Overview of Pennsylvania's Opioid Use Disorder Center of Excellence Program

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Thank you, Chairman Kinsey and Chairman Heffley, for the opportunity to be here today. My name is Sally Kozak, and I serve as the Deputy Secretary for Medical Assistance Programs in the Department of Human Services, and I am the State Medicaid Director. [And I'm Jen Smith, Deputy Secretary for Mental Health and Substance Abuse Services within DHS.]

Together our offices are responsible for the Opioid Use Disorder Center of Excellence, or COE, program. The COEs are a group of providers in Pennsylvania that are transforming the way we care for people with Opioid Use Disorder, or OUD. They are breaking down silos that exist in the healthcare and social services systems. By caring for the entire person and all of their needs, both clinical and non-clinical, the COEs are keeping people engaged in treatment and giving them a better chance at recovery.

Since the beginning, and still today, this model has three stated goals:

- Increasing access to Medication Assisted Treatment, or MAT;
- Improving coordination of physical and behavioral healthcare services; and,
- Using a community-based care management team to keep patients engaged along the continuum of care.

COEs offer enhanced case management services to people who are early in their recovery and new to treatment or people who have a high need for wraparound services and coordination. They do this through community-based care management teams that include physicians, nurses, counselors, social workers, care managers, and Certified Recovery Specialists. The care management teams facilitate transitions between and among levels of care, such as when a person who has been in an inpatient level of care is going to be transitioned to outpatient care with medication for Opioid Use Disorder.

Care managers help make sure that various appointments are coordinated, and that the patient has what they need to attend and make the most out of each visit, regardless of the provider type. This is particularly important in Pennsylvania, because our Medicaid program operates as a carve-out, with physical and behavioral healthcare being paid for by separate managed care organizations.

The COE program started in 2016 as a demonstration grant program. Forty-five providers were selected through a competitive application process, and selected providers were awarded a $500,000 grant. The original COEs included hospitals and health systems, primary care practices, methadone clinics, Federally Qualified Health Centers, and mental health counseling practices. This diversity in provider type allowed the COE model to be tested in various environments and to respond to an individual community's needs.

After a few years of experience with the grant demonstration program, Pennsylvania commissioned an independent evaluation of the program, and the findings were very encouraging. There were statistically significant increases in continued use of medication for OUD, which indicates that patients who are served by COEs stay on their medication longer than those who are not. COE clients also were much more likely to receive medication than non-COE clients, and to receive treatment in general after receiving an OUD diagnosis. COE clients were more likely to receive a follow-up after an emergency department visit, and they also were less likely to go to the ED at all.

These encouraging findings from the grant program convinced us that this program needed to be sustained. In 2019, we transitioned from funding grants to COEs to having COEs bill our Medicaid managed care organizations for their care management services. About 97% of Pennsylvanians covered by Medicaid are enrolled in managed care, so this transition was significant. We used what's called a

State Directed Payment arrangement where we directed the rate the MCOs had to pay the COEs. COEs were paid an additional bundled payment each month for the care management services they provide above and beyond normal treatment services. Our federal regulator, CMS, does not support the indefinite use of these kinds of arrangements. At the end of 2022, we ended the State Directed Payment arrangement.

Because of the transition away from grant funding, we created a new provider specialty type in Pennsylvania's Medicaid program to identify COEs. This expanded participation in the program beyond the initial grantees. The requirements to receive the COE designation were based on the original grant requirements. The goals of the program have not changed, and requirements remain the same. At a high level, to get the COE designation, a provider needs to offer medication for OUD, connect patients to all levels of care for treating OUD and an array of physical healthcare services, accept warm hand-offs 24/7 from emergency departments, correctional institutions or other community locations, and assess, and refer for social services as needed. Providers have been highly supportive of the expansion, as it allows new providers to serve people with OUD and "legacy" COE providers to serve more people. As of today, there are 60 different provider groups operating at over 275 locations statewide that have the COE designation. There are COEs in 54 counties.

With three years of positive experience of having MCOs pay for COE services and expanding the number of COEs, DHS decided to take the final step of sustaining the COE model. In 2022, DHS submitted a State Plan Amendment to CMS to add COE care management services as a State Plan covered service available to all Medical Assistance beneficiaries, including fee-for-service beneficiaries who did not previously have access to these services. CMS approved this amendment, officially cementing the COE program in Medicaid. For those unfamiliar with this process, states, with federal approval, designate all the Medicaid services they will provide in their state plan as Medicaid is a state and federally funded program. The description of COE care management services in the State Plan was based entirely on the original grant requirements document, the HealthChoices Agreement language, and the provider enrollment requirements; there were no changes to the design of the COE program. It's important to remember that COE services refer only to enhanced care management, not to underlying treatment of OUD.

Now that COE care management is a State Plan service and the State Directed Payment arrangement is no longer in effect, MCOs are responsible for developing adequate networks of COE providers and negotiating rates for their services, as is the case for all other State Plan services. MCOs are not required to pay a specific rate. While this is a change for COE services, it is no different from the way other services are covered. We have proven that the COE model works, and we have made it the norm by building it into the State Plan and treating it as we treat other services.

This has resulted in some variation across MCOs in payment methodology, monitoring and oversight. Most MCOs have continued to pay the same per-member-per-month bundled rate that they paid under the State Directed Payment. In some limited instances, some MCOs and COEs have moved to fee-for-service arrangements where COEs get paid for each encounter with a patient, and others have moved toward value-based payment arrangements that bundle together OUD treatment services with care management services or that incentivize quality outcomes. All MCOs meet together regularly to discuss potential value-based payment models and understand the benefit of aligning their models to make it

easier for COEs. There is also some variation in monitoring and oversight approaches, which is no different from any other service. Each MCO uses a different blend of data analysis, chart reviews, regular meetings with COEs, and audits to make sure COEs are following their approved service descriptions and the requirements of the COE program.

The requirements for service delivery are established through the HealthChoices Agreement and the provider enrollment agreement by the Department. The MCOs, together with the Department, have been working to develop guidelines that will promote consistency in the provision of care management services and fidelity to the COE model. They are not new requirements; they are designed to provide more clarity and consistency across MCOs and COEs.

A lot of the work we've talked about so far, including developing the guidelines, has been supported by the University of Pittsburgh's Program Evaluation & Research Unit, or PERU. PERU is the Department's contracted vendor that performs needs assessments of COEs and then provides individualized technical assistance to help them improve their workflow and get the best results for their patients. They also help onboard new COEs and orient new COE staff. They present biweekly learning network sessions to help COE staff increase their knowledge and skills, and they convene groups to help COEs learn from one another and build connections.

PERU works together with the University of Pittsburgh's Medicaid Research Center to evaluate the performance of the COEs and the outcomes of the program. Here are some key outcomes we have seen:

- COEs increased both engagement and retention in treatment by 20%, getting more people with OUD into treatment and keeping them in treatment longer.
- They decreased the wait time between initial contact and the first appointment by 68%, getting people into care faster.
- COEs increased follow-up within 7 days of an emergency department visit related to OUD by 51%, making sure people are not left without help after an overdose event.
- They increased the number of primary care visits by 46%
- They served a diverse group of patients and provided care in an equitable way. No racial or ethnic disparities were identified in outcomes for COE patients.
- COE patients received more prenatal services during pregnancy, more outpatient behavioral health services, and more prescription drugs than patients with OUD who didn't go to a COE. This shows that COEs help connect patients to needed preventive and outpatient care.
- The longer a patient stayed engaged with a COE, the better their health outcomes were.

These outcomes speak for themselves and show that the COE model of care works. We are proud of what the COEs have accomplished, and we thank you for the opportunity to share these accomplishments with you today.