

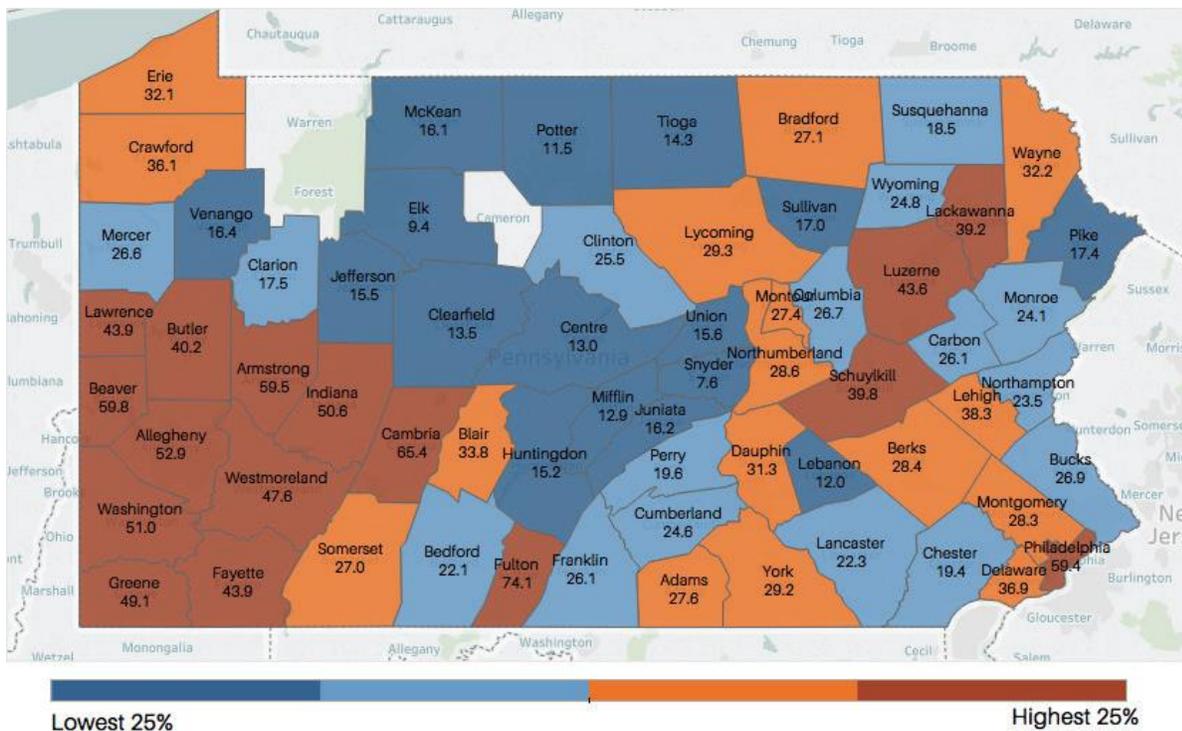
**PENNSYLVANIA SUBSTANCE USE DISORDER (SUD)
1115 DEMONSTRATION**

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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. In 2016, more than 4600 Pennsylvanians¹ 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 2015¹. 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:



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 causes²:

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

² “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

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.³ Pennsylvania also has a poverty rate of 12.9%, which increases to 26.4%⁴ in Philadelphia, the country's poorest large city, which has endured a spike in opioid overdoses in recent years.⁵ 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:

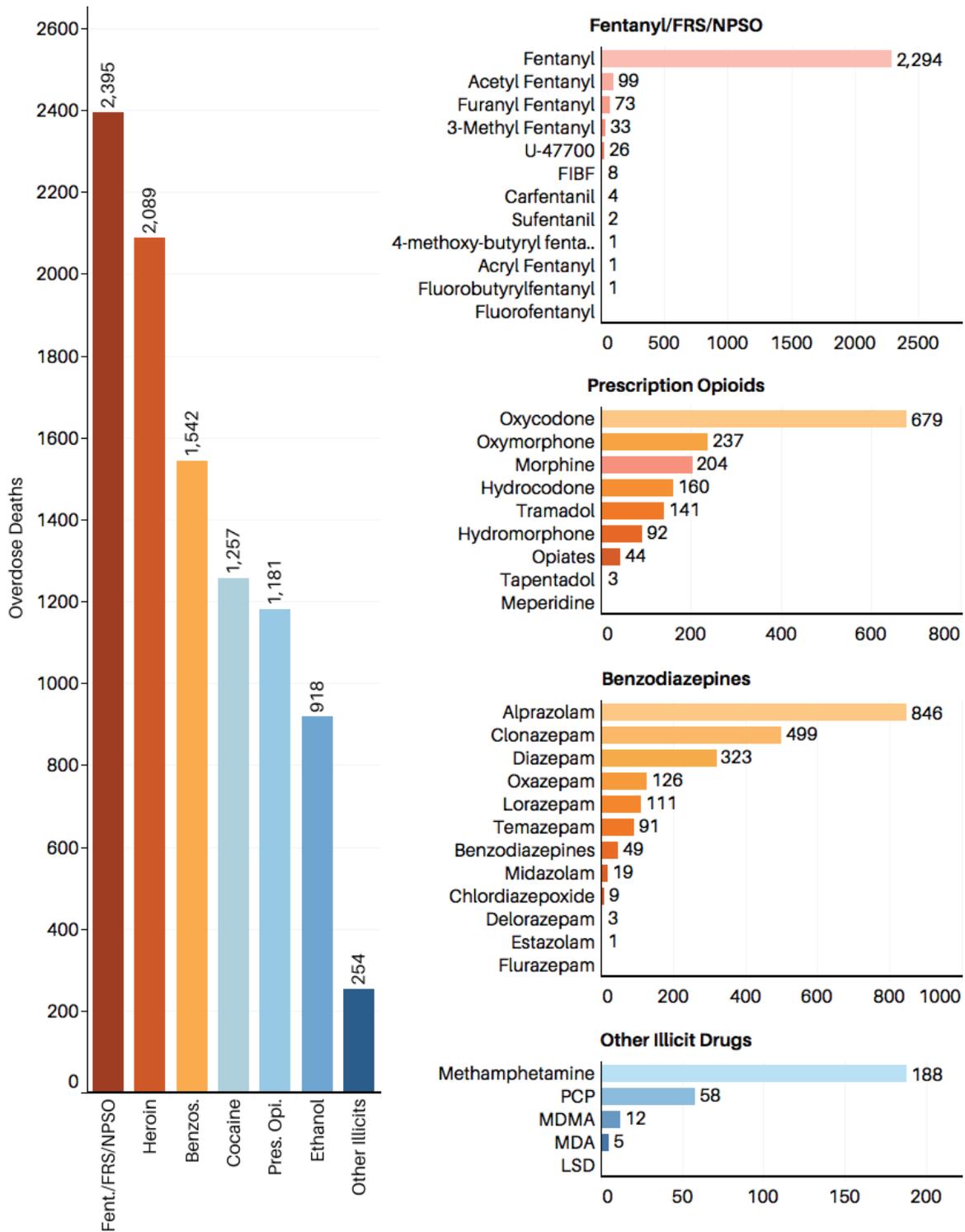
³ Bureau of Labor Statistics, August 2017. Available at:

<https://data.bls.gov/map/MapToolServlet?survey=la&map=state&seasonal=u>

⁴ United States Census. Available at: <https://www.census.gov/quickfacts/fact/table/PA/PST045216>

⁵ "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, 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 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 Institution for Mental Diseases (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 substances⁶. 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 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 may result in negative outcomes such as relapse, resulting in increased costs over time.

⁶ "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 a Level of Care (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.

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

In the services listed above, only Inpatient, Outpatient, and MAT are covered services in the fee-for-service delivery system. The last two items listed are not available under Medicaid FFS and are provided as “in lieu of services” under Pennsylvania’s 1915(b) Waiver (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. 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)*⁷ 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.

⁷ “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)

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. Pennsylvania currently has 498 physicians certified under DATA 2000, with 395 of those certified to treat up to 30 patients and the remaining 103 certified to treat up to 100 patients.

According to a survey conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA), physicians and patients alike reported an average 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.⁸

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 entities⁹. The strategy includes prevention and intervention, treatment and recovery support, quality assurance, and workforce development.

⁸ "MAT Legislation, Regulations, and Guidelines." Available at: <https://www.samhsa.gov/medication-assisted-treatment/legislation-regulations-guidelines>

⁹ DDAP State Plan (2016-2017). Available at <https://www.samhsa.gov/medication-assisted-treatment/legislation-regulations-guidelines>

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:

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.

Service & PCPC Level of Care (LOC)	Corresponding Closest ASAM Level	Description of Service
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.
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.

Service & PCPC Level of Care (LOC)	Corresponding Closest ASAM Level	Description of Service
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

SUD Service	State Plan	Covered under the new 1115 Waiver
Medically Monitored Inpatient Detoxification	No**	Yes
Medically Monitored Short Term Residential	No**	Yes
Medically Monitored Long Term Residential	No**	Yes
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 1915(b) “in-lieu of” authority for permissible ages (under 21, and 65 and above years of age) in IMD and other residential 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 outcome⁷.

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 medications¹⁰. 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®

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:

¹⁰ Center for Substance Abuse Treatment [CSAT], 2005

	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 authorizing agency and admitting provider (if applicable).

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. 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 access standard for ambulatory services to which the member travels is at least two providers for each service:

- Within 30 minutes travel time in urban areas.
- Within 60 minutes travel time in rural areas.

The access standard for inpatient and residential services is at least two providers for each State Plan Service, one of which must be:

- Within 30 minutes travel time in urban areas.
- Within 60 minutes travel time in rural areas.

Network Providers are not required to be located within the county in which the BH-MCO operates. Adherence to the travel 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 complex, multiple problems 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.¹¹

¹¹ Department of Drug and Alcohol Programs, Treatment Manual (2015-2020). Available at: <http://www.ddap.pa.gov/Manuals/Treatment%20Manual.pdf>

Section VIII: Integration of Physical Health and SUD

Pennsylvania has been emphasizing integration between the PH- MCOs and the BH-MCOs and is preparing to implement Community HealthChoices within the next year, which will also include integration efforts between the BH-MCOs and Community HealthChoices.

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 and provider representation, the Offices 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 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 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 with an alternative payment day 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.

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

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.

Additionally, the Department issued Medical Assistance Bulletin Number 99-16-07, titled "Enrollment of Ordering, Referring and Prescribing Providers"¹² 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.

¹² Bulletin 99-16-07 is available at http://www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/c_224393.pdf

The Department requires the BH-MCOs to develop a written compliance plan as stipulated in 42 CFR §438.608 that contains the following elements:

- 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"¹³ 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.

¹³ Bulletin #99-11-05 available at http://www.dhs.pa.gov/cs/groups/webcontent/documents/bulletin_admin/d_005732.pdf

BH-MCOs must also designate a full-time Fraud Waste and Abuse Coordinator who is dedicated to preventing, detecting, investigating, and referring suspected Fraud, 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 G*¹⁴ 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,

¹⁴ The Pennsylvania Code, Subchapter G. HMOs. Available at:
<http://www.pacode.com/secure/data/028/chapter9/subchapGtoc.html>

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 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 PCPC⁷ 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)¹⁵. 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,

¹⁵ 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

Act 191 of 2014¹⁶, which required monitoring Schedule II through Schedule V controlled substances.

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 treatment¹⁷. 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.

¹⁶ 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>

¹⁷ More information is available at: <http://www.ddap.pa.gov/>

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 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 prescription¹⁸ 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 regulations¹⁸.

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.

¹⁸ The Pennsylvania Code: Technology and Automation. Available at: <http://www.pacode.com/secure/data/049/chapter27/s27.201.html>

Section XIII: Strategies to Address Opioid Use Disorder

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.
- Allow Naloxone to be obtained in emergency situations via a standing Naloxone order, which states that in the event that an individual is at risk of death by overdose, Naloxone can be procured for the individual without a prescription. The intent of this standing order is to further minimize accidental or intentional death by overdose. The order may be used by persons who have a family member or friend affected by the opioid crisis, who are strongly encouraged to receive appropriate training so that they will be prepared in the event a family member or friend overdoses. More information on this order can be found on the DOH website¹⁹.
- Provide naloxone to first responders through the standing order or via prescription. Pennsylvania encourages its residents to dial 911 in case of an overdose. To facilitate this first responder – community relationship, the commonwealth grants immunity in some cases to those who call on behalf of a friend or family member. First responders are then equipped with Naloxone in order to treat this individual.

¹⁹ More information available at: www.health.pa.gov

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.

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 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 2018
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

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: Implementation Plan

The following table summarizes the various milestones associated with this Demonstration and the anticipated timeframes to reach those milestones:

<u>Milestone</u>	<u>Anticipated Timeframe</u>
1. Access to Critical Levels of Care for OUD and other SUDs	Within 12 to 24 months of Demonstration approval
2. Use of Evidence-based, SUD-specific Patient Placement Criteria	Within 12 months of Demonstration approval
3. Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities	Within 24 months of Demonstration approval
4. Sufficient Provider Capacity at Critical Levels of Care including for Medication Assisted Treatment for OUD	Within 12-18 months of Demonstration approval

5. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD	Over the course of the Demonstration
6. Improved Care Coordination and Transitions between Levels of Care	Within 12 to 24 months of Demonstration approval

Section XVIII: 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 [†]	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 XIX: 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 short-term residential SUD treatment for BH-MCO members consistent with historical practices. In accordance with approved SUD 1115 demonstrations in other states, the budget neutrality model would be constructed as a supplemental cap where the without-waiver (WOW) projections reflect the expected costs of SUD services to reflect the “hypothetical” nature of these expenditures, which means that the commonwealth would not accrue savings under the budget neutrality model related to related to these expenditures. The tables below include historical expenditures and user months, as well as an estimate of the expected increase under the Demonstration period:

HISTORICAL						
	Year 1	Year 2	Year 3	Year 4	Year 5	Average
	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	Trend
User Months	59,370	57,963	62,376	73,086	88,008	10.3%
Expenditures	\$212,635,930	\$214,428,719	\$227,992,557	\$263,913,509	\$319,651,003	10.7%

PROJECTIONS						
	Year 1	Year 2	Year 3	Year 4	Year 5	Average
	SFY 2019	SFY 2020	SFY 2021	SFY 2022	SFY 2023	Trend
User Months	100,774	103,294	105,876	108,524	111,237	2.5%
Expenditures	\$415,472,278	\$448,005,171	\$483,085,501	\$520,912,739	\$561,701,980	7.8%

Section XX: Expenditure Authorities

The commonwealth seeks expenditure authority under section 1115(a)(2) of the Social Security Act for expenditures for otherwise covered services furnished to otherwise eligible individuals who are primarily receiving treatment and withdrawal management services for SUD who are short-term residents in facilities.
