Pennsylvania plans to use Opioid STR funds to expand capacity for specialty drug courts to provide necessary treatment for offenders by building upon funds proposed in the state budget and any available federal dollars.

For the STR funding, Pennsylvania has developed a cross department implementation approach that builds upon existing efforts and available state and federal resources. The initial planning included DDAP, DHS's OMHSAS and Office of Medical Assistance Office Programs (OMAP), DOH, the Pennsylvania Department of Aging (PDA), and the Pennsylvania Department of Education (PDE). Each department has state and federal dollars that will be leveraged with the Opioid STR funds to implement a comprehensive approach to addressing the goals of the proposed projects.

With this grant funding, Pennsylvania proposes to address the opioid crisis by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose-related deaths through the provision of prevention, treatment, and recovery activities for OUD. The project will support a comprehensive response to the opioid epidemic using a strategic planning process to conduct needs and capacity assessments. The results of the assessments will identify gaps and resources from which to build upon existing substance use prevention and treatment activities. Initial strategies have been developed and include:

- Provide clinically-appropriate treatment services to 6,000 individuals who are uninsured or underinsured.
- Expand treatment capacity for MAT for OUD.
- Expand treatment capacity for underserved populations by targeted workforce development and cultural competency training.
- Improve quality of prescribing practices through prescriber education.
- Increase community awareness of OUD issues and resources through public awareness activities.

- Expand implementation of warm hand-off referral practices to increase the number of patients transferred directly from the emergency department to substance use treatment.
- Expand Pennsylvania’s integration of PDMP data at the point-of-care, promoting ease-of-use of this data in clinical decision making.

New or enhanced strategies to be implemented in year two of the Opioid STR grant funding will include increased services to females with OUD through maternal healthcare and further development of treatment services, expansion of prevention efforts regarding opioid use, expansion of recovery support services and further development of use of MAT within residential SUD treatment.

Warm Handoff

DDAP has begun to establish warm hand off processes to coordinate referrals from EDs to the appropriate level of treatment. Through the warm handoff process, a substance use specialist, often a person with lived experience, engages with patients in acute medical care settings and works with the patient to identify an OUD and to coordinate a referral to care. The process is an opportunity to engage with patients who might not otherwise agree to treatment that could lead them toward recovery. This process provides emergency providers with assistance in meeting the needs of patients with complex OUD issues. Drug and alcohol peer recovery support providers are playing a larger role in the services system in engagement of persons seeking help with an OUD and can assist connecting people to appropriate services in the community.

Overdose Task Force (OTF)

OTF, established by DDAP in July 2013, is comprised of representatives from the national, state, county and local levels that continues to meet approximately quarterly. The initial goal of the OTF was to develop a rapid response mechanism to break down information silos so that law enforcement and emergency medical services could have real-time trends information more readily available to them.

In June 2015, the OTF expanded its leadership to include the commonwealth’s Physician General as co-chair of the group and expanded its focus from its initial rapid

response goal to include: (a) informing and driving public policy on the issue of overdose; (b) informing overdose response; and (c) strategizing and planning robust responses to the crisis.

Centers of Excellence (COEs)

[Please see the discussion on COEs](#) in the “*Integration of Physical Health and SUD*” section.

Community Care Behavioral Health Centers (CCBHCs)

[Please see the discussion on CCBHCs](#) in the “*Integration of Physical Health and SUD*” section.

Section XIV: Services for Adolescents and Youth with an SUD

Pennsylvania will ensure that all appropriate medically necessary 1905(a) services are available and accessible for the youth and adolescent population with SUD under 21 years of age. Youth and adolescents under 21 years of age are not included in this 1115 Demonstration Waiver request. They will continue to receive SUD residential services provided under the “in lieu of” authority in managed care.

Section XV: Reporting of Quality Measures

Current reporting available

DHS reports on many of the Adult and Child Core measures. See the chart below for the statewide results comparing Initiation and Engagement of Alcohol and Other Drug Dependence (I & E AOD) Treatment for Healthcare Effectiveness Data and Information Set (HEDIS) years 2015 and 2016. The chart indicates a decrease in the statewide Medicaid Managed Care (MMC) program rates.

Initiation and Engagement of AOD

Total MMC population-all ages	HEDIS 2015 Statewide MMC	HEDIS 2016 Statewide MMC	Difference
Denominator	34,456	14,676	3,847
Initiation Numerator 1	10,287	6,680	2,275
Engagement Numerator 2	7,101	4,973	1,909

Rate 1 (%)	29.86%	27.47%	(-) 2.39%
Rate 2 (%)	20.61%	19.09%	(-) 1.52%

DHS creates a subset of the I & E AOD measurement which specifically looks at individuals in MMC that initiated and engage into Opioid treatment. The following chart indicates an improvement for this subset group when comparing HEDIS year 2016 and 2015 results.

Opioid Initiation and Engagement (subset of I & E AOD)

Total MMC population- all ages	HEDIS 2015 Statewide MMC	HEDIS 2016 Statewide MMC	Difference
Denominator	10,829	14,676	3,847
Initiation Numerator 1	4,405	6,680	2,275
Engagement Numerator 2	3,064	4,973	1,909
Rate 1 (%)	40.68%	45.52%	(+) 4.84%
Rate 2 (%)	28.29%	33.89%	(+) 5.60%

DHS will continue to produce or build the capacity to enable the reporting of the SUD quality measures listed in the tables below. In addition, the PA HealthChoices program will explore adding other measures as they are developed and added to the CMS Core Set of Medicaid and CHIP Measures as part of our effort to improve the quality of care through data-driven results. These quality measures will be assessed as part of the program evaluation and will be reported to CMS.

Quality Measures Source	Measure	Collection Mechanism	Plan
NQF #0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Claims/encounter data	Continued
NQF #1664	SUB-3 Alcohol and Other Drug Use Disorder Treatment Provider or Offered at Discharge SUB-3a Alcohol and Other Drug Use Disorder Treatment at Discharge	Clinical data/clinical paper chart review	New to start HEDIS year 2019
NQF # 2605	Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence	Claims/encounter data	New to start HEDIS year 2017

NQF # 2940	Use of Opioids at High Dosage in Persons Without Cancer	Claims/encounter data	New to start HEDIS year 2017
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Section XVI: Collaboration with Single State Agency for Substance Abuse

As discussed in *Section III: Delivery System for SUD Services*, DHS-OMHSAS is responsible for public behavioral health services in Pennsylvania, including Medicaid/Managed Care for behavioral health services, and serves as the single state agency for mental health, whereas DDAP is the single state agency for substance use services and is responsible for the licensing of all drug and alcohol treatment facilities.

DHS-OMHSAS works in close collaboration with DDAP as well as other relevant state agencies including DOH, PDA, and PDE on various projects related to SUD. The recent projects in which OMHSAS and DDAP closely collaborated include the [STR grant](#) and the licensing of [CCBHCs](#).

Collaboration on Pennsylvania Coordinated Medication-Assisted Treatment

DHS-OMHSAS, DOH and DDAP will work together to award the grants chosen for the Pennsylvania Coordinated Medication-Assisted Treatment (PacMAT) program. The grants are funded through the federal [STR](#) grant that the commonwealth received to combat the heroin and opioid epidemic by increasing access to treatment, reducing unmet treatment need, and reducing opioid overdose-related deaths through the provision of prevention, treatment, and recovery activities for OUD.

Through PacMAT, organizations and institutions will create a hub-and-spoke network of health care providers to provide access to MAT for patients who are suffering from OUD.

Section XVII: Evaluation Plan

The evaluation will assess the impact of continued access to medically necessary SUD treatment in residential facilities for individuals 21-64 years of age on the following outcomes:

- i. Emergency room utilization for consequences of substance use disorders including opioid overdoses.
- ii. Access to acute inpatient and residential treatment for substance use disorders.
- iii. Quality of discharge planning in making effective linkages to community-based care.
- iv. Readmissions to the same level of care or higher.
- v. Cost of treatment for substance use disorder conditions.
- vi. Drug overdose deaths.

The commonwealth expects to address the following questions in its evaluation:

1. How does the Demonstration affect member's access to and utilization of substance use services across the continuum of care?
2. What is the impact of the appropriate length of stay in residential treatment facilities on emergency department visits, inpatient hospital admissions, and readmissions to the same level of care or higher levels?
3. What is the impact of accessing residential treatment services for an appropriate length of stay on the number of overdose deaths across the commonwealth?
4. How does the Demonstration affect member costs across behavioral and physical health?

Evaluating Effectiveness

The DHS plan for evaluation effectiveness is to use a subset of individuals in the following measures with a primary or secondary diagnosis of SUD.

Utilization	Measure	Collection Mechanism	Plan
Readmission to IP Settings	Readmission rates to the same level of care or higher	Claims/Encounters	Monthly CY 2017
Emergency Department Utilization	Number of Admissions to Emergency Departments	Claims/Encounters	Monthly CY 2017
Inpatient Hospital Utilization	Number of Admissions to an Inpatient Hospital Setting	Claims/Encounters	Monthly CY 2017

Evaluating Adherence and Retention

Measure	Collection Mechanism	Plan
Follow-up after Discharge from Emergency Department for Mental Health or Alcohol or Other Drug Dependence (NQF #2605)	Claims/encounter data	To start HEDIS year 2017-yearly
Percentage of beneficiaries with an SUD diagnosis including those with OUD who used the following services per month (multiple rates reported): <ul style="list-style-type: none"> • Outpatient; • Intensive outpatient services; • Medication assisted treatment for OUDs; • Residential treatment (including average lengths of stay (LOS) in residential treatment aiming for a statewide average LOS of 30 days); and • Medically supervised withdrawal management. 	Claims/encounter data	Monthly Yearly CY 2017

Evaluating Transition

Pennsylvania was one of eight states selected as a Demonstration State for the Certified Community Behavioral Health Clinics. This Demonstration began on July 1, 2017, and includes eight clinic sites across PA. Consequently, the Commonwealth is uniquely positioned to study the effectiveness of the Demonstration and use the

measurement results against benchmarks to support the 1115 Waiver. The following measurement results will be studied for transitions. The increased percentages will allow benchmarking to be studied and created for the BH system.

Quality Measures Source	Measure	Collection Mechanism	Plan
NQF #0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment ⁱ	Claims/encounter data	HEDIS year 2016
NQF # 2605	Follow-up after Discharge from the Emergency Department for Mental Health or Alcohol or Other Drug Dependence	Claims/encounter data	New to start HEDIS year 2017

Section XVIII: Budget Neutrality

Medicaid expenditures and enrollment are not expected to materially change as a result of this Demonstration, but are expected to have normal trend throughout the Demonstration period. The expenditure authority requested under the Demonstration is to permit the Commonwealth to cover substance use disorder (SUD) treatment for BH-MCO members in institutions for mental diseases (IMDs) consistent with historical practices. The budget neutrality model would be constructed as a per capita model. The following narrative describes the key considerations and steps in the development of the budget neutrality per capita limits from Demonstration Year 1 (DY 1), which is July 1, 2018 – June 30, 2019, through Demonstration Year 5 (DY 5), which is July 1, 2022 – June 30, 2023. The With Waiver (WW) projections are provided below.

Base Data Development for Impacted Populations

For purposes of developing budget neutrality, DHS identified Behavioral Health (BH) HealthChoices members and member months in CY 2016 when members were utilizing SUD IMDs. Similarly, the member data was used to assess eligibility for the Physical Health (PH) HealthChoices program or the future Community HealthChoices (CHC) program. Because the SUD IMD utilization was only readily available for CY 2016, the same member mix by geography and rating groups observed in the CY 2016 data was applied to the CY 2012 through CY 2015 data.

The BH HealthChoices and PH HealthChoices capitation data from CY 2012 through CY 2016 were used for the members identified in the SUD IMDs who were eligible for both HealthChoices programs. Additionally, for future CHC eligibles using SUD IMDs, historical FFS expenditures from CY 2016 were extracted, along with the estimated statewide CHC capitation rates for CY 2018, and utilized in order to develop enrollment and per member per month (PMPM) projections.

In order to streamline reporting under this 1115 waiver, DHS has developed the following MEGs to align with the HealthChoices 1915(b) waiver MEGs:

- SUD IMD Temporary Assistance for Needy Families (TANF)
- SUD IMD SSI with Medicare
- SUD IMD SSI without Medicare
- SUD IMD HealthChoices Expansion (HCE)

Currently, the HealthChoices 1915(b) waiver includes MEGs for TANF, SSI and HCE. With the implementation of CHC in the Demonstration period, the proposed MEGs are split for SSI individuals based on the presence of Medicare coverage (i.e., dual eligibility).

With waiver projections

For purposes of the With Waiver projections, Mercer used CY 2016 as the most recent base data year. To ensure the base data accurately represents the population included in the SUD 1115 waiver, adjustments to reflect CHC implementation were incorporated. While the implementation of CHC primarily affects SSI with Medicare (i.e., dual eligibles) individuals in SUD IMDs who are not currently enrolled in the PH HealthChoices program but are enrolled in the BH HealthChoices program, there are also individuals in the other three MEGs who will become eligible for CHC and may or may not be currently enrolled in PH HealthChoices. The waiver projections reflect an adjustment for the estimated impact of CHC implementation between 2018 and 2020. Finally, the PMPMs for DY1 – DY 5 included in this application reflect the use of the

President's budget growth rate for adults for all MEGs except the SUD IMD HCE MEG, which utilizes the President's budget growth rate for newly eligible adults.

ELIGIBILITY GROUP	Demonstration Years (DY)					TOTAL With Waiver
	DY 01 Final	DY 02 Final	DY 03 Final	DY 04 Final	DY 05 Final	
SUD IMD TANF						
Eligible Member Months	9,377	9,611	9,851	10,098	10,350	
Total Cost Per Eligible	\$ 524.53	\$ 552.35	\$ 581.39	\$ 611.62	\$ 643.42	
Total Expenditure	\$ 4,918,518	\$ 5,308,636	\$ 5,727,273	\$ 6,176,139	\$ 6,659,397	\$ 28,789,962
SUD IMD SSI WITH MEDICARE						
Eligible Member Months	3,585	3,675	3,766	3,861	3,957	
Total Cost Per Eligible	\$ 207.18	\$ 248.73	\$ 280.81	\$ 295.41	\$ 310.77	
Total Expenditure	\$ 742,740	\$ 914,083	\$ 1,057,530	\$ 1,140,578	\$ 1,229,717	\$ 5,084,648
SUD IMD SSI WITHOUT MEDICARE						
Eligible Member Months	7,212	7,393	7,577	7,767	7,961	
Total Cost Per Eligible	\$ 1,982.36	\$ 2,141.43	\$ 2,259.96	\$ 2,377.48	\$ 2,501.11	
Total Expenditure	\$ 14,296,780	\$ 15,831,592	\$ 17,123,717	\$ 18,465,887	\$ 19,911,337	\$ 85,629,313
SUD IMD HCE						
Eligible Member Months	63,818	65,414	67,049	68,725	70,443	
Total Cost Per Eligible	\$ 754.04	\$ 795.35	\$ 839.02	\$ 885.17	\$ 933.85	
Total Expenditure	\$ 48,121,325	\$ 52,027,025	\$ 56,255,452	\$ 60,833,308	\$ 65,783,196	\$ 283,020,305

(please also see the attached budget neutrality worksheets)

Section XIX: Expenditure Authorities

The commonwealth seeks expenditure authority under section 1115(a)(2) of the Social Security Act for expenditures for services not otherwise furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are short-term residents in facilities.

APPENDIX A: IMPLEMENTATION PLAN

Milestone 1. Access to Critical Levels of Care for OUD and other SUDs

(Please also see [“Available SUD Services” table](#) in “Section IV: Comprehensive Evidence-Based Benefit Design”)

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Coverage of outpatient services	<p>Covered by the state plan (see “<i>Clinic Services</i>” – “<i>Drug and Alcohol and Methadone Maintenance Clinic Services</i>” on Attachment 3.1A/3.1B, Page 4b of the state plan).</p> <p>Required Services and Support Systems include:</p> <ul style="list-style-type: none"> • Biopsychosocial Assessment • Specialized professional medical consultation, and tests such as a physical examination, psychiatric evaluation, HIV and TB testing, and other laboratory work, as needed • Individualized treatment planning, with reviews at least every 60 days • Psychotherapy, including individual, group, and family (per clinical evaluation) • Aftercare planning and follow-up <p>Recommended Services and Support Systems include:</p> <ul style="list-style-type: none"> • Occupational and vocational counseling • Case management and social services that allow the staff to assist with attendance monitoring, child care, transportation to 	Already provided	None needed. Service already provided

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<p>treatment services, and the provision of shelter and other basic needs</p> <ul style="list-style-type: none"> • Structured positive social activities available within non-program hours, including evenings and weekends • Access to more intensive LOC as clinically indicated • Collaboration between the treatment team and various agencies for the coordinated provision of services <p>Required Staff: The required Staff at an outpatient care facility include a director and counselor(s), and a clinical supervisor for every eight full-time counselors or counselor assistants, or both. The State of PA recognizes that, based on the agency size and profile, a single person may hold one or more of the above positions. The Staff who may be recommended may include a clinical supervisor or lead counselor, social services counselor, a psychiatrist, a psychologist, a medical consultant, and any other health and human services staff or consultants (i.e. SUD counselors or other certified SUD clinicians) who may more effectively serve the facility's population.</p>		

Milestone Criteria	Current State	Future State	Summary of Actions Needed
<p>Coverage of intensive outpatient services</p>	<p>Covered by the state plan (see “<i>Clinic Services</i>” – “<i>Drug and Alcohol and Methadone Maintenance Clinic Services</i>” on Attachment 3.1A/3.1B, Page 4b of the state plan).</p> <p>Required Services and Support Systems include:</p> <ul style="list-style-type: none"> • Biopsychosocial Assessment • Specialized professional medical consultation, and tests such as a physical examination, psychiatric evaluation, HIV and TB testing, and other laboratory work, as needed • Individualized treatment planning, with reviews at least every 60 days (recommended: every 30 days) • Psychotherapy, including individual, group, and family (per clinical evaluation) • Aftercare planning and follow-up • Development of discharge plan and plan for referral into continuum of care <p>Recommended Services and Support Systems include:</p> <ul style="list-style-type: none"> • Psychoeducational seminars • Structured positive social activities available within non-program hours, including evenings and weekends • Access to more intensive LOC, as clinically indicated • Emergency telephone line available when program is not in session 	<p>Already provided</p>	<p>None needed. Service already provided</p>

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<ul style="list-style-type: none"> • Collaboration between the treatment team and various agencies for the coordinated provision of services • Occupational and vocational counseling • Case management and social services that allow the staff to assist with attendance monitoring, child care, transportation to treatment services, and the provision of stable shelter and other basic care needs <p>Required Staff: The required Staff at an intensive outpatient care facility include a director and counselor(s), and a clinical supervisor for every eight full-time counselors or counselor assistants, or both. The State of PA recognizes that, based on the agency size and profile, a single person may hold one or more of the above positions. The Staff who may be recommended may include a clinical supervisor or lead counselor, social services counselor, a psychiatrist, a psychologist, a medical consultant, and any other health and human services staff or consultants (i.e. SUD counselors or other certified SUD clinicians) who may more effectively serve the facility's population.</p>		
Coverage of medication assisted treatment (medications as well as	Counseling and methadone maintenance covered by the state plan under " <i>Clinic Services</i> " – " <i>Drug and Alcohol and Methadone Maintenance Clinic Services</i> " on Attachment 3.1A/3.1B, Page 4b of the state plan.	Already provided	None needed. Service already provided

Milestone Criteria	Current State	Future State	Summary of Actions Needed
<p>counseling and other services with sufficient provider capacity to meet needs of Medicaid beneficiaries in the state)</p>	<p>Methadone maintenance clinics are licensed by DDAP under Pennsylvania regulations, Title 28 § 715, <i>Standards for Approval of Narcotic Treatment Program</i>, which includes requirements for medication management and counseling. This chapter is available at: https://www.pacode.com/secure/data/028/chapter715/chap715toc.html</p> <p>Other medications (buprenorphine, vivitrol) covered under “Prescribed Drugs” - see Attachment 3.1A/3.1B, Page 5a of the state plan.</p> <p>Please also see Medication Assisted Treatment in <i>Section IV: Comprehensive Evidence-Based Benefit Design</i> of this application as well as the Medicaid formulary available at https://papdl.com/sites/default/files/ghs-files/Penn%20PDL%2007252017%20v2017_1_g.pdf (see Opiate Dependence Treatments on page 35 of this Formulary list)</p>		
<p>Coverage of intensive levels of care in residential and inpatient settings</p>	<p>Medically Managed Inpatient Residential (corresponding to ASAM Level 4) covered by the state plan under “Inpatient Services” - see Attachment 3.1A/3.1B, Page 1b of the state plan.</p> <p>Required Services and Support Systems include:</p> <ul style="list-style-type: none"> • 24-hour observation, monitoring, and treatment 	<p>Already provided</p>	<p>None needed. Service already provided</p>

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<ul style="list-style-type: none"> • Full resources of an acute care general or psychiatric hospital, or a medically managed intensive inpatient treatment service • Treatment for SUD and for coexisting medical and/or psychiatric disorders • Access to detoxification or other more intensive medical/psychiatric services for related emotional/behavioral problems or family conditions which could jeopardize recovery • Assistance in accessing support services • Emergency medical services available • Referral to detox, if clinically necessary • Specialized professional/medical consultation, and testing such as HIV and TB tests, and other laboratory work if needed • Biopsychosocial Assessment • Individualized treatment planning, with review at least every 30 days (where treatment is less than 30 days, the review shall occur every 15 days) • Individual therapy • Group therapy (group size: no larger than 12) • Couples therapy and/or family therapy (if appropriate) • Occupational and vocational counseling • Monitoring of medication, as needed • Physical exam 		

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<ul style="list-style-type: none"> • Development of discharge plan and plan for referral into continuum of care <p>Required Staff: The required Staff in a Medically Managed Inpatient Residential facility are appointed according to the Joint Commission on the Accreditation of Hospital Organization's (JCAHO's) standard hospital practices. In addition, they must comply with DDAP staffing requirements. The Staff who may be recommended may include SUD counselors or registered, certified SUD clinicians able to administer planned interventions according to the assessed needs of the individual.</p> <p>Other SUD residential services listed below are currently provided under the 1915(b) "in-lieu" of authority for all ages in non-IMD settings, and for permissible ages (under 21, and 65 and above years of age) in IMD settings:</p> <ul style="list-style-type: none"> ➤ Halfway House (corresponding to ASAM Level 3.1). Required Services and Support Systems include: <ul style="list-style-type: none"> • Physical exam • Regularly scheduled psychotherapy • Biopsychosocial Assessment • Specialized professional/medical consultation, and tests such as a psychiatric evaluation, HIV and TB testing, and other laboratory work, as needed 	<p>Already provided /available (Expenditure authority requested under this 1115 Demonstration</p>	<p>None needed, service already provided/ available (Expenditure authority requested under this 1115 Demonstration)</p>

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<ul style="list-style-type: none"> • Individualized treatment planning, with reviews at least every 30 days • Development of a discharge plan and a plan for referral into continuum of care • Access to services for: vocational assessment, job readiness and job placement, GED preparation and testing, literacy and basic education tutoring, legal, medical and dental care, general health education (esp. AIDS awareness and support), budgeting, credit restoration, housing assistance, income support, and recreational/social activities (e.g. fitness, games, peer interaction). <p>Recommended Services and Support Systems include:</p> <ul style="list-style-type: none"> • Group therapy • Individual therapy • Peer group meetings • Family therapy, if indicated by the individual's treatment plan • Educational or instructional groups, <p>Required Staff: The Required Staff in a halfway house include a director and counselor(s), and a clinical supervisor for every eight full-time counselors or counselor assistants, or both. The State of PA recognizes that, based on the agency size and profile, a single person may hold one or more of the above positions. The Staff who may be Recommended may include a clinical</p>		

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<p>supervisor or lead counselor, social services counselor, a psychiatrist, a psychologist, a medical consultant, and any other health and human services staff or consultants (i.e. SUD counselors or other certified SUD clinicians) who may more effectively serve the facility's population.</p> <p>➤ Medically Monitored Short Term Residential (corresponding to ASAM Level 3.3 or 3.5)</p> <p>Required Services and Support Systems include:</p> <ul style="list-style-type: none"> • 24-hour observation, monitoring, and treatment • Emergency medical services available • Referral to detoxification, if clinically needed • Specialized professional/medical consultation, and tests such as HIV and TB testing, and other laboratory work, as needed • Biopsychosocial Assessment • Individualized treatment planning, with reviews at least every 30 days (where treatment is less than 30 days, review shall occur every 15 days) • Individual therapy • Group therapy (group size: no more than 12 members) • Couples therapy (if appropriate) • Family therapy (if appropriate) 	<p>Already provided/available (Expenditure authority requested under this 1115 Demonstration)</p>	<p>None needed, service already provided/available (Expenditure authority requested under this 1115 Demonstration)</p>

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<ul style="list-style-type: none"> • Access to occupational and vocational counseling • Monitoring of medication, if necessary • Physical exam • Development of discharge plan and plan for referral into continuum of care • Access to services for: vocational assessment, job readiness and job placement, GED preparation and testing, literacy and basic education tutoring, legal, medical and dental care, general health education (esp. AIDS awareness and support), budgeting, credit restoration, housing assistance, income support, and recreational/social activities (e.g. fitness, games, peer interaction) <p>Recommended Services and Support Systems include:</p> <ul style="list-style-type: none"> • Case management and social services that allow the staff to assist with attendance monitoring, child care, transportation to treatment services, and the provision of stable shelter and other basic care needs • Availability of conjoint treatment • Collaboration between the treatment team and various agencies for the coordinated provision of services <p>Required Staff: The required Staff in Medically Monitored Short Term Residential treatment include a director and counselor(s), and a</p>		

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<p>clinical supervisor for every eight full-time counselors or counselor assistants, or both. The State of PA recognizes that, based on the agency size and profile, a single person may hold one or more of the above positions. The Staff who may be recommended may include a clinical supervisor or lead counselor, social services counselor, a psychiatrist, a psychologist, a medical consultant, and any other health and human services staff or consultants (i.e. SUD counselors or other certified SUD clinicians) who may more effectively serve the facility's population.</p> <p>➤ Medically Monitored Long Term Residential (corresponding to ASAM Level 3.5 or 3.7).</p> <p>Required Services and Support Systems include:</p> <ul style="list-style-type: none"> • Regular, scheduled psychotherapy • Biopsychosocial Assessment • Specialized professional/medical consultation, and testing such as a psychiatric evaluation, HIV and TB tests, and other laboratory work, as needed • Individualized treatment planning, with reviews at least every 30 days • Access to services for: vocational assessment, job readiness and job placement, GED preparation and testing, literacy and basic education tutoring, medical and dental care, general health education (especially 	<p>Already provided/available (Expenditure authority requested under this 1115 Demonstration)</p>	<p>None needed, service already provided/available (Expenditure authority requested under this 1115 Demonstration)</p>

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<p>AIDS awareness and support), budgeting, credit restoration, housing assistance, income support, and recreational and social activities (e.g. fitness, games, peer interaction)</p> <ul style="list-style-type: none"> • Monitoring of medication, as needed • 24-hour observation, monitoring, and treatment • Emergency medical services available • Referral to detoxification, if clinically necessary • Individual therapy • Couples therapy (if appropriate) • Family therapy (if appropriate) • Physical exam (within 48 hours expected, but no later than 7 days) • Development of discharge plan and plan for referral into continuum of care <p>Recommended Services and Support Systems include:</p> <ul style="list-style-type: none"> • Group therapy • Individual therapy • Peer groups • Educational/instructional groups <p>Required Staff: The required Staff in Medically Monitored Long Term Residential treatment include a director and counselor(s), and a clinical supervisor for every eight full-time counselors or counselor assistants, or both. The State of PA recognizes that, based on the agency size and profile, a single person may hold one or more of the above positions. The</p>		

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<p>Staff who may be recommended may include a clinical supervisor or lead counselor, social services counselor, a psychiatrist, a psychologist, a medical consultant, and any other health and human services staff or consultants (i.e. SUD counselors or other certified SUD clinicians) who may more effectively serve the facility's population.</p>		
<p>Coverage of medically supervised withdrawal management</p>	<p>This is provided in Medically Managed Inpatient Detoxification (corresponding to ASAM Level 4 WM) covered by the state plan under <i>"Inpatient Services"</i> - see Attachment 3.1A/3.1B, Page 1b of the state plan.</p> <p>Required Services and Support Systems include:</p> <ul style="list-style-type: none"> • Assessment and treatment of adults with SUDs or addicted individuals with concomitant acute biomedical and/or emotional/behavioral disorders. Clinicians in this setting must be knowledgeable about the biopsychosocial dimensions of SUDs, biomedical problems, and emotional/behavioral disorders. • 24-hour physician availability • 24-hour primary nursing care and observation • Professional therapeutic services • Referral agreements among different LOC • Biopsychosocial Assessment • Monitoring of medication, as needed • Health care education services 	<p>Already provided</p>	<p>None needed. Service already provided</p>

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<ul style="list-style-type: none"> • Services for families and significant others • Medication administered in accordance with the substance-specific withdrawal syndrome(s), other biomedical or psychiatric conditions, and recognized detoxification procedures • Comprehensive nursing exam upon admission • Physician-approved admission • Physician who is responsible for a comprehensive history (including drug and alcohol) and a physical examination within 24 hours following admission • Specific assessments performed on an individualized basis, with consideration of risk guiding the evaluation (because this population frequently suffers from communicable, infectious, or transmittable diseases). Furthermore, the facility must have appropriate policies and procedures for identification, treatment, and referral of individuals found to have such illnesses, in order to protect other individuals and staff from acquiring these diseases. <p>Required Staff: The required Staff in a Medically Managed Inpatient Detox facility is chosen according to the Joint Commission on the Accreditation of Hospital Organization's (JCAHO's) standard hospital practices. In</p>		

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<p>addition, they must comply with DDAP staffing requirements. The staff who may be recommended may include trained clinicians, SUD counselors, or registered, certified SUD clinicians able to administer planned interventions according to the assessed SUD needs of the individual.</p> <p><u>This service is also provided in Medically Monitored Inpatient Detoxification</u> (corresponding to ASAM Level 3.7 WM) – provided under the 1915(b) “in-lieu” of authority for all ages in non-IMD settings, and for permissible ages (under 21, and 65 and above years of age) in IMD settings as discussed below:</p> <p>Required Services and Support Systems include:</p> <ul style="list-style-type: none"> • 24-hour observation, monitoring, and treatment • Emergency medical services available • Referral to medically managed detox, if clinically appropriate • Specialized professional/medical consultation, and tests such as HIV and TB testing, and other laboratory work, as needed • Biopsychosocial Assessment • Monitoring of medication, as needed • Development of discharge plan, and plan for referral into continuum of care 	<p>Already provided/available (Expenditure authority requested under this 1115 Demonstration)</p>	<p>None needed. Service already provided/available (Expenditure authority requested under this 1115 Demonstration)</p>

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<ul style="list-style-type: none"> • Medications ordered by a licensed physician and administered in accordance with the substance-specific withdrawal syndrome(s), other biomedical or psychiatric conditions, and recognized detoxification procedures • Physical examination by a physician within 24 hours following admission, or a physical examination which was conducted within 7 days prior to admission, and was evaluated by the facility physician within 24 hours following admission • Specific assessments performed on an individualized basis, with consideration of risk guiding the evaluation (because population frequently suffers from communicable, infectious, or transmittable diseases). Furthermore, the facility must have appropriate policies and procedures for identification, treatment, and referral of individuals found to have such illnesses, in order to protect other individuals and staff from acquiring these diseases. • Access to services for: vocational assessment, job readiness and job placement, GED preparation and testing, literacy and basic education tutoring, legal, medical and dental care, general health education (esp. 		

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<p>AIDS awareness and support), budgeting, credit restoration, housing assistance, income support, and recreational/social activities (e.g. fitness, games, peer interaction)</p> <p>Recommended Services and Support Systems include:</p> <ul style="list-style-type: none"> • Ability to conduct and/or arrange for appropriate laboratory and toxicology tests • 24-hour physician available by telephone • Face-to-face assessment by a physician within 24 hours after admission, with further assessments thereafter as medically needed (but not less than 3 times per week) • Alcohol- or drug-focused nursing assessment by a registered nurse upon admission • Oversight and monitoring of the individual's progress and medication administration by licensed medical staff under the physician's direction • Professional counseling services available 12 hours a day, provided by appropriately qualified staff • Health education services • Clinical program activities designed to enhance the individual's understanding of his/her SUD • Family/significant other services, as appropriate. 		

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<p>Required Staff: The required Staff at a medically monitored inpatient detox facility include a director and counselor(s), and a clinical supervisor for every eight full-time counselors or counselor assistants, or both. The State of PA recognizes that, based on the agency size and profile, a single person may hold one or more of the above positions. The Staff who may be recommended may include a clinical supervisor or lead counselor, social services counselor, a psychiatrist, a psychologist, a medical consultant, and any other health and human services staff or consultants (i.e. SUD counselors or other certified SUD clinicians) who may more effectively serve the facility's population.</p>		
<p>Additional Information</p>	<p>Pennsylvania regulations, Title 28 § 704 available at https://www.pacode.com/secure/data/028/chapter704/chap704toc.html outlines the staffing requirements and qualifications of various staff positions for drug and alcohol treatment activities.</p>		

Milestone 2: Use of Evidence-based, SUD-specific Patient Placement Criteria

(Please also see Section V: Appropriate Standards of Care)			
Milestone Criteria	Current State	Future State	Summary of Actions Needed
<p>Implementation of requirement that providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools that reflect evidence-based clinical treatment guidelines</p>	<p>Pennsylvania currently uses PCPC²³, which is a set of guidelines designed to provide clinicians with a basis for determining the most appropriate care for individuals with SUDs. PCPC uses a multidimensional (six dimensions – Acute Intoxication and Withdrawal; Biomedical Conditions and Complications; Emotional/Behavioral Conditions and Complications; Treatment Acceptance/Resistance; Relapse Potential; Recovery Environment) approach in interpreting the information gathered through assessment.</p>	<p>The state intends to replace PCPC with ASAM effective July 1st, 2018.</p>	<p>Here’s a timeline/summary of the actions that have already been taken/or remain to be taken in order to transition to ASAM by July 1st, 2018:</p> <p>February/March 2017: Pennsylvania made the decision to transition from PCPC to The ASAM Criteria and stakeholders were notified.</p> <p>April – present: Initiated an FAQ for the field regarding transition updates and concerns. Posted to DDAP’s website.</p> <p>April – May 2017: Conducted a training survey to the field to determine impact and training need for the state.</p> <p>April – May 2017: Announced the</p>

²³ “Pennsylvania’s Client Placement Criteria,” Third Edition (2014). Available at: [http://www.ddap.pa.gov/Manuals/PA%20Client%20Placement%20Criteria%20\(PCPC\)%20Edition%203%20Manual.pdf](http://www.ddap.pa.gov/Manuals/PA%20Client%20Placement%20Criteria%20(PCPC)%20Edition%203%20Manual.pdf)

		<p>discontinuation of the PCPC training.</p> <p>May 2017: Summarized survey data for training considerations and planning purposes.</p> <p>May 2017: Convened the ASAM Transition Workgroup with various subcommittees to explore the implications of the transition.</p> <p>June 2017: PA's ASAM Transition Workgroup participated in a 2-day, in-person ASAM training with <i>The Change Company</i>.</p> <p>August – Present: Ongoing internal reviews of Pennsylvania Web Infrastructure for Treatment Services (PA WITS) screening and assessment tools, licensing regulations, contractual language (DDAP's Treatment Manual) to determine any conflicts or areas of concern to address as a department or with the ASAM Transition Workgroup.</p> <p>Current: OMHSAS, in collaboration with DDAP is exploring options to</p>
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			<p>support providers in the transition to the use of ASAM. This includes reviewing funding sources that may be utilized to support the training costs, recommending to providers that they identify the key staff that need to be trained, and collaborating regionally to schedule trainings for cost effectiveness.</p> <p>July 1, 2018: Target Date for transition to ASAM</p>
<p>Implementation of a utilization management approach such that (a) beneficiaries have access to SUD services at the appropriate level of care</p>	<p>HealthChoices Managed Care contracts have access standards for services in all of the MCO agreements. These access standards will apply to 1115 Demonstration Waiver services as well:</p> <p>The provider network must provide face-to-face treatment intervention within one hour for emergencies, within twenty-four (24) hours for urgent situations, and within seven (7) days for routine appointments and for specialty referrals.</p>	<p>Pennsylvania will continue to contractually enforce current access standards.</p>	<p>Pennsylvania will continue to contractually enforce the current access standards. No other action needed.</p>

<p>Implementation of a utilization management approach such that (b) interventions are appropriate for the diagnosis and level of care</p>	<p>Pennsylvania statute, Act 152 of 1988 requires the utilization of placement criteria approved by DDAP to address the type, level, and length of stay in treatment for individuals SUD.</p> <p>HealthChoices contracts and DDAP Treatment Manual require that assessment be done within 7 days, and mandates the use of PCPC to determine the level of care.</p>	<p>Beginning July of 2018, Pennsylvania will replace PCPC with ASAM as the tool to determine the level of care and interventions needed.</p>	<p>Please see the actions outlined in the beginning of this table.</p>
<p>Implementation of a utilization management approach such that (c) there is an independent process for reviewing placement in residential treatment settings</p>	<p>The BH-MCO is required to coordinate service planning and delivery with human services agencies.</p> <p>The BH-MCO is required to have a letter of agreement with the county Drug & Alcohol agency that include procedures for coordination with the SCA for placement and payment for care provided to members in residential treatment facilities outside the HC zone.</p> <p>Managed Care contracts require prior approval for residential services, independently reviewed by a clinician and medical director.</p>	<p>Will continue to follow the current processes.</p>	<p>No action needed</p>

Milestone 3: Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

Milestone Criteria	Current State	Future State	Summary of Actions Needed
<p>Implementation of residential treatment provider qualifications in licensure requirements, policy manuals, managed care contracts, or other guidance. Qualification should meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding, in particular, the types of services, hours of clinical care,</p>	<p>Pennsylvania regulations, Title 28 § 704 available at https://www.pacode.com/secure/data/028/chapter704/chap704toc.html outlines the staffing requirements and qualifications of various staff positions for drug and alcohol treatment activities.</p> <p>Required full-time equivalents (FTE) for various services are as listed below:</p> <p>Medically Monitored Inpatient Detoxification:</p> <ul style="list-style-type: none"> • One FTE primary care staff person available for every seven clients during primary care hours. • A physician on call at all times. <p>Medically Managed Inpatient Detoxification</p> <ul style="list-style-type: none"> • One FTE primary care staff person available for every five clients during primary care hours. <p>Medically Monitored Residential</p> <ul style="list-style-type: none"> • Projects serving adult clients shall have one FTE counselor for every eight clients. <p>Medically Managed Inpatient residential</p> <ul style="list-style-type: none"> • Projects serving adult clients shall have one FTE counselor for every seven clients. <p>All residential facilities operate 24/7 and provide clinical treatment on a structured schedule, including individual, group, family therapy,</p>	<p>Will provide residential services to comply with ASAM criteria.</p>	<p>The state is in process of cross-walking PCPC with ASAM to determine if any changes will be needed.</p>

<p>and credentials of staff for residential treatment settings</p>	<p>medication monitoring, psychoeducational groups, recovery support services.</p> <p>Pennsylvania regulations, Title 28 § 709 – Subchapter K <i>Standards for Inpatient Hospital Drug and Alcohol Activities Offered in Freestanding Psychiatric Hospitals</i> outlines the standards for Medically Managed Inpatient Residential settings (comparable to ASAM Level 4). Available at: https://www.pacode.com/secure/data/028/chapter709/subchapKtoc.html</p> <p>Pennsylvania regulations, Title 28 § 710 outlines the requirements for the provision of drug and alcohol treatment and rehabilitation activities in general hospitals. Available at: https://www.pacode.com/secure/data/028/chapter710/chap710toc.html</p> <p>Pennsylvania regulations, Title 28 § 711 outlines the <i>Standards for Certification of Treatment Activities which are a Part of a Health Care Facility</i>. Available at: https://www.pacode.com/secure/data/028/chapter711/chap711toc.html</p> <p>Pennsylvania regulations, Title 28 § 709 – Subchapter E: <i>Standards for Inpatient Nonhospital Activities – Residential Treatment and Rehabilitation</i> outlines the standards for licensure of all Medically Monitored Residential Treatment settings (comparable to ASAM levels 3.1 through 3.7). Available at: https://www.pacode.com/secure/data/028/chapter709/subchapEtoc.html</p>		
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<p>Implementation of a state process for reviewing residential treatment providers to ensure compliance with these standards</p>	<p>All residential settings are licensed by DDAP on an annual basis. Complaints regarding facilities require an immediate onsite review by DDAP.</p> <p>Annual site inspections are conducted for all levels of care. The inspections include but not limited to the follow:</p> <ul style="list-style-type: none"> a. Physical plant inspection b. Client chart review c. Personnel (staffing) chart review d. Level of care specific P&P e. Medication review (if applicable) f. Direct observation of services g. Staff and client interviews <p>Licensing procedures are outlined in Pennsylvania regulations, Title 28 § 709 – Subchapter B available at: https://www.pacode.com/secure/data/028/chapter709/subchapBtoc.html</p> <p>Clicking on any county on the map in this link will show the providers in the county and the licensing surveys associated with each provider and other related information: http://sais.health.pa.gov/commonpoc/Content/PublicWeb/DAFind.aspx</p>	<p>DDAP will continue to license the residential setting and ensure compliance with the standards</p>	<p>No action needed</p>
<p>Implementation of requirement that residential treatment facilities offer MAT on-site or facilitate access off site</p>	<p>Facilities may be licensed to provide treatment approaches using a primary medication other than for detoxification. Licensing regulations also require the facilities to coordinate in obtaining other benefits as needed.</p>	<p>The current regulations will stay in place</p>	<p>No action needed</p>

Milestone 4: Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD

Milestone Criteria	Current State	Future State	Summary of Actions Needed
<p>Completion of assessment of the availability of providers enrolled in Medicaid and accepting new patients in the following critical levels of care throughout the state (or at least in participating regions of the state) including those that offer MAT:</p> <ul style="list-style-type: none"> • Outpatient Services; • Intensive Outpatient Services; 	<p>This is a link to a searchable database of all D&A facilities in the Commonwealth: http://sais.health.pa.gov/commonpoc/Content/PublicWeb/DAFind.aspx</p> <p>HealthChoices Managed Care contracts will require the following access standards for 1115 Demonstration Waiver services: The Provider network must provide face-to-face treatment intervention within one hour for emergencies, within twenty-four (24) hours for urgent situations, and within seven (7) days for routine appointments and for specialty referrals.</p> <p>The Commonwealth has 802 licensed Outpatient and Intensive Outpatient facilities with capacity to serve 91863 individuals. Additionally, there are 177 SUD Partial Hospitalization programs that can serve 4738 individuals.</p>	<p>Will continue to ensure that access standards are met and required capacity is available.</p>	<p>None needed</p>

<ul style="list-style-type: none"> • Medication Assisted Treatment (medications as well as counseling and other services); • Intensive Care in Residential and Inpatient Settings; • Medically Supervised Withdrawal Management 	<p>In November 2017, Outpatient Maintenance was provided by 75 providers serving 30291 individuals.</p> <p>Since 2002 till January 2018, 3717 Pennsylvania physicians have been certified under DATA 2000, with 2725 of those certified to treat up to 30 patients and the remaining 992 certified to treat up to 100 patients⁹.</p> <p>Vivitrol can be administered by any licensed physician.</p> <p>Pennsylvania has 250 licensed facilities that provide intensive care in residential and inpatient settings, with a capacity to serve 10,071 individuals.</p> <p>Pennsylvania has 87 licensed Detoxification facilities in various levels of care serving 1783 individuals.</p>		
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Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

Milestone Criteria	Current State	Future State	Summary of Actions Needed
Implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse	<p>The Commonwealth has taken significant steps to improve prescribing practices for opioids. DOH and the DDAP have lead roles in the <i>Safe and Effective Prescribing Practices Task Force</i>. The task force membership is drawn from various state agencies, representatives from medical associations, provider advocates and community members. The task force developed and adopted guidelines for ten medical specialties on the safe and effective use of opioids in the treatment of pain. The following link provides those guidelines:</p> <p>http://www.health.pa.gov/My%20Health/Diseases%20and%20Conditions/M-P/opioids/Pages/Prescribing-Guidelines.aspx#.WIZm5K8o5iz.</p>	<p>Will continue to ensure the efficacy of the opioid prescribing guidelines.</p>	<p>None needed at this time.</p>
Expanded coverage of, and access to, naloxone for overdose reversal	<p>Pennsylvania’s Act 139 of 2014 allows first responders including law enforcement, fire fighters, EMS or other organizations the ability to administer naloxone to individuals experiencing an opioid overdoses. The law also allows individuals such as friends or family members that may be in a position to assist a person at risk of experiencing an opioid related overdose to obtain a prescription for naloxone. This legislation also provides immunity from prosecution for those responding to and reporting overdoses.</p>	<p>This order will be reviewed and updated as needed, if there is relevant new science about Naloxone administration, or at least in 4 years.</p>	<p>None needed at this time.</p>

	<p>The Commonwealth has made naloxone available for any Pennsylvanian. Individuals can go to a participating pharmacy and secure naloxone for themselves or a family member under Commonwealth's Physician General's standing order for prescription available at: http://www.health.pa.gov/My%20Health/Diseases%20and%20Conditions/M-P/opioids/Documents/General%20Public%20Standing%20Order-001-2018.pdf</p>		
<p>Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs</p>	<p>The following is a discussion of the activities undertaken by Pennsylvania's PDMP office:</p> <p><u>Mass communication and Outreach</u></p> <p>Starting May 2016, PDMP office conducted several communication and outreach activities to all the prescribers and dispensers in PA. Additionally, the office partnered with the professional medical societies and associations, and executive leadership of the health care entities to send communications about the launch of the PDMP system, tutorials on how to use the PDMP system and identify red flags, etc. With the continued efforts, PA PDMP saw uptake in the registration and use of the system. As of Dec 2017, there are about 97,000 registered users of the system and on an average about 52,000 patient queries are conducted each day, with over 1.1 million patient searches completed by the users each month. The outreach activities included:</p> <ul style="list-style-type: none"> • E-mail blasts • Online tutorials • Mass mailings • Online video resources • Conference booths at various professional societies 	<p>The seven education modules discussed in the previous column under <i>PDMP and Opioid Prescriber Education Initiative</i> will be available early Q1 2018 for prescriber and dispenser face to face education as well as through online training, and continuing medical education units (CME) will be provided.</p>	<p>The Commonwealth will continue to monitor practices and needs and take steps as needed.</p>

	<ul style="list-style-type: none"> • Social media, radio and TV PSAs • Webinars • Outreach through medical professional societies and state licensing boards • PA – Health Alerts Network (PA-HAN) • County and municipal health department outreach <p><u>Ensuring all authorized users can assign delegates</u></p> <p>To ease the burden on the licensed medical professionals such as the prescribers and dispensers, PA PDMP allowed the authorized users to assign delegates that can run the patient searches on behalf of them. This is a very important feature especially when providers are busy addressing patient health concerns. This feature has overall improved the clinical workflows for the providers.</p> <p><u>Interstate data sharing capability</u></p> <p>Right after the launch of the PA PDMP system, the Commonwealth worked towards interstate data sharing with the neighboring states. This allows users of the PA PDMP system to search for their patients across state lines. The states that are now connected also allow their respective states to search PA PDMP system for their patients. This functionality is especially critical for the health care practices where they are closely bordered to another state and their patients are traveling across state line to locate multiples providers and pharmacies for controlled substances. These multiple provider episodes (doctor shopping) can be reduced or eliminated if providers have access to their patient’s prescription history from bordering states. In Pennsylvania, patients that went to 5+</p>	<p>More information will be posted on www.doh.pa.gov/PDMP</p>	
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	<p>prescribers and 5+ pharmacies in the span of 3 months have been reduced to 86% since the launch of the PA PDMP system. Additionally, patients that went to 10+ prescribers and 10+ pharmacies in the span of 3 months have been completely eliminated. As of December 2017, PA PDMP is now connected with CT, DE, IL, LA, MA, MD, ME, MN, NJ, NY, OH, OK, SC, TX, VA, WV and Washington D.C.</p> <p><u>Registration and query requirements of PA PDMP</u></p> <p><i>Achieving Better Care by Monitoring All Prescriptions Program (ABC-MAP) Act 191 of 2014</i> legislation required prescribers to query the PDMP system 1) before they prescriber any new controlled substances to their patients or 2) if they have reason to believe that their patients are involved in abuse, misuse or diversion of controlled substances. In November 2016, the legislation required all the licensed prescribers and dispensers to register with the program. With the effective date of Jan 1, 2017, PA PDMP system registrants increased. The use of the system almost doubled since the effective date. Additional query requirements were included for both prescribers and dispensers. Prescribers were now required to check the PDMP system each time they prescribe opioids or benzodiazepine. Dispensers shall query the PDMP before dispensing an opioid drug product or a benzodiazepine prescribed to a patient if any of the following apply: 1) The patient is a new patient of the dispenser. 2) The patient pays cash when they have insurance. 3) The patient requests a refill early. 4) The patient is</p>		
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	<p>getting opioid drug products or benzodiazepines from more than one prescriber.</p> <p><u>Integrate the PA PDMP system with Electronic Health Record (EHR) and Pharmacy Management System (PMS)</u></p> <p>The Pennsylvania Department of Health (DOH) is integrating the Prescription Drug Monitoring Program (PDMP) system into electronic health records and pharmacy systems across the commonwealth. The goal is to minimize any workflow disruption by providing near-instant and seamless access to critical prescription history information to both prescribers and pharmacists. All health care entities in Pennsylvania legally authorized to prescribe, administer or dispense controlled substances are eligible to apply for integration. This includes ambulatory care units, acute care facilities, emergency care units, physician practices, pharmacies, drug treatment facilities and others. Once the integration with the health care entities that use the Certified Electronic Health Record Technology (CEHRT) is successfully completed, the Eligible Professionals (Eps) and Eligible Hospitals (EHs) also meet the definition of a Meaningful Use (MU) Stage 2 specialized registry.</p> <p><u>PDMP and Opioid Prescriber Education Initiative</u></p> <p>PA PDMP Office developed an Education Workgroup that consisted of PA Physician General's Office, staff from Department of Drug and Alcohol Programs, members of the ABC-MAP Advisory Committee, members of two Single county authority that help refer patients to treatment programs, health care administrators,</p>		
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	<p>pharmacists and physicians. The purpose of this workgroup was to provide recommendations to the PA PDMP office on the creation and development of innovative and evidence-based education materials for prescribers and dispensers. The workgroup prioritized four topics that consisted of 1) how to effectively build the PDMP system into clinical workflows, 2) how to effectively use the PDMP data to make informed clinical decisions and refer patient to treatment, 3) how to safely taper high doses of opioids to recommended levels, and 4) how to create a culture of change and promote the above strategies in their respective clinical settings. Using these topics, the PDMP Office partnered with University of Pittsburgh and developed seven education modules that consisted of pocket cards, flow diagrams, resource flyers and guide documents.</p>		
<p>Other</p>	<p>Please see Section XII: Strategies to Address Prescription Drug Abuse and Section XIII: Strategies to Address Opioid Use Disorder</p>		

Milestone 6: Improved Care Coordination and Transitions between Levels of Care

Milestone Criteria	Current State		Summary of Actions Needed
<p>Implementation of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities</p>	<p>Please see Section VII: Care Coordination Design</p> <p>Additionally, Pennsylvania regulations Title 28 § 709.52. Treatment and Rehabilitation services available at https://www.pacode.com/secure/data/028/chapter709/s709.52.html require that the Individual Treatment and Rehabilitation Plan include information about the various support services needed.</p>	<p>Already meeting the requirement</p>	<p>None needed</p>
<p>Additional policies to ensure coordination of care for co-occurring physical and mental health conditions</p>	<p>Please see the discussion on CCBHCs</p> <p>Based on a person and family-centered plan of care aligned with the requirements of Section 2402(a) of the ACA and aligned with state regulations and consistent with best practices, the CCBHC coordinates care across the spectrum of health services, including access to high-quality physical health (both acute and chronic) and behavioral health care, as well as social services,</p>	<p>The Commonwealth will review data from CCBHCs and decide on any future steps.</p>	<p>The Commonwealth will review data from CCBHCs.</p>

	housing, educational systems, and employment opportunities as necessary to facilitate wellness and recovery of the whole person.		
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Attachment A – Template for SUD Health Information Technology (IT) Plan

Section I.

Table 1. State Health IT / PDMP Assessment & Plan

Milestone Criteria	Current State	Future State	Summary of Actions Needed
<p>5. Implementation of comprehensive treatment and prevention strategies to address Opioid Abuse and OUD, that is: --Enhance the state’s health IT functionality to support its PDMP; and --Enhance and/or support clinicians in their usage of the state’s PDMP.</p>	<p>Provide an overview of current PDMP capabilities, health IT functionalities to support the PDMP, and supports to enhance clinicians’ use of the state’s health IT functionality to achieve the goals of the PDMP.</p>	<p>Provide an overview of plans for enhancing the state’s PDMP, related enhancements to its health IT functionalities, and related enhancements to support clinicians’ use of the health IT functionality to achieve the goals of the PDMP.</p>	<p>Specify a list of action items needed to be completed to meet the HIT/PDMP milestones identified in the first column. Include persons or entities responsible for completion of each action item. Include timeframe for completion of each action item</p>
Prescription Drug Monitoring Program (PDMP) Functionalities			
<p>Enhanced interstate data sharing in order to better track patient specific prescription data</p>	<p>The PDMP is connected to an interstate sharing hub (PMP Interconnect) and is actively sharing with 16 other states and Washington DC.</p>	<p>PDMP routinely analyzes data to see if patients are traveling from other states to Pennsylvania for prescriptions. As this analysis continues, and if patients are coming from other states, the Commonwealth will work towards interconnecting with those states.</p>	<p>None needed at this time.</p>
<p>Enhanced “ease of use” for prescribers and other state and federal stakeholders</p>	<p>The PDMP has a user-friendly web portal for prescribers, dispensers</p>	<p>Already in place</p>	<p>None needed at this time.</p>

	<p>and their delegates. Additionally, it has the option to integrate one's EHR or pharmacy management system with the PDMP to minimize any workflow disruption. It provides near-instant and seamless access to critical prescription history information to both prescribers and pharmacists.</p>		
<p>Enhanced connectivity between the state's PDMP and any statewide, regional or local health information exchange (HIE)</p>	<p>The PDMP Office is not yet connected to an HIE.</p>	<p>The PDMP Office is actively working with the PA eHealth Partnership to establish a connection to the Public Health Gateway (PHG).</p>	<ol style="list-style-type: none"> 1. Establish connection from PHG to PDMP (3 weeks) <ul style="list-style-type: none"> • Configure (1 week) • Test (1 week) • Production (1 week) 2. Establish connection from HIO to PHG (8 weeks) <ul style="list-style-type: none"> • Evaluate options and determine scope of work (2 weeks) • Design and Develop (4 weeks) • Test (1 week)

			<ul style="list-style-type: none"> Production (1 week) Responsible organization: PA eHealth Partnership
Enhanced identification of long-term opioid use directly correlated to clinician prescribing patternsⁱ (see also “Use of PDMP” #2 below)	The PDMP Office does not currently utilize predictive analytic capabilities relating to predicting long-term opioid use.	The PDMP Office will evaluate the feasibility of utilizing predictive analytics to forecast increased risk of long-term opioid use based on initial prescribing characteristics.	The epidemiologist and statistician from the PDMP Office will evaluate the feasibility of this by Q2 2018.
Current and Future PDMP Query Capabilities			
Facilitate the state’s ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e. the state’s master patient index (MPI) strategy with regard to PDMP query)	The PDMP vendor uses an algorithm that automatically links patient records (coming from pharmacies) based on name, DOB, zip code, and street address.	N/A	N/A
Use of PDMP – Supporting Clinicians with Changing Office Workflows / Business Processes			
Develop enhanced provider workflow / business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance to address the issues which follow	The PDMP Office partnered with a university to develop evidence-based educational materials including a module on integrating the PDMP into the provider workflow. These materials will soon be available online (with continuing education credits offered) and taught during in-person	See the previous column.	None needed at this time.

	sessions at hospitals, clinics, and provider offices.		
Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions provided through the PDMP—prior to the issuance of an opioid prescription	The PDMP system currently provides a patient's controlled substance history and calculates the patient's total morphine milligram equivalence (MME) per day as well as the MME for every medication.	The PDMP system will soon generate email alerts to prescribers and dispensers when their patients meet any of the following: multiple provider threshold, daily MME threshold, or has active concurrent opioid & benzodiazepine prescriptions. These alerts will also be prominently displayed on PDMP reports.	Requirements were finalized and send to the PDMP system vendor on 1/3/2017. Awaiting a change order. No specific timeline has been established yet. Target is Q2 2018.
Master Patient Index / Identity Management			
Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery.	The PDMP system already uses an algorithm that automatically links patient records (coming from pharmacies) based on name, DOB, zip code, and street address.	See the previous column	No action needed at this time

Overall Objective for Enhancing PDMP Functionality & Interoperability			
Leverage the above functionalities / capabilities / supports (in concert with any other state health IT, TA or workflow effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing and to ensure that Medicaid does not inappropriately pay for opioids	The PDMP Office is cooperating with the Department of Human Services to provide them with data to aid them in their efforts to implement effective controls to minimize the risk of inappropriate opioid overprescribing—and to ensure that Medicaid does not inappropriately pay for opioids.	Already in place.	None needed at this time.

Attachment A - Section II – Implementation Administration

Please provide the contact information for the state’s point of contact for the SUD Health IT Plan.

Name and Title: Meghna Patel, Director PDMP Office.
 Telephone Number: 717-547-3144
 Email Address: megpatel@pa.gov

Attachment A - Section III – Other Relevant Documents

All relevant information and references have been provided.

PUBLIC NOTICE AND HEARINGS

On November 17, 2017, Pennsylvania Department of Human Services published in the Pennsylvania Bulletin, a public notice pertaining to the proposed Section 1115 Demonstration for substance use disorders. This notice is available at: <https://www.pabulletin.com/secure/data/vol47/47-46/1889.html> (a hard copy of the notice is also attached). The Pennsylvania Bulletin is the Commonwealth's official gazette for information and rulemaking. On the same day, the Department also sent out a communication regarding this Demonstration through various email listservs that include general stakeholders, Single County Authority (SCA) Administrators, MH/ID Administrators, Human Services Administrators, Mental Health Planning Council members and the Behavioral Health Managed Care Organizations (hardcopy of this email attached). Additionally, the Department also posted information regarding this Demonstration on its Medicaid Managed care website (HealthChoices) Website: <http://www.healthchoices.pa.gov/info/about/behavioral/1115WaiverApplicationforSUD/index.htm> (hard copy of the webpage attached). In addition, copies of the Demonstration draft were also available upon written request.

The public notice and process adhered to the requirements in 42 CFR 431.412(a)(1)(viii) and 42 CFR 431.408. The Waiver draft included a comprehensive description of the Demonstration that satisfied the requirements delineated in the federal regulations. The draft Demonstration included the following:

- Background for this Demonstration
- Demonstration purpose and goals
- A description of the delivery system for SUD services
- A discussion on the comprehensive evidence-based benefit design
- A discussion on how the Commonwealth determines and provides appropriate care for SUD
- Discussion on provider network and access standards for SUD services
- Discussion on the Commonwealth's care coordination design

- How the Commonwealth promotes and assures the integration of physical health and SUD
- How the Commonwealth ensures program integrity
- Benefit/Utilization Management
- Community integration and assurance that those receiving services under the Home and Community based services will have access to all services available through the managed care program and the this Demonstration
- Description of strategies to address prescription drug abuse
- Description of strategies to address opioid disorder
- An assurance that children under 21 years of age will receive all medically appropriate 1905 (a) services although they are not included in this 1115 Waiver. They will also continue to receive residential services for SUD in IMD as well as non-IMD settings under the “in-lieu of” option in our 1915(b) managed care waiver.
- A discussion on what quality measures will be tracked and reported
- A description on collaboration with the Single State Agency for SUD
- An evaluation plan for the Demonstration
- A discussion on the estimated changes in expenditures and enrollment
- Expenditure authority for this Demonstration

Public Hearings/Comments

The 30-day public comment period began on November 18, 2017, and ended on December 18, 2017. Individuals had numerous options to provide input into the Demonstration: testify in person at one of the four public hearings; submit written comments at any of the public hearings; email comments to RA-PWOMHSASComm@pa.gov; or send the comments by mail to the address identified in the public notice. Persons with a disability who required auxiliary aid or service could submit comments using the Pennsylvania AT&T Relay Service at (800) 654-5984 (TDD users) or (800) 654-5988 (voice users).

The Department held four public hearings throughout the state to accept testimony on the proposed 1115 Demonstration waiver application.

The schedule of dates, times and locations for the public hearings were as follows:

- December 4, 2017, 10 a.m. to 12 p.m.
OMHSAS NE Field Office Conference Room
100 Lackawanna Avenue
Scranton, PA
- December 5, 2017, 10 a.m. to 12 p.m.
Norristown State Hospital Auditorium
1001 Sterigere Street
Norristown, PA
- December 8, 2017, 8 a.m. to 10 a.m. *
Child Welfare Resource Center
403 East Winding Hill Road
Mechanicsburg, PA
- December 11, 2017, 1 p.m. to 3 p.m.
Shenango Crossing
2520 New Butler Road
New Castle, PA 16101

*A toll free conference line was available for any interested party to participate in this public hearing.

The Department also presented updates and solicited comments on the waiver application at the Medical Assistance Advisory Committee meeting on December 14, 2017. An overview of the demonstration was provided by representatives from the Department at every public hearing. A power point presentation which summarized the purpose, goals, and other relevant information, including who would be covered under this waiver (ages 21-64 enrolled in Pennsylvania's managed care program) was provided to all attendees at each public hearing. The Department representatives also answered questions from the attending public/stakeholders. The Department received 11 written testimonies from the public comment process.

The document titled “**Public Comments Summary with State's Responses on Pennsylvania's SUD 1115 Demonstration**” contains the summary of all comments received and the Department’s responses and actions to the comments. The Department has also included with this submission copies of all written comments received which also include the testimonies that individuals provided at the public hearings.

Public Comments Summary with State’s Responses on Pennsylvania’s SUD 1115 Demonstration

Brief summary of comments	Support/Not in Support – If not, why?	Specific Concerns/Changes Requested	DHS Action in Response to Concerns/Changes Requested
<p style="text-align: center;"><u>Commenter 1</u></p> <p>Emphasizes the need for an array of clinical and psychosocial components in order to battle the complex disorder of substance dependence. The loss in federal matching dollars impacts an individual’s ability to receive treatment for adequate lengths of time. Access to proper care should not be based upon an arbitrary length of stay but upon the level of clinical need and medical necessity.</p>	Support	None	The commenter supports the Waiver as written. No specific concerns expressed.
<p style="text-align: center;"><u>Commenter 2</u></p> <p>Emphasizes that access to treatment should be determined by clinical need as laid out in the Waiver. Agrees that the Demonstration waiver is critical for the availability of residential treatment services.</p>	Support	None	The commenter supports the Waiver as written. No specific concerns expressed.
<p style="text-align: center;"><u>Commenter 3</u></p> <p>The CMS rule change will negatively affect 160 providers and 12,240 individuals. Substance dependence is a complex disease and requires the right amount and type of care that will not be able to be provided without the Demonstration Waiver.</p>	Support	None	The commenter supports the Waiver as written. No specific concerns expressed.
<p style="text-align: center;"><u>Commenter 4</u></p> <p>Supports that the Demonstration is constructed to afford continued access to medically necessary treatment for OUD and SUD. Believes that this policy will save lives.</p>	Support	None	The commenter supports the Waiver as written. No specific concerns expressed.
<p style="text-align: center;"><u>Commenter 5</u></p> <p>Supports the waiver but has some concerns as outlined in the “Specific Concerns/Changes Requested” column. Supports the quality measures and evaluation plan aspects of the 1115 Demonstration. Emphasizes that failure to provide adequate lengths of treatment for these populations can be life and death. They are pleased to see that the application has quality measures involving</p>	Support	<p>Concerns/comments pertaining to transition to ASAM: Worried that ASAM may not capture the importance of Pennsylvania’s whole continuum of services,</p>	<p>Department of Drug and Alcohol Programs (DDAP) will provide guidance on application of ASAM criteria so that all types of services within PA’s continuum of care will be available, including Halfway House. Halfway House is listed as example of clinically managed low intensity residential service in Level 3.1 of ASAM.</p>

Brief summary of comments	Support/Not in Support – If not, why?	Specific Concerns/Changes Requested	DHS Action in Response to Concerns/Changes Requested
<p>alcohol and other drug disorder treatment. Share the concern about the potential loss of federal match dollars.</p> <p>Appreciates that Commonwealth is working to ensure that requirements of MH Parity and Addiction Equity Act of 2008 are met. Urges the Department to schedule a follow up hearing on the Parity issue to develop a plan of action on enforcement of the Parity.</p> <p>Expressed concerns regarding the transition from PCPC (Pennsylvania Client Placement Criteria) to ASAM.</p> <p>Please also see the column “Specific Concerns/Changes Requested”.</p>		<p>specifically the need for licensed halfway houses.</p> <p>Recommends maintaining the use of the PCPC or adapting the ASAM tool to develop better sensitivity to the needs of various populations. The commenter believes this would also eliminate any conflict with PA’s Act 152 of 1988.</p> <p>Concerned about the cost of training the entire field on ASAM.</p>	<p>DDAP, as the Single State Authority, has the authority to delineate how LOC assessment criteria is to be applied and how it best fits PA’s system of care. Therefore, while an official “re-writing”, “adaptation”, or “modification” of ASAM will not be done, DDAP is working with an ASAM Transition Workgroup to ensure appropriate application of the criteria to PA by cross-walking the current PCPC criteria.</p> <p>All system partners will be working collaboratively to share training costs. The cost of training, be it the responsibility of stakeholders (SCAs/providers/BH-MCOs) or DDAP, has been considered when making the decision to transition to ASAM. While there will be an initial cost to the system, it is believed that the benefits to the establishment and/or strengthening of PA’s Recovery Oriented System of Care (ROSC) will be realized and supported by the transition to ASAM. The cost to a single provider would be relative to the number of clinicians needing to be trained. DDAP has strongly encouraged that those individuals whose primary job duties are to apply or supervise the ASAM Criteria be those who participate in the 2- day training. Those providers who wish to send facility directors and other staff who do not have this function would do so voluntarily; and, in fact could have such persons complete the less expensive, online trainings.</p>

Brief summary of comments	Support/Not in Support – If not, why?	Specific Concerns/Changes Requested	DHS Action in Response to Concerns/Changes Requested
		<p>Concerns/comments on the Evaluation Plan: One of the outcomes listed is the reduction of overdose deaths. They are concerned that unless adequate lengths of stay are provided, decrease in overdose deaths is unlikely.</p>	<p>We concur. The purpose of this Waiver is to request expenditure authority to provide adequate lengths of stay in SUD treatment.</p>
<p style="text-align: center;"><u>Commenter 6</u></p> <p>Applauds the Department for recognizing the importance of a full continuum of care of SUD services. Appreciates the dedication that has Pennsylvania has had over the last 40 years in developing a comprehensive system of care. Agrees with the flaws in the IMD Exclusion that the Department has drawn attention to. Points out that D&A recovery support services are not part of care determination either in PCPC or ASAM, however, as per current research findings, it is critically important in the development of a recovery oriented system of care to define, develop, and fund services that support recovery for the first five years of sustained recovery. Expressed concerns regarding the transition to ASAM.</p> <p>Please also see the column “Specific Concerns/Changes Requested”.</p>	<p>Support</p>	<p>Concerns/comments pertaining to transition to ASAM: Concerned that the transition to ASAM may dramatically increase training costs to providers and does not fit the care system in the state. The commenter stated that a small provider that they spoke with identified the training cost as \$6000 for a 2-day training.</p>	<p>All system partners will be working collaboratively to share training costs. The cost of training, be it the responsibility of stakeholders (SCAs/providers/BH-MCOs) or DDAP has been considered when making the decision to transition to ASAM. While there will be an initial cost to the system, it is believed that the benefits to the establishment and/or strengthening of PA’s ROSC will be realized and supported by the transition to ASAM. The cost to a single provider would be relative to the number of clinicians needing to be trained. DDAP has strongly encouraged that those individuals whose primary job duties are to apply or supervise the ASAM Criteria be those who participate in the 2- day training. Those providers who wish to send facility directors and other staff who do not have this function would do so voluntarily; and, in fact could have such persons complete the less expensive, online trainings. Therefore, unless a provider could fill an entire 2-day training class with those who must have ASAM training, there would not likely be a scenario in which a single provider would incur a cost of \$6000 for the in-person training, especially if stakeholders are working together to arrange for the trainings.</p>

Brief summary of comments	Support/Not in Support – If not, why?	Specific Concerns/Changes Requested	DHS Action in Response to Concerns/Changes Requested
		<p>States that cross-walking licensed Halfway Houses as level 3.1 in ASAM does not reflect the care that these facilities are designed to provide. Concerned that adoption of ASAM criteria would risk the loss of this level of care.</p> <p>Concerns/comments on the Evaluation Plan: States that the use of medical services as a measure of efficacy may not take into account the possibility that early medical care utilization may increase as the person stabilizes their physical health and the savings are realized over time.</p> <p>The commenter states it is unclear how overdoses would be measured in relation to the acute and residential care. Further states that this measure would not account for the holistic care provided to persons seeking help for the full range of substance use</p>	<p>DDAP will provide guidance on application of ASAM criteria so that all types of services within PA’s continuum of care will be available, including Halfway House. Halfway House is listed in Level 3.1 of ASAM as an example of clinically managed low intensity residential service.</p> <p>CMS in its SMDL#15-003 directed the states to use these services in evaluating effectiveness.</p> <p>The Department agrees that opioid deaths may not be associated with the residential treatment LOS, and that the issues presented by the individual are clinically complex. It would be the initial goal of this waiver to collect the data obtainable and with review further develop the evaluative component over time. It is expected that the Department’s monthly data collection of LOCs/utilization/LOS (residential), with the analysis over time will further refine the evaluative component.</p>

Brief summary of comments	Support/Not in Support – If not, why?	Specific Concerns/Changes Requested	DHS Action in Response to Concerns/Changes Requested
		<p>conditions that exist beyond opioid dependence in these settings.</p> <p>Comments on Expenditure Projections: Wants to more fully understand the expenditure projections in the waiver application as we are considering the importance of properly funding care to support recovery across our service system.</p>	<p>In developing the expenditure projections, historical annual enrollment and cost trends were reviewed. The historical expenditure trends were largely driven by high enrollment growth under HealthChoices expansion (during 2015) . It is assumed that enrollment trends will return to normal levels observed prior to expansion, which results in more moderate expenditure growth in the projection period. Note that these expenditure projections are merely estimates and projections agreed to as part of the waiver process will be discussed with CMS in the coming months. DHS recognizes the importance of properly funding care to support recovery across our SUD service system.</p>
<p><u>Commenter 7</u></p> <p>The organization supports the waiver, however they had two comments to make as listed in the “Specific Concerns/Changes Requested” column.</p>	<p>Support</p>	<p>Comments on the scope of the Waiver: Suggest that while the focus on SUD is timely and appropriate, MH IMD issue should not be overlooked.</p> <p>Comment on Section VIII: Integration of Physical Health and SUD: States the entire section indicates that exchange</p>	<p>The Department recognizes the commenter’s concern; CMS however is currently considering 1115 Waivers only for SUDs.</p> <p>There is no reference about exchanging SUD information in the referenced section. In 2016, the</p>

Brief summary of comments	Support/Not in Support – If not, why?	Specific Concerns/Changes Requested	DHS Action in Response to Concerns/Changes Requested
		of SUD treatment information is permissible. Also states that the current guidelines for P4P/Integrated Care Planning do not allow sharing of SUD and HIV information between BH and PH MCOs.	Integrated Care Program (ICP) data submitted by the BH-MCOs showed that 33% of the individuals diagnosed with SMI statewide had a co-occurring diagnosis of SUD. The Department assumes that there are individuals in ICP care planning that have co-occurring diagnosis of SUD not discussed due to confidentiality law requirements. It is the Department’s position that having the MH and PH care needs better managed in the above instance is still of value for the individuals potentially served in this Waiver.
<p align="center"><u>Commenter 8</u></p> <p>Is submitting comments on behalf of the low income population they represent. They are concerned with the IMD issue and are pleased that DHS are doing the 1115 waivers. However, they comment that Medicaid recipients in the Commonwealth are grappling with complex mental health conditions that also may necessitate longer residential treatment stays.</p>	Support	Strongly urges the Department to expand the 1115 application to encompass all behavioral health issues.	The Department recognizes the commenter’s concern; CMS however is currently considering 1115 Waivers only for SUDs.
<p align="center"><u>Commenter 9</u></p> <p>The Council of Southeast PA, Inc, serves 5 counties and has a mission to provide resources and opportunities to reduce the impact of addiction. The commenter incorrectly suggests that IMD residential stays are not included in the waiver. Concerned that importance of peer support services is not reflected in the Waiver.</p>	Concerns about not including the items listed in the next column in the waiver.	<p>Believe that adequate residential treatment should be covered under the new 1115 Waiver</p> <p>Wants Recovery Supports (Peer) covered.</p>	<p>IMD residential services are covered in this 1115 Waiver. Non IMD residential services will continue to be provided under the “in lieu of” authority in the 1915(b) waiver.</p> <p>This Waiver is specifically to obtain expenditure authority pertaining to SUD IMDs. Recovery services are already reimbursable under the “in lieu of” authority in the 1915(b) waiver. Recovery services are also provided through other federal and state funding streams including the Substance Abuse Treatment and Prevention Block Grant and state Human Services funding.</p>

Brief summary of comments	Support/Not in Support – If not, why?	Specific Concerns/Changes Requested	DHS Action in Response to Concerns/Changes Requested
		Inclusion of early interventions services such as SBIRT.	Prevention and intervention services are provided through other federal and state funding streams including the Substance Abuse Treatment and Prevention Block Grant and state Human Services funding. Intervention services can also be provided under the 1915(b) “in lieu of” authority.
<p align="center"><u>Commenter 10</u></p> <p>They applaud the Department’s work with the 1115 Waiver and agree with the points that have been made.</p>	Support	None	The commenter supports the Waiver as written. No specific concerns expressed.
<p align="center"><u>Commenter 11</u></p> <p>They agree with the list of services and levels of care proposed in the 1115 Demonstration waiver and support the waiver’s endorsement of MAT’s.</p>	Support	<p>Suggest that the waiver application should include additional information about the role and responsibilities of the PA OUD Centers of Excellence.</p> <p>Concern expressed about the training costs associated with the transition to ASAM.</p>	<p>Most of the currently available information pertaining to Centers of Excellence is already included in the Waiver application. Pursuant to the commenter’s recommendation, a web-link that contains flowcharts that demonstrate how COEs improve provision of care has been added in the relevant section in the Waiver.</p> <p>All system partners will be working collaboratively to share training costs. The cost of training, be it the responsibility of stakeholders (SCAs/providers/BH-MCOs) or DDAP has been considered when making the decision to transition to ASAM. While there will be an initial cost to the system, it is believed that the benefits to the establishment and/or strengthening of PA’s ROSC will be realized and supported by the transition to ASAM. The cost to a single provider would be relative to the number of clinicians needing to be trained. DDAP has strongly encouraged that those individuals whose primary job duties are to apply or supervise the ASAM Criteria be those who participate in the 2- day training. Those providers who wish to send facility directors and other staff who do not have this function would do so voluntarily; and, in fact could have such persons complete the less expensive, online trainings.</p>

NOTICES

DEPARTMENT OF HUMAN SERVICES

Proposed Federal Section 1115 Application for Substance Use Disorder; Public Hearing Schedule

[47 Pa.B. 7127]

[Saturday, November 18, 2017]

The Department of Human Services (Department) is making available for public review and comment the proposed Federal Section 1115 Demonstration waiver application for substance use disorder (SUD) services.

The purpose of this Demonstration is to afford continued access to high quality, medically necessary treatment for opioid use disorder and other SUDs. The Commonwealth recognizes the importance of a full continuum of treatment services, including residential services that are provided in a cost-effective manner and for a length of stay that is governed by appropriate clinical guidelines. This Demonstration is critical to provide the necessary funding to support the continuation of medically necessary services.

The goals of this Demonstration are to:

1. Improve the overall population health outcomes for Medicaid beneficiaries diagnosed with an SUD by:
 - a. Reducing overdose deaths
 - b. Increasing the number of Medicaid beneficiaries who access substance use treatment
 - c. Increasing the rate of retention in treatment across all levels of care
2. Decrease utilization of high-cost emergency department and hospital services by:
 - a. Decreasing the number of emergency department visits and inpatient admissions
 - b. Decreasing the number of readmissions to the same level of care or higher levels of care for a primary SUD diagnosis
3. Improve care transition across the continuum of substance use services by:
 - a. Enhancing coordination of care with other behavioral and physical health services

b. Enhancing the process for transitions between levels of care

The 1115 Demonstration waiver application is available at <http://www.healthchoices.pa.gov/info/about/behavioral/1115WaiverApplicationforSUD/index.htm>. In addition, copies of the application are available upon written request to the Director, Bureau of Policy, Planning, and Program Development, Office of Mental Health and Substance Abuse Services, 11th Floor, Commonwealth Tower, 303 Walnut Street, Harrisburg, PA 17101.

Public Hearing Schedule

The Department will hold four public hearings throughout this Commonwealth to accept testimony on the proposed 1115 Demonstration waiver application. The Department will also present updates and solicit comment on the waiver application at the Medical Assistance Advisory Committee meeting on December 14, 2017.

The schedule of dates, times and locations for the public hearings is listed as follows:

December 4, 2017, 10 a.m. to 12 p.m.
OMHSAS NE Field Office Conference Room
100 Lackawanna Avenue
Scranton, PA

December 5, 2017, 10 a.m. to 12 p.m.
Norristown State Hospital Auditorium
1001 Sterigere Street
Norristown, PA

December 8, 2017, 8 a.m. to 10 a.m.
Child Welfare Resource Center
403 East Winding Hill Road
Mechanicsburg, PA

December 11, 2017, 1 p.m. to 3 p.m.
Shenango Crossing
2520 New Butler Road
New Castle, PA 16101

Public Comment

The Department seeks public input on the proposed 1115 Demonstration waiver application for SUD services. The 30-day public comment period will begin on November 18, 2017, and end on December 18, 2017. Persons who wish to testify on the proposed 1115 Demonstration waiver application at one of the public hearings should schedule a time by calling (717) 772-7900. Persons from outside the Harrisburg area may send a written request, including telephone number, to Satoko Hariyama, Bureau of Policy, Planning and Program Development, Office of Mental Health and Substance Abuse Services, 11th Floor, Commonwealth Tower, 303 Walnut Street, Harrisburg, PA 17101.

Individuals also may submit written comments at any of the public hearings or by e-mail to RA-PWOMHSASComm@pa.gov or by mail to the address of the previously identified

contact person. The Department will consider all comments received by December 18, 2017, in developing the final waiver application.

Persons with a disability who require auxiliary aid or service may submit comments using the Pennsylvania AT&T Relay Service at (800) 654-5984 (TDD users) or (800) 654-5988 (voice users).

TERESA D. MILLER,
Acting Secretary

Fiscal Note: 14-NOT-1190. No fiscal impact; (8) recommends adoption.

[Pa.B. Doc. No. 17-1889. Filed for public inspection November 17, 2017, 9:00 a.m.]

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1115 Waiver Application for SUD

The Department of Human Services is making available for public review and comment the proposed Federal Section 1115 Demonstration waiver application(/cs/groups/webcontent/documents/document/c_267449.pdf)

for substance use disorder (SUD) services.

The purpose of this demonstration is to afford continued access to high-quality, medically necessary treatment for opioid use disorder (OUD) and other substance use disorders (SUDs) through Pennsylvania's mandatory behavioral health managed care program (Behavioral Health HealthChoices) administered by the Behavioral Health Managed Care Organizations. Services furnished through this Demonstration will not be available under the Fee-for-Service delivery system. Pennsylvania recognizes the importance of a full continuum of treatment services, including residential services that are provided in a cost-effective manner and for a length of stay that is governed by appropriate clinical guidelines. This demonstration is critical to provide the necessary funding to support the continuation of medically necessary services.

Copies of the application are available upon written request:

Director, Bureau of Policy, Planning, and Program Development,

Varghese, Benny

COPY OF EMAIL SENT TO
VARIOUS LISTSERVS

From: Klucar, Shanna
Sent: Friday, November 17, 2017 12:55 PM
To: County Human Svcs; County MH-MR; County SCA Admins; OMHSAS Adult Committee; OMHSAS Child Committee; OMHSAS General; OMHSAS MH-MR Adv Committee; OMHSAS Older Adult Committee; OMHSAS Recovery Sub-Committee; Youth Sub-Committee
Subject: Proposed Federal Section 1115 Application for SUD and Public Hearing Schedule

The Department of Human Services is making available for public review and comment the proposed Federal Section 1115 Demonstration waiver application for substance use disorder (SUD) services.

The purpose of this Demonstration is to afford continued access to high quality, medically necessary treatment for opioid use disorder (OUD) and other substance use disorders (SUDs). Pennsylvania recognizes the importance of a full continuum of treatment services, including residential services that are provided in a cost-effective manner and for a length of stay that is governed by appropriate clinical guidelines. This Demonstration is critical to provide the necessary funding to support the continuation of medically necessary services.

The goals of this Demonstration are to:

1. Improve the overall population health outcomes for Medicaid beneficiaries diagnosed with a substance use disorder by:
 - a. Reducing overdose deaths
 - b. Increasing the number of Medicaid beneficiaries who access substance use treatment
 - c. Increasing the rate of retention in treatment across all levels of care
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 - a. Enhancing coordination of care with other behavioral and physical health services
 - b. Enhancing the process for transitions between levels of care

The 1115 Demonstration waiver application is available at <http://www.healthchoices.pa.gov/info/about/behavioral/1115WaiverApplicationforSUD/index.htm>. In addition, copies of the application are available upon written request to the Director, Bureau of Policy, Planning, and Program Development, Office of Mental Health and Substance Abuse Services, 11th Floor Commonwealth Tower, 303 Walnut Street, Harrisburg, PA 17101.

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1001 Sterigere Street
Norristown, PA

December 8, 2017, 8:00 a.m. to 10:00 am
Child Welfare Resource Center
403 East Winding Hill Road
Mechanicsburg, PA

December 11, 2017 from 1:00 p.m. to 3:00 pm
Shenango Crossing
2520 New Butler Road
New Castle, PA 16101

Public Comment

The Department seeks public input on the proposed 1115 Demonstration waiver application for SUD services. The 30-day public comment period will begin on November 18, 2017 and end on December 18, 2017. Persons who wish to testify on the proposed 1115 Demonstration waiver application at one of the public hearings should schedule a time by telephoning (717) 772-7900. Persons from outside the Harrisburg area may send a written request, including telephone number, to Satoko Hariyama, Bureau of Policy, Planning, and Program Development, Office of Mental Health and Substance Abuse Services, 11th Floor, Commonwealth Tower, 303 Walnut Street, Harrisburg, PA 17101.

Individuals also may submit written comments at any of the public hearings or by e-mail to RA-PWOMHSASComm@pa.gov or by mail to the address of the contact person identified above. The Department will consider all comments received by December 18, 2017 in developing the final waiver application.

Persons with a disability who require auxiliary aid or service may submit comments using the Pennsylvania AT&T Relay Service at (800) 654-5984 (TDD users) or (800) 654-5988 (voice users).



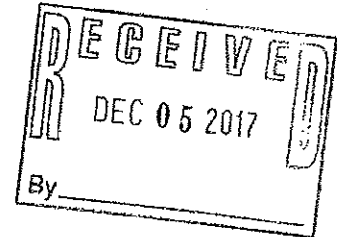
Alternative Counseling Associates Inc.

Executive Director: Randall Shanley; MA, CADC, CCDP

SUPPORT AND STRUCTURE FOR ADDICTION / MENTAL HEALTH TREATMENT

November 30, 2017

Bureau of Policy, Planning, and Program Development
Office of Mental Health and Substance Abuse Services
11th Floor, Commonwealth Tower
303 Walnut Street
Harrisburg, PA 17101
Attn: Satoko Hariyama



Re: Public Comment on the Federal Section 1115 Demonstration Waiver Application for Substance Use Disorder (SUD) Services

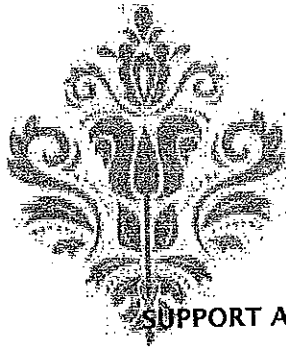
As the Executive Director of a licensed, residential substance use disorder program, I witness first-hand the absolute need to support Pennsylvania's Demonstration Waiver of Rules from the Centers for Medicare and Medicaid Services (CMS) regarding Federal Medicaid match for patients in licensed addiction treatment facilities with more than sixteen (16) beds.

This Demonstration is constructed to afford continued access to high quality, medically necessary treatment for opioid use disorder (OUD) and other substance use disorders (SUDs). Clearly, Pennsylvania recognizes the importance of a full continuum of treatment services, including residential services that are provided in a cost-effective manner and for a length of stay that is governed by appropriate clinical guidelines. The acceptance of their Demonstration is absolutely critical to continue the federal funding needed to support the continuation of medically necessary services, including SUD treatment in residential facilities for individuals 21-64 years of age, regardless of the bed count of the facility and the length of stay of the individuals.

Until recently, CMS has approved these residential services as cost-effective alternatives to state plan services in HealthChoices, Pennsylvania's Medicaid mandatory managed care program. However, the recent requirements in the Medicaid Managed Care rule allow states to receive

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Executive Director: Randall Shanley; MA, CADC, CCDP

SUPPORT AND STRUCTURE FOR ADDICTION / MENTAL HEALTH TREATMENT

federal funding for an Institution for Mental Diseases (IMD) facility only for individuals 21 to 64 years old if the length of stay is no longer than fifteen (15) days. Pennsylvania has estimated that this rule change would impact nearly one hundred and sixty (160) SUD service providers encompassed within the definition of an IMD, negatively affecting about 12,240 individuals statewide.

Residential treatment services provide a structured recovery environment in combination with high-intensity clinical services. Individuals in residential settings receive daily clinical services to stabilize symptoms; a range of cognitive, behavioral, and other therapies to develop recovery skills in a protected environment; and recovery support services to assist in developing a social network supportive of recovery. Dependence on substances is a complex disease that affects multiple brain circuits, and effective treatment must incorporate an array of clinical and psychosocial components

provided in a safe environment, as determined by appropriate clinical guidelines.

Residential treatment is a core service in the continuum of care for many individuals with a SUD.

The National Institute for Drug Abuse (NIDA) identified key principles for effective treatment which include the ability to remain in treatment services for an adequate period of time.

The appropriate duration of treatment depends on the clinical needs of the individual.

NIDA's own research indicates the majority of individuals need at least ninety (90) days of treatment to significantly reduce or stop using substances.¹ Recovery is a long-term process, and the best outcomes occur with longer durations of treatment across the entire continuum of care based upon clinical needs.

In a November 1, 2017 letter to The Honorable Donald J. Trump, President of the United States,

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Alternative Counseling Associates Inc.

Executive Director: Randall Shanley; MA, CADC, CCDP

SUPPORT AND STRUCTURE FOR ADDICTION / MENTAL HEALTH TREATMENT

The President's Commission on Combating Drug Addiction and the Opioid Crisis, which was charged with "the responsibility of developing recommendations to combat the addiction crisis

that is rampantly impacting our country"² specifically noted "You acted to remove one of the biggest federal barriers to treatment by announcing the launch of a new policy to overcome the restrictive, decades-old federal rule that prevents states from providing more access to care at treatment facilities with more than 16 beds. This action will take people in crisis off waiting lists where they are at risk of losing their battle to their disease and put them into a treatment bed and on the path to recovery.

We urge all Governors to apply to CMS for a waiver. This policy will – without any doubt – save lives."³

Pennsylvania has provided residential treatment services to individuals based upon a comprehensive assessment and standardized level of care placement criteria to ensure appropriate treatment. Access to residential treatment services has not been based upon an arbitrary length of stay but upon the determination of clinical need and medical necessity for this level of care. The loss in federal matching dollars due to the current changes to the managed care rule places an enormous financial burden on the commonwealth, thereby impacting its ability to provide adequate residential treatment services to individuals if the residential facility meets the definition of an IMD. This severely impacts an individual's ability to remain in treatment for adequate lengths of time which would result in negative outcomes such as a relapse, resulting in increased costs over various systems.

Pennsylvania recognizes the importance of these residential services in the continuum of care and believes this Demonstration is critical in ensuring that they can sustain the availability of these services to the impacted population. I agree, and that is why I am supporting their effort.

Sincerely,

Randall Shanley

Randall Shanley, Executive Director
Alternative Counseling Associates

438 E High St. Pottstown, PA 19464 (P) 610--970-9060 (F) 610-970-4280

E-mail ACA438@aol.com



Alternative Counseling Associates Inc.

Executive Director: Randall Shanley; MA, CADC, CCDP

SUPPORT AND STRUCTURE FOR ADDICTION / MENTAL HEALTH TREATMENT

- 1 "Principles of Drug Addiction and Treatment-- A Research-Based Guide", Third Edition (2012). Available at:
https://www.drugabuse.gov/sites/default/files/podat_1.pdf
- 2 The President's Commission on Combating Drug Addiction and the Opioid Crisis, November 1, 2017, page 5. Available at:
<https://www.whitehouse.gov/sites/whitehouse.gov>
- 3 The President's Commission on Combating Drug Addiction and the Opioid Crisis, November 1, 2017, page 6. Available at:
<https://www.whitehouse.gov/sites/whitehouse.gov>

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HARWOOD

Harwood House – 9200 West Chester Pike – Upper Darby, PA 19082
610-853-3440 Fax: 610-853-1067 email: jdouglas@harwoodhouse.us
Website: www.harwoodhouse.us

December 4, 2017

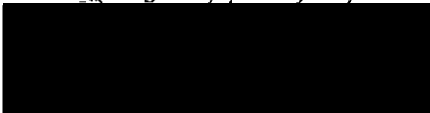
Bureau of Policy, Planning, and Program Development
Office of Mental Health and Substance Abuse Services
11th Floor, Commonwealth Tower
303 Walnut Street
Harrisburg, PA 17101
Attn: Satako Hariyama

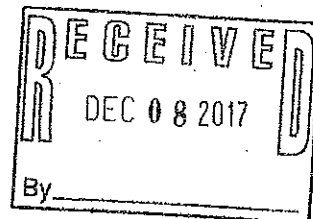
Re: Public Comment on the federal Section 1115 Demonstration Waiver Application for Substance Use Disorder (SUD) Services

The state of Pennsylvania has provided residential treatment services to individuals based upon a comprehensive assessment and a standardized level of care placement criteria to ensure appropriate treatment. Access to treatment has been determined by the clinical need for the level of care. As the Executive Director of a licensed, residential substance use disorder program, I support the Pennsylvania's Demonstration Waiver of Rules from the Centers for Medicare and Medicaid Services regarding Federal Medicaid match patients in licensed addiction treatment facilities with more than 16 beds.

Pennsylvania recognizes the importance of residential services in the continuum of care and I agree this Demonstration Waiver is critical for the availability of residential treatment services for this population.

Best Regards,


Joy Douglas
Executive Director
Harwood House





November 29, 2017

Bureau of Policy, Planning, and Program Development
Office of Mental Health and Substance Abuse Services
11th Floor, Commonwealth Tower
303 Walnut Street
Harrisburg, PA 17101
Attn: Satoko Hariyama

Re: Public Comment on the Federal Section 1115 Demonstration Waiver Application for Substance Use Disorder (SUD) Services

As the Executive Director of a licensed, residential substance use disorder program, I witness first-hand the absolute need to support Pennsylvania's Demonstration Waiver of Rules from the Centers for Medicare and Medicaid Services (CMS) regarding Federal Medicaid match for patients in licensed addiction treatment facilities with more than sixteen (16) beds.

This Demonstration is constructed to afford continued access to high quality, medically necessary treatment for opioid use disorder (OUD) and other substance use disorders (SUDs). Clearly, Pennsylvania recognizes the importance of a full continuum of treatment services, including residential services that are provided in a cost-effective manner and for a length of stay that is governed by appropriate clinical guidelines. The acceptance of their Demonstration is absolutely critical to continue the federal funding needed to support the continuation of medically necessary services, including SUD treatment in residential facilities for individuals 21-64 years of age, regardless of the bed count of the facility and the length of stay of the individuals.

Until recently, CMS has approved these residential services as cost-effective alternatives to state plan services in HealthChoices, Pennsylvania's Medicaid mandatory managed care program. However, the recent requirements in the Medicaid Managed Care rule allow states to receive federal funding for an Institution for Mental Diseases (IMD) facility only for individuals 21 to 64 years old if the length of stay is no longer than fifteen (15) days. Pennsylvania has estimated that this rule change would impact nearly one hundred and sixty (160) SUD service providers encompassed within the definition of an IMD, negatively affecting about 12,240 individuals statewide.

Residential treatment services provide a structured recovery environment in combination with high-intensity clinical services. Individuals in residential settings receive daily clinical services to stabilize symptoms; a range of cognitive, behavioral, and other therapies to develop recovery skills in a protected environment; and recovery support services to assist in developing a social network supportive of recovery. Dependence on substances is a complex disease that affects multiple brain circuits, and effective treatment must incorporate an array of clinical and psychosocial components

Building Bridges to Recovery

P.O. Box 165 • Morrisville, PA 19067 • Tel: 215-736-2861 • Fax: 215-736-1966
info@goodfriendsinc.org • www.goodfriendsinc.org • facebook.com/GoodFriendsInc

provided in a safe environment, as determined by appropriate clinical guidelines. Residential treatment is a core service in the continuum of care for many individuals with a SUD.

The National Institute for Drug Abuse (NIDA) identified key principles for effective treatment which include the ability to remain in treatment services for an adequate period of time. The appropriate duration of treatment depends on the clinical needs of the individual. NIDA's own research indicates the majority of individuals need at least ninety (90) days of treatment to significantly reduce or stop using substances.¹ Recovery is a long-term process, and the best outcomes occur with longer durations of treatment across the entire continuum of care based upon clinical needs.

In a November 1, 2017 letter to The Honorable Donald J. Trump, President of the United States, The President's Commission on Combating Drug Addiction and the Opioid Crisis, which was charged with "the responsibility of developing recommendations to combat the addiction crisis that is rampantly impacting our country"² specifically noted "You acted to remove one of the biggest federal barriers to treatment by announcing the launch of a new policy to overcome the restrictive, decades-old federal rule that prevents states from providing more access to care at treatment facilities with more than 16 beds. This action will take people in crisis off waiting lists where they are at risk of losing their battle to their disease and put them into a treatment bed and on the path to recovery. We urge all Governors to apply to CMS for a waiver. This policy will – without any doubt – save lives."³

Pennsylvania has provided residential treatment services to individuals based upon a comprehensive assessment and standardized level of care placement criteria to ensure appropriate treatment. Access to residential treatment services has not been based upon an arbitrary length of stay but upon the determination of clinical need and medical necessity for this level of care. The loss in federal matching dollars due to the current changes to the managed care rule places an enormous financial burden on the commonwealth, thereby impacting its ability to provide adequate residential treatment services to individuals if the residential facility meets the definition of an IMD. This severely impacts an individual's ability to remain in treatment for adequate lengths of time which would result in negative outcomes such as a relapse, resulting in increased costs over various systems.

Pennsylvania recognizes the importance of these residential services in the continuum of care and believes this Demonstration is critical in ensuring that they can sustain the availability of these services to the impacted population. I agree, and that is why I am supporting their effort.

Sincerely,

Ted Millard

Ted Millard, Executive Director
Good Friends, Inc.

¹ "Principles of Drug Addiction and Treatment – A Research-Based Guide", Third Edition (2012). Available at: https://www.drugabuse.gov/sites/default/files/podat_1.pdf

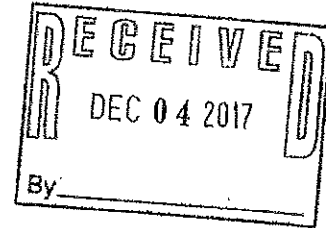
² The President's Commission on Combating Drug Addiction and the Opioid Crisis, November 1, 2017, page 5. Available at: <https://www.whitehouse.gov/sites/whitehouse.gov>

³ The President's Commission on Combating Drug Addiction and the Opioid Crisis, November 1, 2017, page 6. Available at: <https://www.whitehouse.gov/sites/whitehouse.gov>

Pennsylvania Halfway House Association

November 30, 2017

Bureau of Policy, Planning, and Program Development
Office of Mental Health and Substance Abuse Services
11th Floor, Commonwealth Tower
303 Walnut Street
Harrisburg, PA 17101
Attn: Satoko Hariyama



Re: Public Comment on the Federal Section 1115 Demonstration Waiver Application for Substance Use Disorder (SUD) Services

As the Vice President and past President of the Pennsylvania Halfway House Association, I witness first-hand the absolute need to support Pennsylvania's Demonstration Waiver of Rules from the Centers for Medicare and Medicaid Services (CMS) regarding Federal Medicaid match for patients in licensed addiction treatment facilities with more than sixteen (16) beds. This Demonstration is constructed to afford continued access to high quality, medically necessary treatment for opioid use disorder (OUD) and other substance use disorders (SUDs). Clearly, Pennsylvania recognizes the importance of a full continuum of treatment services, including Residential services that are provided in a cost-effective manner and for a length of stay that is governed by appropriate clinical guidelines. The acceptance of their Demonstration is absolutely critical to continue the federal funding needed to support the continuation of medically necessary services, including SUD treatment in residential facilities for individuals 21-64 years of age, regardless of the bed count of the facility and the length of stay of the individuals.

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Residential treatment services provide a structured recovery environment in combination with high-intensity clinical services. Individuals in residential settings receive daily clinical services to stabilize symptoms; a range of cognitive, behavioral, and other therapies to develop recovery skills in a protected environment; and recovery support services to assist in developing a social network supportive of recovery. Dependence on substances is a complex disease that affects multiple brain circuits, and effective treatment must incorporate an array of clinical and psychosocial components outcomes occur with longer durations of treatment across the entire continuum of care based upon clinical needs.

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Pennsylvania Halfway House Association

This action will take people in crisis off waiting lists where they are at risk of losing their battle to their disease and put them into a treatment bed and on the path to recovery. We urge all Governors to apply to CMS for a waiver. This policy will – without any doubt – save lives.”

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Sincerely,

Fern B. Wilcox Vice President



Drug & Alcohol Service Providers Organization of Pennsylvania
dasdbeck@hotmail.com 717-652-9128

Satoko Hariyama
Bureau of Policy, Planning, and Program Development
Office of Mental Health and Substance Abuse Services
11th Floor, Commonwealth Tower
303 Walnut Street
Harrisburg, PA 17101
Via Email: RA-PWOMHSASComm@pa.gov

RE: Pennsylvania's Proposed Federal Section 1115 Application for Substance Use Disorder

Thanks greatly for providing this opportunity for public comment on Pennsylvania's Federal Section 1115 Demonstration Waiver application for Substance Use Disorder Services.

We are in the midst of the worst drug and drug addiction epidemic of our lifetime that cries out for vigorous assistance from state and federal governments.

As part of addressing this public health epidemic, addiction treatment must be expanded and stabilized, not held back or reduced by the IMD Exclusion or the new 15- day limit proposed by CMS.

For this reason, we are pleased that CMS has provided the opportunity for states to apply for an 1115 Demonstration Waiver. We are also pleased to support Pennsylvania's application for a Demonstration Waiver and for the Department's continuing strong support for the full continuum of addiction treatment services, including licensed residential treatment.

In review of the Demonstration Waiver, we want to draw attention to several items.

According to the application, "*Research indicates that the majority of individuals need at least 90 days of treatment to significantly reduce or stop using substances.*" This important addiction-specific research finding from the National Institute of Health's National Institute on Drug Abuse contrasts starkly with CMS's 15 day limit that is admittedly based on acute psychiatric admissions. The NIDA drug and alcohol addiction-specific finding

can't be emphasized enough, particularly with individuals who are deteriorated enough to be dependent on Medicaid and have addictions. Failure to provide adequate lengths of treatment for these populations can be life and death important and minimally, such failure will lead to costly health care utilization, incarceration and other needless human tragedy.

The Department's application includes an excellent description of Pennsylvania's locally tailored patient placement criteria, the Pennsylvania Client Placement Criteria (PCPC). PA's Act 152 of 1988 explicitly directs the Department of Drug and Alcohol Programs to develop, not adopt, patient placement criteria for use with Medicaid and Medicaid recipients.

The PCPC is attuned to the greater physical, mental and economic deterioration that we see among people on Medicaid compared to the commercially insured. For this reason, the PCPC is tailored to allow utilization of the full continuum of licensed addiction treatment services available in the state of Pennsylvania, including licensed halfway houses.

We worry that the ASAM may not capture the importance of Pennsylvania's whole continuum of licensed addiction treatment services, in specific the need for licensed halfway houses. These licensed halfway houses are quite different from unlicensed recovery houses or similar living environments.

Finally, we recommend maintaining the use of the PCPC or adapting the ASAM tool to develop better sensitivity to the needs of deteriorated individuals who are on Medicaid, including pregnant addicted women, addicted women with dependent children, veterans with addictions, addicted homeless individuals and criminal offenders with addictions. Many of these individuals will need licensed residential treatment and licensed halfway house services.

We are concerned about the cost of retraining our entire field on the use of the ASAM but mostly, we are concerned about the need to tailor the ASAM to reflect the special needs of the deteriorated Medicaid populations noted above. If the ASAM were tailored in this way, it would also assure compliance with and eliminate conflict with PA's Act 152 of 1988.

Quality measures – We are pleased to see that CMS and PA's application have quality measures involving alcohol and other drug disorder treatment as well as focus on the opioid problem.

Evaluation plan – One of the outcomes listed is the reduction of overdose deaths. We are concerned that unless adequate lengths of stay are provided in addiction treatment, decreases in the number of overdose deaths is unlikely. In addition, in response to appropriate treatment, reductions in the utilization of health care are certainly to be expected. However, many people starting down the pathway to recovery begin to use medical services to take care of long neglected physical problems. As a result, most studies of the utilization of health care pre and post addiction treatment show a brief increase in the use of health care after admission to treatment followed by a decrease in health care utilization over time as the person recovers.

We are glad to see that OMHSAS will be working to ensure that the requirements of the federal Mental Health Parity & Addiction Equity Act of 2008 are followed. This is incredibly important. We would like to work with you to make real the promise of the federal Parity Act and finally eliminate all discriminatory barriers to addiction treatment. We urge the Department to schedule a follow-up hearing on this issue to develop a plan of action on enforcement and include all the appropriate departments well as the addiction treatment and recovering community.

Finally, we share the concern of the Department about the potential loss of federal match due to the 15 day rule, the enormous financial burden that will fall on the Commonwealth and the reduction in access to life-saving addiction treatment services for the citizens of Pennsylvania.

Sincerely,

A solid black rectangular box redacting the signature of Deb Beck.

Deb Beck
President/DASPOP

12/7/17



PROA

Pennsylvania Recovery
Organizations Alliance

900 S Arlington Ave, Suite 254A
Harrisburg, PA 17109-1014

December 8, 2017

Pennsylvania Department of Human Services
Public Hearing on Proposed Federal Section 1115 Demonstration Waiver
Child Welfare Resource Center
403 East Winding Hill Road
Mechanicsburg, PA 17055

Public Comment:

The Pennsylvania Recovery Organizations – Alliance, the statewide recovery community organization of Pennsylvania wishes to thank the Department of Human Services for the opportunity to provide public comment to the proposed Federal Section 1115 Demonstration Waiver Application.

We believe that the IMD Exclusion, limiting federal match for patients in licensed addiction treatment facilities with more than sixteen (16) beds is inadequate to our care needs. The IMD exclusion is a serious barrier to the provision of substance use services for the appropriate intensity and duration needed to develop and sustain recovery for members of our community. We applaud the Department for recognizing the importance of a full continuum of treatment and recovery support services, including residential treatment provided in a cost-effective manner and for a length of stay that is governed by appropriate clinical guidelines. This demonstration waiver is an opportunity to fund these life-saving services and move our systems towards providing the kinds of care and services needed to support and sustain recovery for our community.

We agree that as noted in the waiver application, 90 days of continuous care is the minimum effective “dose” of treatment and to allow the ability to form therapeutic relationships at each level. Care provided must meet the clinical needs of the individual. We also applaud the Department for acknowledging that we need to treat the whole person and move towards a system of care that include a full range of treatment and recovery support services available to all Pennsylvania citizens across the Commonwealth.

We deeply appreciate the dedication that Pennsylvania has had over the last 40 years in developing a comprehensive care system that includes treatment and to lay the groundwork to support drug and alcohol recovery support services. Our current drug and alcohol licensing regulations already require the coordination of drug and alcohol care with physical and mental health services, and we applaud efforts to effectively fund this work so that it may be more robustly implemented. We have more work ahead of us. It is vitally important that we commit to a system that provides Drug and Alcohol peer recovery support services in parity with mental health peer support services. Drug and Alcohol recovery support services must be made available in every county, on a permanent basis, provided in a consistent manner, and available to all citizens who need them in a way similar to the way that Mental Health peer services have been available for the last 15 years. We note that the use of Drug and Alcohol recovery support services are not part of the care determination either in the PCPC or in the ASAM criteria. As current research is finding, it is critically important in the development of a recovery oriented system of care to define, develop and fund services that support recovery for the first five years of sustained recovery.

The waiver describes the Pennsylvania Client Placement Criteria (PCPC) as the medical necessity criteria utilized within our current system of care. The PCPC is substantively similar to the American Society of Addiction Medicine Criteria (ASAM). Research showed that the PCPC demonstrated its reliability and value in Pennsylvania under the Villanova study in its evaluation and implementation of Act 152. This 1115 waiver proposal describes moving our placement criteria to

The proprietary, ASAM criteria. We have several concerns about this change and worry that it may dramatically increase training costs to providers across Pennsylvania and does not fit the care system that we have worked so hard to develop. One small provider we spoke with identified that they were quoted a cost of \$6000 for a two-day training through the Change Companies, a Nevada based company who we understand to be the sole trainer for all of Pennsylvania. We would ask if the additional training costs have been calculated into the consideration to move away from the PCPC criteria, which we believe to be best suited to the needs of our community.


Additionally, in the waiver application, licensed Halfway Houses (which is level 2B under our current placement criteria), are identified as level 3.1 low intensity residential services under ASAM. We note with concern, that the description of level 3.1 states that the clinical services are "usually outpatient services" and can be used for "individuals who may not yet acknowledge that they have a substance use or other addictive problem" and receive "discovery & dropout prevention services" as opposed to "recovery & relapse prevention services." This is not consistent with nor does it reflect the care that these treatment facilities are designed to provide. In Pennsylvania, Halfway House are licensed under the non-hospital residential standards just like other kinds of residential programs. We are deeply concerned about implementing the ASAM criteria as proposed under this waiver, the implications of these changes on our current care system and the impact on citizens of Pennsylvania who use these services. Adopting the ASAM criteria would risk the loss of an entire level of care we have here in Pennsylvania that we developed to meet the needs of our citizens.

We note that the Evaluation Plan of the waiver describes very narrow criteria. One example is the use of medical services as a measure of efficacy. The studies we are aware of show that recovery dramatically reduces the utilization of medical care over time, so we agree that this is an area of significant cost savings. However, early recovery medical care utilization may increase as the person stabilizes their physical health and the savings are realized over time.

The Evaluation Plan also identifies the outcome measure for acute and residential treatment as being the impact of accessing residential treatment services for an appropriate length of stay on the number of overdose deaths across the Commonwealth. It is unclear how overdoses would be measured in relation to the acute and residential care. We would also note that this measure would not account for the holistic care provided to persons seeking help for the full range of substance use conditions that exist beyond an opioid dependence condition in these care settings. For perspective according to the 2016-17 state plan, roughly half (49%) of the treatment admissions were not opioid related, so overdose would not be a meaningful or effective measure of care for any of these individuals.

Finally, the projected expenditures moving forward project a slowed rate of increase in expenditures in comparison to historical rates for services covered under this proposal. As described in the waiver application, from 2012 to 2016, expenditures increased by 10.7%, the application forecasts a slower rate of increase in expenditures between 2019 to 2023 in the amount of 7.8%. We would like to more fully understand how these projections were calculated as are we considering the importance of properly funding care to support recovery across our service system.

Respectfully Submitted,


William Stauffer, LSW, CCS, CADC
Executive Director

Mee-Lee, D., Shulman, G. D., Fishman, M., Gastfriend, D. R., Miller, M. M., & Provenca, S. M. (2013). *The ASAM criteria: treatment for addictive, substance-related, and co-occurring conditions*. Chevy Chase, MD: American Society of Addiction Medicine.

Pennsylvania Drug and Alcohol State Plan 2016-17. (n.d.). Retrieved from
<http://www.ddap.pa.gov/Reports/State%20Plan%20and%20Annual%20Reports/2014-2015%20DDAP%20Data%20Analysis%20and%20Outcome%20Report.pdf>

717-545-8929 F 717-545-9163 www.pro-a.org Billstauffer@pro-a.org

Peters, Sherry

From: Suhring, Scott <ssuhring@cabhc.org>
Sent: Wednesday, December 06, 2017 7:59 AM
To: PW, OMHSAS Communications
Cc: Board
Subject: 115 Waiver Demonstration Waiver

Please accept the following comments on the proposed 1115 Demonstration Waiver for SUD.

CABHC, representing the counties of Cumberland, Dauphin, Lancaster, Lebanon and Perry, which are primary contractors for the HealthChoices Behavioral Health program, support this application for the demonstration waiver. We would like to make two comments on the application:

1. The issue of IMD funding that directly impacts the non-hospital D&A rehabilitation services covered in this waiver also impacts the non-hospital mental health inpatient services. We understand that the focus on SUD services is timely and may be better received, but it should not be lost that this is also a mental health issue.
2. Section VIII: Integration of Physical Health and SUD. This entire section indicates that the exchange of SUD treatment information is permissible. Under the current guidelines of the P4P/Integrated Care Planning, there are two conditions that cannot be shared between the BH and PH MCOs; Substance Use Disorder and HIV treatment. This section should be removed if this restriction is still the standard or if it is not, then DHS needs to provide clarification to the HealthChoices contractors that this standard is no longer required.

Scott Suhring, CEO
Capital Area Behavioral Health Collaborative
2300 Vartan Way, Suite 206
Harrisburg, PA 17110
717.671.7190
(fax) 717.671.7289

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December 11, 2017

VIA E-MAIL (ra- RA-PWOMHSASComm@pa.gov)

Pennsylvania Department of Human Services

P.O. Box 2675

Harrisburg, Pennsylvania 17105-2675

RE: Pennsylvania Substance Use Disorder (SUD) 1115 Demonstration

Dear Sir/Madam:

Thank you for the opportunity to comment on the draft Pennsylvania Substance Use Disorder (“SUD”) 1115 Demonstration application.

Community Legal Services of Philadelphia (“CLS”) submits these comments on behalf of the nearly 10,000 low income Philadelphians that we represent each year. Most of our clients are enrolled in Pennsylvania Medicaid, and many receive behavioral health care through Community Behavioral Health, Philadelphia’s Behavioral Health Managed Care Organization (“BH-MCO”). Our clients rely on behavioral health care not only to get and stay healthy, but also to stabilize their lives and resolve their legal issues: to maintain custody of their children; to work so they can pay for housing and utilities; and, for those who cannot work, to prove that they have disabling conditions so they may receive income supports from Social Security. Comprehensive behavioral health care is thus critically important to the clients we represent.

We were very concerned when we learned that the federal Centers for Medicare & Medicaid Services (“CMS”) would no longer allow states to receive federal funding for managed care for individuals between the ages of 21 and 64 who require residential behavioral health treatment for stays of more than fifteen days. Establishing an arbitrary endpoint for treatment for people with complex behavioral health diagnoses, despite demonstrated medical necessity, results in markedly worse health, social, and legal outcomes. And, from a practical standpoint, the corollary reduction in capitation for CBH and Pennsylvania’s other BH-MCOs weakens the provision of behavioral health care for *everyone* on Medicaid.

We are very pleased, then, that the Pennsylvania Department of Human Services is pursuing an 1115 Demonstration waiver to receive federal funding for individuals who need longer-term treatment for SUDs. As the draft Demonstration application notes, Pennsylvania is in the midst of an opioid crisis, and effective treatment of opioid use disorder and other SUDs is a long-term process. We know from representing our clients that many individuals with SUDs need extended care. The Department’s draft application correctly acknowledges that CMS’s limitations on residential treatment are detrimental to the health of Pennsylvanians who rely on



Medicaid, and we applaud the Department for pursuing the 1115 Demonstration waiver to ensure that Medicaid enrollees with SUDs can receive the treatment that they need to recover.

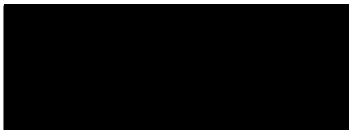
To be sure, Pennsylvania faces a specific and severe public health crisis due to opioid and other substance use. However, Medicaid recipients in Pennsylvania are also grappling with complex mental health conditions that may also necessitate longer residential treatment stays. City of Philadelphia data show that more than 20% of adult residents report potentially serious mental health diagnoses like clinical depression, anxiety disorder, or bipolar disorder, and in certain high poverty neighborhoods, the prevalence of mental health diagnoses among adults can top 35% of the population. And while prevalence of mental health diagnoses has not spiked in the same way as the prevalence of SUDs, it has climbed steadily since 2000.¹

Limiting residential treatment for adults with complex mental health diagnoses like resistant depression or post-traumatic stress disorder forecloses appropriate and medically necessary care. It leads to worse health, social, and legal outcomes. It also results in significant cuts in behavioral health capitation, weakening behavioral health systems for *all* enrollees, at a time when the systems face unprecedented demand.

Accordingly, we strongly urge the Department to expand the 1115 Demonstration application to encompass *all* behavioral health conditions. Alternatively, we urge the Department to pursue a complementary 1115 Demonstration application that addresses federal funding for medically necessary longer-term residential treatment for mental health conditions.

Once more, we thank you for the opportunity to submit comments. Should you have any questions, please feel free to contact Kristen Dama via telephone at (215) 981-3782 or e-mail at kdama@clsphila.org.

Sincerely yours,



Kristen M. Dama, Managing Attorney
Amy E. Hirsch, Managing Attorney
Richard P. Weishaupt, Senior Attorney
For Community Legal Services, Inc.

¹ PHILA. DEP'T OF PUB. HEALTH, 2017 COMMUNITY HEALTH ASSESSMENT (2017) 199, 201, <http://www.phila.gov/health/pdfs/2017%20CHA%20slides.pptx>.

Varghese, Benny

From: Jennifer Wolff <jwolff@mhphope.org>
Sent: Monday, December 18, 2017 3:33 PM
To: PW, OMHSAS Communications
Subject: Proposed Federal Section 1115 Application for SUD Commentary
Attachments: 1115 Demonstration Waiver Commentary.pdf

Hello,

My name is Jennifer Wolff and, on behalf of Mental Health Partnerships (formerly known as the Mental Health Association of Southeastern Pennsylvania) and The Council of Southeast Pennsylvania, I am pleased to submit our joint commentary on Pennsylvania's 1115 Demonstration Waiver application.

Please do not hesitate to contact me should you have any questions or require any additional information. Thank you very much for this opportunity, and I hope you have a wonderful holiday season!

Best,
Jennifer Wolff

--

Jennifer Wolff, MSW
Policy Specialist
Mental Health Partnerships
1211 Chestnut Street, 11th Floor
Philadelphia, PA 19107
(P) [267-507-3191](tel:267-507-3191)
(E) jwolff@mhphope.org

**Mental Health Partnerships and The Council of Southeast Pennsylvania Comments on
Pennsylvania Substance Use Disorder 1115 Demonstration Waiver**

Founded in 1951, Mental Health Partnerships (MHP) has been fighting for access to high quality behavioral healthcare for nearly 7 decades. Located in Pennsylvania, Delaware, and New Jersey, MHP serves nearly 7,500 people with mental health conditions and their families annually and employs 250 people—many of whom are in recovery from mental health conditions themselves. As one of the first behavioral health organizations in the country to deliberately hire people with self-identified behavioral health conditions, MHP is a leading provider of Peer-Support Services, an evidence-based practice provided by folks with lived experience of a mental health condition to help other people on their recovery journey by providing mentoring, connection to valuable community resources, and most importantly, hope.

The Council of Southeast Pennsylvania, Inc. (The Council), a 42 year affiliate of the National Council on Alcoholism and Drug Dependence, is a private non-profit organization serving 5 counties; Bucks, Chester, Delaware, Montgomery and Philadelphia. Our mission is to provide resources and opportunities to reduce the impact of addiction, trauma and related health issues for the entire community which is accomplished through prevention, education, advocacy, assessment, intervention and recovery support services. The Pennsylvania Recovery Organization-Achieving Community Together (PRO-ACT) is the grass roots advocacy and recovery support initiative of The Council. PRO-ACT launched in 1998 and is rooted in the Recovery Oriented System of Care. The Council/PRO-ACT was designated a Recovery Community Organization in 2001. The Council/PRO-ACT Certified Recovery Specialists (CRS) work with individuals and are currently working in hospital emergency rooms with individuals who have experienced an opioid overdose and most recently with individuals who are suffer from mental health and substance use disorders and are being diverted from the criminal justice system into the behavioral health system. The Council/PRO-ACT impacts over 25,000 people a year.

Access to comprehensive and high quality treatment for opioid use disorder (OUD) and substance use disorders (SUDs) is a critical piece of ensuring that recovery is attainable for all Pennsylvanians. As such, we are grateful for the opportunity to provide feedback on Pennsylvania's SUD 1115 Demonstration Waiver which, as our comments demonstrate, does not reflect the importance or benefit of Peer Support services, including both Certified Recovery Specialists and Certified Peer Specialists, leaving a large gap in services, and opportunities, for folks living with OUD or SUDs.

We have developed the comments below on several portions of the 1115 Demonstration Waiver Request through the lens of their impact on behavioral health access and opportunities for recovery.

Thank you for the opportunity to submit these comments and for your consideration.

SUD Service	Covered Under the new 1115 Waiver	Position
IMD Residential Stays	No	<p>Oppose: According to the waiver request, and the National Institute on Drug Abuse, "...participation [in residential treatment] for less than 90 days is of limited effectiveness in maintaining positive outcomes"¹. Given that, CMS's 15 day limit for time in an IMD is of serious concern, especially for folks experiencing opioid addiction.</p> <p>Failure to provide adequate residential treatment will be a large cost later and will force the Commonwealth to spend dollars on expensive crisis services, as well as services pertaining to housing, unemployment and incarceration.</p>
Recovery Supports - Peer Services	No	<p>Oppose: As demonstrated by the language in this waiver application, peer support services are critical to recovery-oriented health, and provide crucial assistance to folks with OUD or SUDs by bridging folks into the community from the state hospital system, helping access and connect to treatment, reconnecting with families and loved ones, and finding pathways to employment. They are also found to be cost effective, having dramatically reduced the average number of days in hospital settings, as well as the use of expensive crisis services.</p> <p>The waiver application notes that peer support services are not included in this demonstration waiver due to those services being currently provided under 1915(b) "in-lieu of" authority. We assume these two waivers will be utilized in conjunction with one another, thereby providing peer services as well as the services offered in the 1115 Demonstration.</p> <p>Note: On page 24, there is reference to health clinicians and PCPs having the obligation to make referrals for social, vocational, education or human services when a need for such services is identified through assessment.</p> <p>At this point, we believe these referrals are best done through peer support instead of clinical support. Harm reduction, and a recovery focused approach to OUD and SUDs, requires this type of holistic technique that CRSs are uniquely qualified to address, and will benefit folks far beyond treatment.</p>

¹ National Institutes of Health. (2012). Principles of Drug Addiction Treatment. Retrieved from: https://www.drugabuse.gov/sites/default/files/podat_1.pdf

Medication-Assisted Treatment	Yes	<p>Support:</p> <p>We are in support of medication-assisted treatment (MAT) and the opportunities for recovery that it brings. As noted in the waiver request, physicians and patients who utilized MAT reported an average of an 80% reduction in opioid use.</p> <p>While we are supportive of this proposal, we think that it is important that the waiver detail creative strategies for mitigating barriers to MAT. For example, 23% of publicly funded treatment programs report offering any FDA-approved medications to treat substance use disorders, and less than half of private-sector treatment programs reported that their physicians prescribed FDA-approved medication².</p> <p>Creating a wider provider network for MAT would allow for greater accessibility and increased recovery opportunities. This is especially important given the absurd wait times that individuals with OUD and SUDs are facing to receive MAT. Wait times for treatment are not in line with the Commonwealth's dedication to reducing deaths from opioids, and we should be working to break down barriers, not sustain them.</p>
Early Intervention	No	<p>Oppose:</p> <p>This waiver is an opportunity to open the Screening and Brief Intervention and Referral to Treatment (SBIRT) codes in Pennsylvania. SBIRT should be viewed as an upstream intervention that can address the Heroin and Prescription Opioid Epidemic while students are in the K-12 school system. Youth using alcohol and marijuana are 2 -3 times more likely to abuse prescription drugs. Estimates are that 90% of drug and alcohol addiction starts before the age of 18.</p> <p>West Virginia has conducted SBIRT in some middle schools for 4 years and results have shown a significant drop in youth self-reported usage of drugs and alcohol. Also Georgia, Massachusetts, New Jersey, Ohio and Wisconsin have focused on SBIRT where there may be lessons learned upon which Pennsylvania can capitalize. An SBIRT program could be implemented in one or more of the school systems in Allegheny, Berks, Clearfield, Jefferson , McKean, Montgomery and Philadelphia Counties.</p> <p>In addition to to funding the SBIRT assessment component the waiver should also cover OUD and SUD services, treatment, recovery support, halfway housing, outpatient and the appropriate level of care that will sustain their long term recovery and journey for a productive life.</p>

² PEW Charitable Trusts. (2016). Medication-Assisted Treatment Improves Outcomes for Patients With Opioid Use Disorder. Retrieved from: <http://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2016/11/medication-assisted-treatment-improves-outcomes-for-patients-with-opioid-use-disorder>

Satoko Hariyama
Bureau of Policy, Planning, and Program Development
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Gateway Health
Four Gateway Center, Floor 21
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December 18, 2017

Dear Ms. Hariyama:

Gateway Health appreciates the opportunity to provide this letter of support for Pennsylvania's 1115 Substance Use Disorder Demonstration Waiver. Gateway Health is a non-profit managed care organization serving individuals through Medicaid and Medicare Advantage plans (including Dual Eligible Special Needs plans). Our Medicaid plans serve members across Pennsylvania, Delaware, and West Virginia and we administer Medicare services to individuals in Pennsylvania, Ohio, North Carolina, and Kentucky. For more than 25 years, we have worked alongside state partners, providers, and communities to bring comprehensive care to members, including older adults, children, and those diagnosed with chronic diseases.

Gateway Health has grown into a top-ranked managed care organization that serves over 540,000 members across 6 states. Our network includes over 35,000 health care providers, 300 hospitals and more than 21,000 physicians, pharmacies and clinics. Gateway Health positively impacts the health of its Pennsylvania membership through a healthcare delivery system that provides access to high-quality medical services in a cost-effective manner.

Our organizational goals are in alignment with those of the Demonstration Waiver and we support the Commonwealth's efforts to:

- Increase the number of residential substance use disorder treatment options by expanding the current substance use disorder treatment service array
- Increase access to care by enhancing care coordination, transition of care management, and discharge planning
- Align programs and systems with best practices and evidence-based models of care
- Decrease inpatient costs and emergency department utilization by increasing access to medication assisted treatment (MAT)

Gateway Health's Opioid Use Disorder workgroup is an example of our dedication to this issue. This multidisciplinary committee works to expand and ensure the quality of our MAT provider network, improve care coordination processes, enhance community service referrals and linkages, and decrease emergency department utilization. This workgroup, along with our ongoing work as a physical health managed care organization (PH-MCO), continues to aid the Commonwealth's effort to save lives and improve the quality of life for the most vulnerable Pennsylvanians.

Gateway Health acknowledges the Commonwealth's proactive work towards containing the opioid epidemic by partnering with the Department of Human Services (DHS) to establish the Opioid Use Disorder Centers of Excellence (COEs). These centers provide MAT and other treatment services and have been instrumental in providing increased access to opioid use treatment services. Gateway Health has designated a single point of contact for the COEs to assure collaboration and communication. We are also contracted with all the physical health COEs in all of the Pennsylvania HealthChoices zones we serve, as required by DHS. Gateway Health will continue to support this initiative by participating in COE and DHS collaborative meetings.

We applaud the Commonwealth of Pennsylvania's efforts toward achieving Medicaid reform and look forward to working with stakeholders across the system to innovate and achieve superior health outcomes for the individuals and families we serve.

Sincerely,



Jessica Cromer
Vice President and Executive Director, PA HealthChoices
Gateway HealthSM

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December 15, 2017

Satoko Hariyama
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Harrisburg, PA 17101

Dear Ms. Hariyama:

Magellan Healthcare, Inc. (Magellan) welcomes the opportunity to comment on the Department of Human Services proposed Federal Section 1115 Demonstration Waiver Application for Substance Use Disorder (SUD) Services. We are writing to comment favorably on the proposal from both a public health perspective and because of its favorable impact on access to high quality, medically necessary treatment for opioid use disorder (OUD) and other substance use disorders (SUDs) for Pennsylvanians. For more than two decades, Magellan Behavioral Health of Pennsylvania, Inc. has been managing behavioral health services for HealthChoices members. Magellan works closely with its customers-- Bucks, Cambria, Delaware, Lehigh, Montgomery and Northampton counties; individuals; providers; and local communities. We are proud of the innovative efforts that have helped to increase access to care, improve service use rates, expand the continuum of services in alignment with evidence-based models, and maximize clinical appropriateness and quality services.

We share the stated concern over the recent requirements in the Medicaid Managed Care rule that allow states to receive federal funding, for individuals 21-64 years old, in a residential facility that is an Institution for Mental Diseases (IMD) only if the length of stay is no longer than 15 days. We have identified approximately 60 in-network substance abuse facilities meeting the definition of IMD in our HealthChoices Medicaid network that would be impacted by this requirement. Magellan, along with our partner counties, recognizes the importance of these services in the continuum of care, and support efforts to sustain the availability of these services to Medicaid recipients.

Specific comments/recommendations:

- We agree with the list of services/levels of care that Pennsylvania is proposing to cover under the 1115 Demonstration waiver authority.
- We support the waiver's endorsement of MAT's.
- Coordination of care recommendations are consistent with current practices and would further support the methods we are already employing.
- We support the waiver's position on integration of Physical Health and SUD.
- The waiver application should include additional information about the role and responsibilities of the Pennsylvania OUD Centers of Excellence (COE), the data they are collecting and how they are able to connect members to treatment. We believe these resources could provide additional support to meeting the goals of the demonstration.
- The waiver references the upcoming, planned transition from PCPC to ASAM. Although not directly the subject of this waiver application, we believe they are underestimating the impact of this change. There are reportedly 4,000

professionals statewide who will need the ASAM training. DDAP is requiring everyone to attend a two-day, in-person training facilitated by the Change Companies. The cost for the training and manuals for everyone in the State is estimated at over 1 million dollars. Initially, DDAP committed to funding the training but recently backed out of the funding. Now the trainings will need to be funded by the SCA's, Counties, BH-MCO's and Providers. Notification that DDAP would not be funding the DDAP training came late in the year after most agencies developed their budget for 2018. There are other less expensive options available for ASAM training but the State has made the commitment to the Change Companies. There should be consideration of the cost to providers, counties and BH-MCO's and the disruption of staff being out of the office/treatment setting for two days and review of alternative training options.

Improving overall health outcomes, decreasing utilization of emergency department and hospital services and improving care transition across the continuum of services for Medicaid beneficiaries with a substance use disorder remains a top priority in Pennsylvania; we believe the waiver addresses existing barriers to access, improved quality of care as well as the associated costs. Based upon our evaluation of the proposal by the Department of Human Services, Magellan Healthcare, Inc. highly recommends that the Department apply for the waiver.

Sincerely,

A large black rectangular redaction box covering the signature of Diane Marciano.

Diane Marciano, MBA
Vice President, Government Relations Business Development
Magellan Healthcare