

VI. Substance Use Disorder Services

Background

In Pennsylvania, administration of services for persons with substance use disorders (SUD) is shared by the Bureau of Drug and Alcohol Programs (BDAP) in the Department of Health and OMHSAS in the Department of Public Welfare. BDAP is the Single State Authority for substance abuse policy and provides federal block grant and state funds to each of the 67 counties for substance abuse prevention, intervention, and treatment services. DPW is the Medicaid authority for the Centers for Medicare and Medicaid Services (CMS) and OMHSAS is responsible for managing the Medical Assistance services for the treatment of substance use disorders. In addition, OMHSAS manages the BHSI and ACT 152 funding that goes to the counties as a part of their base funding allocation.

“Substance abuse and addiction constitute the nation’s number one public health problem, contributing to ... the five leading causes of death. Our failure to prevent and treat it costs society more than \$600 billion each year.” Joseph A. Califano, Chairman and President, Columbia University, 2009

of the primary services that are deemed needed: non-hospital detoxification, non-hospital rehabilitation, and half-way house. All three of these services are covered in the HealthChoices plan. From the beginning of the HealthChoices Medicaid managed care program, OHMSAS has been committed to a program that increases the quality of, access to, and cost-effectiveness of drug and alcohol services. Because of the known negative consequences for the individual and society of substance use disorders, access to drug and alcohol services has been monitored closely. OMHSAS

Snapshot – Substance Use Disorder Services

- In HealthChoices in 2008-2009
 - 1,708 consumers received inpatient detox or rehabilitation
 - 22,361 consumers received non-hospital residential drug and alcohol services
 - 57,512 consumers received outpatient drug and alcohol services
- Access to SUD services in 2008-2009 increased between 6% and 11% from the prior year across the various services
- HealthChoices funding for SUD services was more than \$230M in 2008-2009

Within OMHSAS, the bulk of the SUD services are within the HealthChoices program. The Medicaid state plan has limited services in Fee for Service and does not include some

has assured and maintained this focus through continuous data analysis, stakeholder feedback and program monitoring.

Funding for SUD Services in OMHSAS

OHMSAS has three different funding mechanisms to fund services to treat substance use disorders in Pennsylvania. These include Medical Assistance, Act 152 funds, and BHSI funds.

- Medical Assistance –In FY 08-09, the last year for which full data is available, total spending in Medical Assistance for SUD services was almost \$233M. Of that \$6.5M was for inpatient services, \$146.5M for non-hospital residential services, and \$80M for outpatient services. HealthChoices became statewide in 2007 and all zones provide services for substance use disorders, accounting for the vast majority of SUD funding. Of those totals, FFS accounted for approximately \$800,000 in inpatient services and \$1M in outpatient spending. As noted earlier, FFS does not cover non-hospital D&A services.
- Act 152 Funding - In 1988 Act 152 provided state funding for non-hospital residential detoxification and rehabilitation services for individuals eligible for Medical Assistance. The intent of Act 152 was to provide state funds to pay for residential rehabilitation, detoxification, and halfway house services not available under Fee-For-Service Medicaid. Act 152 funds are allocated by OMHSAS to the Single County Authorities (SCAs), and in FY 10-11, the Department approved over \$16M in Act 152 funds to serve an estimated 6,000 individuals.
- Behavioral Health Service Initiative (BHSI) – BHSI was established at the request of the Department of Public Welfare to provide a safety net of state funding for individuals with the most serious mental health and substance use disorders that were impacted by Act 35 (welfare reform initiative) and are not eligible for MA. BHSI funds are allocated by OMHSAS to the Single County Authorities (SCAs), and in FY 10-11, the Department approved almost \$32M in D&A BHSI funds to serve an estimated 46,000 individuals.

HealthChoices Services

To determine the impact of HealthChoices on SUD services, OMHSAS conducted an assessment of utilization of services in the three initial HealthChoices zones, looking at changes in persons served as well as overall funding for services between 2001/2002 and 2006/2007. The analysis time frame was chosen because the three zones were all in place by 2001 and

five years of data was available. A detailed trend analysis of the new zones will be undertaken in the near future when a sufficient number of years have elapsed since the implementation of those zones in 2006 and 2007.

“Through the efforts of our HealthChoices behavioral program, we have realized an improvement in access to substance abuse services for adults and adolescents, with the greatest increase occurring with our youth,” Administrator, HealthChoices Multi-County Collaborative

In each of the three initial zones, the number of persons receiving services and funding for services increased substantially. As the most mature zone (1997), the Southeast increased the least, having already expanded access to services prior to 2001. In spite of that, between 2001 and 2007, persons served increased by 33.4% and funding by 30.3%.

The Southwest zone was implemented later than the Southeast (1999), and the increase in treatment for SUDs increased more dramatically. Persons served increased by 111.7% and funding increased by 154.6%. As expected, the newest zone (Lehigh/Capital) showed the greatest increase, with persons served increasing 127.5% and funding increasing 229.8%.

HealthChoices SUD Users and Expenditures

	Average Annual Users 2001/2002	Average Annual Users 2006/2007	Average Annual Expenditures 2001/2002	Average Annual Expenditures 2006/2007
Southeast	24,654	32,889	\$69,644,164	\$90,729,562
Southwest	8,992	19,038	\$16,573,933	\$42,194,216
Lehigh/Capital	4,447	10,119	\$7,388,862	\$24,365,260

Note: For the SE and SW, the average of 2001 and 2002 was used as the base; The Lehigh/Capital zone was being implemented during 2001 so 2002 was used as the base. All three zones show the average annual expenditure for calendar years 2006 and 2007

OMHSAS also looked at utilization of non-hospital residential services. Increases were seen in all areas of the state with the exception of the Southeast where residential rehabilitation units per user decreased. This was driven primarily by Philadelphia where the length of residential rehab decreased and outpatient increased. Even with the decrease, average days per consumer remained greater than 30.

Utilization of SUD Residential Services

		Average Units per User 2002	Average Units per User 2007	Average Expenditure per User 2002	Average Expenditure per User 2007
Southeast	Detox	4.5	4.8	\$968	\$1,207
	Residential	42.8	34.4	\$7,074	\$7,024
	Half-way House	53.8	55.5	\$3,759	\$5,012
Southwest	Detox	3.1	3.8	\$522	\$715
	Residential	25.2	29.1	\$3,791	\$4,614
	Half-way House	62.5	67.1	\$4,644	\$5,386
Lehigh/Capital	Detox	3.9	4.8	\$671	\$958
	Residential	23.0	31.0	\$3,610	\$5,331
	Half-way House	45.7	55.0	\$3,281	\$4,779

OMHSAS continues to monitor trends in access to treatment for substance use disorders. The trend of increasing funding for these needed services has continued as shown in the tables below which track funding through the most recent complete data set for 2008/2009. Overall in HealthChoices, including all six zones, expenditures in HealthChoices in 2008/2009 for SUD services were \$230,595,929.

HealthChoices SUD Funding

	Average Annual Expenditures 2001/2002	Average Annual Expenditures 2006/2007	Annual Expenditures 2008/2009
Southeast	\$69,644,164	\$90,729,562	\$117,530,006
Southwest	\$16,573,933	\$42,194,216	\$51,892,390
Lehigh/Capital	\$7,388,862	\$24,365,260	\$30,086,030

Note: The Lehigh/Capital zone was implemented in 2001 and data was incomplete. For Lehigh/Capital 2002 was used as the base. All three zones have an average expenditure for calendar years 2006 and-2007 and annual expenditures for SFY 2008-2009.

Clearly, the HealthChoices program has been successful in improving access to drug and alcohol services for Medicaid-eligible persons in the

Commonwealth. OMHSAS continues to monitor service availability and delivery to ensure high quality, cost-effective programs.

Recovery-Oriented System of Care

The recovery movement for substance use is similar to that occurring in the mental health field. Although substance use treatment and recovery stakeholders have discussed and lived recovery for decades, the development of a common understanding of a recovery-oriented system of care in the substance use

“What better partnership than treatment professionals who, ideally, stay abreast of the very latest in treatment techniques ... and persons in recovery who, too often, have themselves been knocked to their knees only to get back up, dust themselves off and try again, one day or minute at a time. *Addictions Recovery, When Knowing the Facts Can Help in Pennsylvania*, Institute for Research, Education and Training on Addictions, 2009

community is a recent phenomenon. OMHSAS has supported the transformation of the behavioral health system to a recovery-oriented model and continues to be an active participant in the process. The model includes the concept that there is no wrong door for recovery, giving individuals a genuine choice of pathways that meet their needs.

OMHSAS works in collaboration with key state stakeholders on developing and sustaining a Recovery-Oriented System of Care (ROSC) for Pennsylvania. Developing a ROSC may involve changes in the content, service delivery/infrastructure, outcomes and financing mechanisms of the current drug and alcohol treatment system. As discussed later in this section, development of the ROSC requires cooperation and collaboration among a variety of organizations, funders, and advocates to ensure a unified approach that maximizes resources for consumers.

Co-occurring Mental Health/Drug and Alcohol Recovery

For many years, providers treated co-occurring disorders (COD) using the traditional clinical interventions and program services developed for either a mental health or substance use disorder. In 1997, a statewide Mental Illness and Substance Abuse (MISA) Consortium (now called the COD

Consortium) was established to identify integrated approaches to treat people with co-occurring mental illness and substance use disorders.

In 2003, OMHSAS obtained one of 15 COSIG (Co-occurring State Incentive Grant) grants to increase the capacity of states to provide effective, coordinated, and integrated treatment services to persons with COD. This grant initiated a pilot program to increase payment flexibility across the mental health and substance abuse systems, designed a cross-systems licensing project, and implemented five MISA/COD pilot projects.

For additional information on Co-occurring capabilities, see expanded discussion in the section *Adults – Targeted Services and Approaches*.

Working with Our Partners

In order to ensure the most coordinated service delivery, it is important for OMHSAS to work closely with its partners, including other commonwealth departments as well as stakeholders in the community. Among the joint activities include

- Drug and Alcohol Coalition – OMHSAS, in collaboration with the Department of Health/Bureau of Drug and Alcohol Programs, convened a Drug and Alcohol Coalition comprised of key stakeholders to identify and build a coordinated system of care to address substance use and co-occurring disorders. The Coalition includes representatives from government, advocacy, providers, families, and persons in recovery. Subcommittees include Workforce Development, Accessibility and Standardization, Finance and Funding, Recovery-Based Issues, Criminal Justice, and Prevention.
- Workforce Development - OMHSAS sponsors annual trainings and webinars to expand and support the Commonwealth’s addictions workforce. Trainings are designed to promote evidenced-based practices in partnership with Drexel University and the Institute for Research, Education and Training in Addictions (IRETA). Workforce trainings are approved by the Departments of Health and Public Welfare, and meet the requirements of the Pennsylvania Certification Board for certified addiction professionals. OMHSAS has also collaborated with the PCB to develop a co-occurring disorder professional credential (CCDP) that has become the international standard.
- PCPC and ASAM - OMHSAS participates on the Clinical Standards Committee convened by BDAP to review and revise the Pennsylvania

Client Placement Criteria for Adults (PCPC). The PCPC is contractually required in the HealthChoices program. For children, the American Society of Addiction Medicine (ASAM) Patient Placement Criteria – Revised is the required medical necessity criteria for all adolescents being assessed for substance use treatment in the state. Both BDAP and OMHSAS require providers to use ASAM criteria.

- Persons In Recovery Committee – The Persons in Recovery Committee was formed to ensure that the voice of recovery from substance use and/or co-occurring psychiatric disorders was represented in the OMHSAS Advisory structure. The committee is responsible to BDAP and OMHSAS to provide input, feedback, and recommendations pertaining to developing and implementing substance use programs, integrating co-occurring services, and transforming to a recovery-oriented system of care. The members represent persons with co-occurring psychiatric and substance use conditions, persons in recovery, family members and other interested stakeholders.
- D&A Program Licensing - OMHSAS works collaboratively with the Department of Health’s Division of Drug and Alcohol Program Licensure to ensure coordination of responsibilities, maximize efficiency and reduce duplication of efforts for programs licensed by both departments. The departments have developed a Memorandum of Understanding to continue the collaboration.
- Pennsylvania Recovery Organizations Alliance - OMHSAS supports the voices of recovery by partnering and collaborating with the Pennsylvania Recovery Organizations Alliance (PRO-A) and its affiliates across the state. PRO-A represents the face and voice of recovery by providing education on the disease of addiction, reducing stigma associated with substance use, and advocating in the best interest of the recovering community. OMHSAS works with PRO-A to build partnerships and resources within the recovering community.
- MOMSTELL - OMHSAS recognizes the significant impact of substance use disorders on the family. By supporting MOMSTELL, a non-profit advocacy organization comprised of parents and family members, OMHSAS provides resources to assist families in their struggle to access appropriate services and supports for family members with substance-related disorders. MOMSTELL promotes awareness of substance use and works to reduce stigma through advocacy and education to families attempting to negotiate a complex service system. The Director of MOMSTELL is a member of the OMHSAS

Advisory Committee and a member of the OMHSAS Quality Management Committee.

HealthChoices Initiatives

One of the important features of the HealthChoices program is its ability to develop services that are not specifically identified in the Medicaid State Plan but which serve as an alternative to State Plan services. Since 2005, there were 144 approved requests for drug and alcohol supplemental services.

- Drug and alcohol services in the schools – Often, youth are reluctant to enter substance use treatment through a traditional clinic program, but are more open to receive the services if they are available in schools. In 2009, OMHSAS issued a policy clarification specifying that licensed D&A clinics enrolled in HealthChoices could offer treatment services in a home or school setting as a supplemental service.
- Buprenorphine Coordinator - The Buprenorphine Care Coordination Program is an innovative and unique approach designed to assist individuals who are being prescribed buprenorphine in the HealthChoices program. The primary objective is to ensure that substance use treatment is coordinated among the individual, treating physician, and D&A treatment provider to support recovery.
- Intensive Outpatient Programs - For some people with substance use disorders, traditional outpatient treatment may be insufficient, but residential care is either more intensive than needed or too disruptive to their lives in the community. Through HealthChoices, OMHSAS has funded outpatient programs that allow the person to get intensive treatment while remaining in the community.
- Expedited Enrollment – Because of the limited set of services available for SUD treatment in Fee for Service, OMHSAS and the Office of Income Maintenance (OIM) developed a pilot program in 2008 to expedite enrollment of consumers into HealthChoices. By late 2010, nineteen counties participated and over 1,000 consumers were enrolled in HealthChoices in an expedited manner in order to allow them to receive non-hospital residential services.
- D&A Transitional Housing for Men and/or Women - This program serves MA eligible adult men and/or women 18 years of age and older diagnosed with substance abuse or co-occurring disorders who have successfully completed a substance abuse treatment program such as D&A half-way house. The program offers transitional housing and

support in securing permanent housing, finding and maintaining employment, and maintaining sobriety.

- D&A Outpatient Forensic Core Program - This program provides community treatment and transition assistance to adults with SMI and co-occurring substance abuse addiction involved with the criminal justice system. It focuses on people who are being discharged from state hospitals, jails, prisons, or being diverted from possible admissions. The Re-Entry Liaison provides recovery-oriented support, advocacy, and assistance in accessing needed services and resources.
- D&A Recovery Specialist - Recovery Specialists provide peer support and guidance to MA eligible adults struggling with addiction issues and co-occurring issues. It offers outreach, mentoring and peer support at all stages of recovery. The services are developed within the Best Practice Guidelines of a Recovery-Oriented System of Care (ROSC) and the Specialists receive certification from the Pennsylvania Certification Board (PCB).
- Recovery-Oriented Methadone Pilot Project - OMHSAS supported a recovery focused methadone pilot project in southwest Pennsylvania. Using a multi-stakeholder approach and consensus development, the group made recommendations regarding clinically-based, recovery-oriented approaches to the delivery of opiate treatment programs using methadone.

Buprenorphine Services

OMHSAS supports the prescribing of buprenorphine by behavioral health physicians as well as by physicians funded by the Office of Medical Assistance Programs (OMAP). Of all illicit substances, addiction to heroin arguably has the greatest stigma and is seen as a moral failing best addressed in the criminal justice system. Often, it leads to doing whatever is needed to get the money to purchase the drug, and prison can be the end result. HIV is also a significant risk due to sharing needles. For many years, the only choice for persons with opioid dependence was methadone.

On October 2002, the Federal Food and Drug Administration approved the use of buprenorphine for the treatment of opioid addiction. Buprenorphine treatment can be provided in a physician's office, and although many people feel "back to normal" within a week, a period of maintenance therapy and counseling is recommended to solidify gains and ensure that the individual is establishing healthy life routines. OMHSAS recognizes buprenorphine as a

best practice pharmacologic approach to opioid dependence, and as an effective adjunct to counseling and therapy.

OMHSAS, OMAP, BDAP and stakeholders participated in a Buprenorphine Workgroup to discuss best practices. OMHSAS and OMAP work together to review buprenorphine prescribing patterns to ensure that providers are meeting the requirements as well as to monitor prescribing patterns to prevent abuse. DPW released a buprenorphine bulletin that required that persons receiving buprenorphine have documentation of "referral to or participation in a substance abuse or behavioral health (BH) treatment program" in order to improve the likelihood that recovery will be maintained.

Progress

- In 1997, the first HealthChoices zone is implemented in the Southeast and includes a full range of drug and alcohol services including non-hospital residential treatment.
- The use of buprenorphine to treat opioid addiction was approved by the FDA in October 2002.
- Pennsylvania is one of 15 states to receive a COSIG grant to develop an approach to persons with co-occurring disorders.
- In 2007 the final HealthChoices zones were implemented, ensuring statewide access to non-hospital residential services for substance use disorders through Medical Assistance.
- In 2008 the Drug and Alcohol Coalition was formed, bringing together government agencies and other interested parties to help form recommendations to enhance SUD services in Pennsylvania.
- OMHSAS was successful in creating a cost model to allow Children in Substitute Care who received SUD services out-of-zone to remain in HealthChoices.
- In 2010 the Persons in Recovery Subcommittee was added to the OMHSAS Advisory Committee.

Resources

- DPW Substance Abuse Services site (<http://www.dpw.state.pa.us/foradults/substanceabuseservices/index.htm>)

- PA Department of Health Bureau of Drug and Alcohol Programs
(<http://www.portal.state.pa.us/portal/server.pt?open=512&objID=14221&mode=2>)
- A Collaborative Plan and Metrics to Improve Substance Use Related Care for Pennsylvanians
(http://www.ireta.org/ireta_main/Drug_and_Alcohol_Coalition_Final_Report.pdf)
- Certified Recovery Specialist Information
(<http://www.pro-a.org/about-certified-recovery-specialist.html>)
- Recovery Oriented System of Care White Paper
(http://www.facesandvoicesofrecovery.org/pdf/White/rosc_community_perspective_2010.pdf)