House Human Services COE Committee Hearing
Scott Constantini Written Testimony
February 7, 2024

Dear Members of the Commonwealth of Pennsylvania's House Human Services Committee:

On behalf of The Wright Centers for Community Health and Graduate Medical Education, thank you for your leadership in expanding access to overall, and especially primary care integrated, behavioral health services. The Wright Center for Community Health is proud to be a Pennsylvania Center of Excellence (COE), a HRSA designated Federally Qualified Health Center Look-Alike and Ryan White HIV/AIDS provider, a recognized National Committee on Quality Assurance (NCQA) Patient Centered Medical Home, with distinction in Behavioral Health Services Integration. The Wright Center serves over 35,000 patients, operating ten primary care community health centers (CHCs) throughout Northeastern Pennsylvania, inclusive of public school settings and a mobile medical and dental unit. The Wright Center for Community Health serves as the cornerstone ambulatory whole person health services delivery clinical learning platform for our Teaching Health Center Graduate Medical Education Safety-Net Consortium (GME-SNC), operated by our affiliated entity, The Wright Center for Graduate Medical Education. Together with GME-SNC partners, The Wright Center trains over 250 primary care residents and specialty fellows in a community-based, needs-responsive, interprofessional workforce development model to advance our shared mission to improve the health and welfare of our communities through inclusive and responsive health services and the sustainable renewal of an inspired, competent workforce that is privileged to serve.

I am Scott Constantini, the Associate Vice President of Primary Care, Behavioral Health, and Recovery Services Integration at The Wright Center for Community Health. Over the past seven years, I've had the privilege to spearhead The Wright Center's efforts to establish and integrate high-performing behavioral health and recovery service lines into our physical health services. Serendipitously, my second day of work at The Wright Center coincided with the moment we received notification of the organization's welcomed designation as an Opioid Use Disorder (OUD) COE. Since that day seven years ago, The Wright Center has been privileged to learn many lessons about effectively delivering high-quality treatment services for patients, families, and communities struggling with OUD. I am honored to testify on the cascading benefits of the program, the power of partnerships across government, managed care, healthcare, and social service organizations, and the ongoing opportunities for the Commonwealth to further remove barriers to access and to eliminate stigma and advance health equity.

When The Wright Center sought designation as an OUD COE, the realm of substance use disorder (SUD) treatment was uncharted territory for us, much like it was for most primary care providers at the time. Yet, our primary care physicians and clinicians alike witnessed the tragic toll that the opioid epidemic had on the patients and families we serve and our communities, and we could not quietly bear witness to the lack of access to desperately needed, life sustaining OUD treatment services. The Pennsylvania OUD COE Program enabled The Wright Center to develop a behavioral health workforce, expand our clinical expertise, provide OUD treatment to our existing patients and community, and embrace a culture of both recovery-oriented care and harm reduction. This also ignited our passionate, extremely valuable pursuit, and launch of the Sanctuary certification journey to become a trauma-competent enterprise.

Since the inception of our COE program, The Wright Center has delivered COE services to over 2,600 patients struggling with OUD across Northeastern Pennsylvania. Of these patients, 728 remain actively engaged in the program, the overwhelming majority of whom are Medicaid recipients. Additionally, throughout our COE journey, over 40 of The Wright Center's physicians received the previously required DEA waiver to prescribe medication for OUD (MOUD), four physicians, including our President and CEO, have become board certified in addiction medicine, and all primary care internal and family medicine residents receive training on treatment for OUD. Notably, all clinicians at The Wright Center sign an annual pledge to be a part of the solution to the opioid epidemic by ridding stigma, embracing a recovery-oriented mindset, promoting harm reduction, and practicing opioid stewardship. The COE Program has undoubtedly shaped The Wright Center's corporate identity, purpose, culture, and legacy, with a relatively nominal but tremendously powerful financial investment by the Pennsylvania Department of Human Services (DHS).

Between becoming a COE in 2017 and having a fully established COE in 2019, The Wright Center worked quickly to develop plans to sustain the work of the COE, in the inevitable event that the annual $500,000 award from the DHS did not continue. We had proactive discussions with behavioral health MCOs on the process to become approved to bill for case management and certified recovery specialist (CRS) services due to the unknown funding stability of the program. Our commitment to sustaining this work motivated us to jump through every hoop– including getting multiple counties' support for this program, having it approved by the County Behavioral Health Consortium Board, applying for a specific Promise number with DHS, and completing a supplemental service description with CCBH. While these processes brought additional burden to our executive team and our primary care and behavioral health workforce, The Wright Center knew these services were too dire for the extremely vulnerable patients we served, and we were committed to continuing the work of the COE, regardless of the status of the annual funding. Our governing boards have faithfully and passionately supported our

courageous decisions to push forward with our mission driven initiatives, despite programmatic funding uncertainties.

Fortunately, in 2019, the DHS announced that the COE Program would transition from being directly overseen and administered by the Department, to being overseen and administered by the Commonwealth's MCOs. The Wright Center was pleased with this transition, as it provided the sustainability framework we were searching for. As a physical health services provider, this meant that The Wright Center's COE was now overseen by physical health MCOs, such as Geisinger Health Plan, AmeriHealth Caritas Northeast, PA Health and Wellness, Health Partners and UPMC For You, Inc. However, the majority of The Wright Center's patients are covered by Geisinger Health Plan. While challenges are expected with any transition, The Wright Center's experience of working with the physical health MCOs on the COE program has been a journey of shared purpose and shared learning overall. This is largely due to the physical health MCO's leadership and supportive spirit of partnership and collaboration, as well as their willingness to listen and promote provider autonomy to do the right things for the right reasons.

I'd like to share a brief anecdote that demonstrates the degree of coordination and collaboration with one of our physical health MCOs within the realm of the COE Program. As those in the treatment community know, when an individual is ready to abstain from substances and seek treatment, timely access to services is absolutely critical. When a patient engaged in The Wright Center's COE Program was at this crossroad seeking inpatient care after recently experiencing an overdose, there was a barrier– the patient was not able to enter the inpatient unit until hours later at 7pm. For someone living with a SUD, every minute, hour, and day is a battle to abstain from substance misuse– hence, every minute counts. With this in mind, our behavioral health professionals called our physical MCO to strategize more immediate solutions for this patient rather than hours spent in an emergency room. Within no time at all, the MCO successfully arranged for transportation and an early admission for the patient to an inpatient unit. This patient has since sustained recovery, which may have never happened without that powerful, supportive collaboration between the physical health MCO and our COE.

A major contributor to the physical health MCO and COE's effective working relationship is the MCO's willingness to empower clinical autonomy and decision-making. While insurance claims data provides highly valuable information on patients and population health, the qualitative and quantitative data that only the clinical and behavioral health COE providers have is essential. Primary care and behavioral health providers often have long standing, trusted relationships with the patients they serve, and the power of knowing individual patients' stories, medical history, social circumstances, trauma history, and background cannot be overstated. The Wright Center is grateful that our MCOs recognize this sacred relationship, and that they are willing to work with us to understand what the most appropriate metrics are to be monitored to measure success within the COE program.

We all understand that an essential next step to the collection of this meaningful data is using it to incorporate value-based payment into the COE Program. This is unchartered territory and getting it right will require fundamental trusting relationships and intentional conversations. Since the program transitioned to MCOs in 2019, the per member per month (PMPM) reimbursement rate has remained the same at $277.22 a month, despite the rising costs of services due to inflation. The expressed intent of the transition to MCOs was to move towards a value-based reimbursement model, however, there is a need for both physical health and behavioral health MCOs to fully embrace this model, ensuring its execution aligns with the intended vision of the transition and the realities of what is feasible and best in the provider service lines. In that spirit, The Wright Center urges DHS to apply a single, thoughtful, and transparent value-based reimbursement methodology across all MCOs that is designed by consensus discovered through active engagement and input from providers and payers– Such a methodology should augment the base PMPM rate in order to ensure the sustainability and expansion of the program, hopefully into the challenging arenas of misuse of stimulants and alcohol as well. In addition to incorporating value-based payment models into the program, there are several additional opportunities to promote greater equity while removing access and engagement barriers for our patients.

Given their complex health and socioeconomic determinants of health needs, integration of primary health and behavioral health services is critical for individuals facing SUDs. To remove barriers, promote equity, and streamline care, DHS should work with MCOs to expand reimbursement directly to providers for providing transportation and translation services, covering the true cost of purchasing and administering the now commercialized COVID-19 and related preventive vaccinations, and expanding the COE Program beyond patients solely with an OUD, to include all SUDs. Research demonstrates the need for improved access to treatment across all of these SUDs, and leveraging the capacity and expertise of the existing OUD treatment providers and established essential community provider clinical platforms across the Commonwealth is a logical decision.

An important component of supporting those living with SUDs is providing whole-person care, inclusive of primary medical services, dental services, HIV services, Hepatitis C services, obstetric and gynecological and reproductive health services, and mental health services. However, there are several, complex barriers within the physical and behavioral health realm that hinder access, particularly for those with OUD. Some of the most notable include barriers related to transportation services, translation services, and vaccination.

Transportation is a leading barrier to care for many of the COE patients that we serve. In fact, according to the Pennsylvania Department of Health's 2020 Health Access Survey, transportation is a leading obstacle hindering access to essential healthcare services across the Commonwealth.

The Pa. DHS provides funding to MCOs to provide transportation services, however greater investment is needed in order to fully meet the real-time needs of patients. The Wright Center depends on grant funding and fundraising to support the cost of Ubers and bus passes to get patients to and from appointments, despite having a 14-passenger commercial mini bus that could be utilized for patient services if DHS allowed for reimbursement directly to providers for transportation services. The Wright Center urges CMS to incorporate transportation services as a fundamental health-related social need (HRSN) into its pending Medicaid Section 1115 waiver, or to allow CHCs to bill directly for transportation services outside of their PPS rate. In doing so, we can significantly expand access and coordination of care for all patients, especially those with SUDs who often do not have the means to operate a vehicle.

Like transportation services, translation services are an essential service for patients facing complex socioeconomic determinants of health, but gaps in coverage remain. The Wright Center is deeply appreciative that the Pennsylvania Medicaid Behavioral Health MCO Community Care Behavioral Health reimburses a time-based code to providers for the time and costs associated with providing translation services during a visit, however DHS should mandate all MCOs to follow suit in order to reduce language-related disparities for all patients, but particularly those navigating addiction. The Wright Center pays approximately $50,000 per year out-of-pocket to provide over 300 language services to patients around the clock. If the Commonwealth truly plans to advance health equity, reimbursing providers for translation services universally is a common sense, low cost, and straightforward way to do so. In addition to promoting equity, making translation services more accessible can also increase patient engagement, enhance adherence to treatment and recovery plans, reduce medical errors, improve patient and provider relationships, and ultimately improve overall health outcomes.

Among the most "bread and butter" methods to improve public health and promote health equity is vaccination for preventable illness. In the spirit of whole-person care and the mission and fundamental operations of the Patient-Centered Medical Home model, when a COE patient is in person for a visit, they should be able to access all the services they need under one roof. However, the current state of poor reimbursement for vaccines, such as the now commercialized COVID-19 vaccines, is causing many health centers to make the tough decision to refer their patients to retail pharmacies, where their vaccine will be covered with minimal to no cost-sharing. For a variety of reasons including inadequate transportation, patients often do not follow through and get those vaccinations. As the Commonwealth emerges from the tragic COVID-19 pandemic, we must apply the lessons learned about how critical investment in prevention is. A lack of adequate reimbursement in vaccines undermines the Patient Centered Medical Home model, leading to vaccine hesitancy– Patients get mixed signals on the importance of vaccines when they are not covered during primary care visits. This lack of adequate reimbursement for vaccines in primary care settings burdens primary health providers significantly, increases the prevalence of illness, the incidence of preventable hospital visits,

disproportionately harms historically underserved populations, like COE patients. In light of the sweeping benefits of vaccine access and the harmful disparities due to the lack thereof, we recommend DHS release an updated bulletin, advising MCOs to cover the true costs of COVID-19 vaccinations in all settings.

Finally, to improve the overall healthcare delivery system across the Commonwealth, we urge the House Human Services Committee to support the Pa. DHS in deploying a plan to exercise its authority to increase the oversight and accountability of MCOs to promote resource and responsibility concordance in health services provider systems. The Wright Center is grateful for the productive and positive partnership with our physical health MCOs in the context of the COE program, but there's opportunity to promote greater standardization across MCO programs. Furthermore, the inconsistencies in reimbursement for services outside of the COE program ultimately contribute to gaps in access for patients, increased administrative burden on clinicians, and an overall inefficient use of resources. By collaboratively addressing the concerns outlined herein, we can build upon the existing success of the COE Program and ensure that individuals grappling with SUDs receive the standardized, comprehensive, and compassionate care they rightly deserve.

In closing, I extend my most sincere gratitude to the Pa. DHS and the House Human Services Committee for its unwavering dedication to enhancing the OUD COE Program and taking the time to hear from COE stakeholders. I thank you for your time, consideration, and commitment to this critical cause. For any follow up questions, please don't hesitate to reach out to me at constantinis@thewrightcenter.org.

Sincerely,

Scott Constantini
Associate Vice President of Primary Care and Recovery Services Integration
The Wright Center for Community Health and Graduate Medical Education