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***DELIVERED VIA EMAIL TO IWRIGHT@PAHOUSE.NET***

The Hon. Stephen Kinsey, Chair
Human Services Committee
Pennsylvania House of Representatives
317 Irvis Office Building
P.O. Box 202201
Harrisburg, PA 17120-2201

The Hon. Doyle Heffley, Republican Chair
Human Services Committee
Pennsylvania House of Representatives
317 Irvis Office Building
P.O. Box 202201
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**RE: Pyramid Healthcare Testimony in Favor of Opioid Use Disorder ("OUD") Centers of Excellence ("COE") Reform Efforts**

Good morning, Chairman Kinsey, Chairman Heffley, and distinguished members of the Committee:

On behalf of the Pyramid Healthcare, Inc. ("Pyramid Healthcare") family of companies, we are submitting the following thoughts and recommendations for reform within the Pennsylvania Department of Human Services' ("DHS") Opioid Use Disorder ("OUD") Centers of Excellence ("COE") program. We urge you to listen to our experience and design appropriate revisions to the program based on our feedback.

Pyramid Healthcare, founded in Blair County, is an integrated behavioral healthcare system serving Medicaid and commercial clients in nine (9) states across a continuum of residential and outpatient substance abuse, mental health, autism, and eating disorder treatment services. We employ over 3,100 team members across our 80+ active facilities. We care for over 12,000 unique commercial and Medicaid patients per day throughout our locations across an integrated network of service lines and affiliated behavioral healthcare organizations. We have a significant footprint throughout the Commonwealth of Pennsylvania, including our corporate headquarters in Altoona and our 50 residential and outpatient behavioral healthcare treatment locations throughout the state.

Of Pyramid's locations throughout Pennsylvania, eight (8) have been designated by DHS as Opioid Use Disorder COEs: the Erie Outpatient Treatment Center; Foundations Medical Services in Butler; Pittsburgh Outpatient Treatment Center; Altoona Outpatient Treatment Center (Dolminis); Chambersburg Outpatient Treatment Center; York Methadone Maintenance Treatment Center; Allentown Outpatient Treatment Center; and our Bartonsville Outpatient Treatment Center. Our Bartonsville location was recently destroyed in a fire and our COE designation is being shifted to our East Stroudsburg treatment center. We were the first COE in the Altoona area. We serve clients across thousands of visits per year through these locations and have an average census of over 250 clients at any given time throughout the year across our COE programs in the Commonwealth.

Effectively treating clients with OUD is challenging. They have complex medical issues and social needs that demand creative and comprehensive interventions as well as effective care management. The COE program, as designed, is an essential tool to address these needs, but the program as it operates today is in need of significant reform. Under the current structure, incumbent providers are unlikely to extend operations further and it becomes increasingly challenging for providers to sustain existing programs without appropriate changes that benefit patients, providers, and the Commonwealth.

We echo the comments made by Jason Snyder of the Rehabilitation and Community Providers Association ("RCPA"), of which we are a member. We also endorse the testimony of my colleague, Pam Gehlmann with Pinnacle Treatment Centers. We appreciate the opportunity to provide comments and feedback below regarding the following topics:

- Intention & Purpose of the COE Program
- Managed Care Audit Challenges
- Data Collection Barriers & Administrative Burden
- Inconsistent Interpretation of the Guidelines & Unclear Purpose of the Program
- Financial Obstacles & Payment Models

**Intention & Purpose of the COE Program**

Individuals struggling with addiction to opioids are statistically less likely to successfully complete treatment and more likely to return to active substance use. Contributing factors include care not being available, clients may leave programs prematurely, or they may leave programs without appropriate safety nets and supports in the community. To address these needs and gaps in care, individuals seeking assistance at one of the Pyramid Healthcare's COEs are paired with care management staff and a Certified Recovery Specialist ("CRS") in their area who provides advocacy and support to help them successfully stay in treatment. The care management team helps facilitate access to care for individuals who are on Medicaid and have an OUD, utilizing the hub and spoke model. These services prevent premature departures from treatment by helping individuals make appropriate and effective decisions about their paths to recovery. They often focus on the points of transfer, when clients move from prisons or emergency departments to treatment or from one level of substance use and/or medical care to another. These are all points that pose a high risk of loss of connection and relapse. The COE care managers help clients navigate the system of housing, medical, employment, transportation, and other services that can assist them with long-term abstinence and recovery. The program also aims to increase the number of individuals who are successful in their recovery from opioid addiction by integrating behavioral health and primary care.

Within the COEs affiliated with Pyramid Healthcare, the typical length of engagement with a client is between six to eight months. This engagement begins with a high frequency of contact to address a client's needs and then decreases over time as they establish stability. We have assisted hundreds of clients in obtaining behavioral health and mental health services as well as accessing primary care physicians, housing, and transportation resources. The teams also work on skill building for independent problem resolution, life skills, self-esteem building, and recovery support system development and strengthening. The largest need among this population, however, is substance use disorder treatment, with the vast majority of clients reporting a history of substance use, including overdoses.

In addition to the invaluable role of care managers, a critical component of the COE program is the Certified Recovery Specialist ("CRS")—an individual in recovery who can draw upon their own experience and knowledge to provide compassionate, empathetic, and accountable support to remove barriers to successful completion of treatment. They act as recovery coaches, connections to community resources, confidants, advocates, and role models to encourage clients to develop a sense of independence while achieving recovery.

The COE program is effective at reducing silos and treating the whole person. It has also been largely successful based on outcomes based on data from the University of Pittsburgh's Program Evaluation and Research Unit ("Pitt PERU"). In spite of this, the program as it is currently operated is unsustainable and requires a number of reforms related to the processes, policies, procedures, financial models and metrics, and the administrative burden placed on providers by the behavioral health managed care organizations ("BH-MCOs") which jeopardize the recovery of our clients. Having conflicting requirements and expectations both between the five different BH-MCOs we serve—and often within the same BH-MCO—degrades the integrity of the program and makes it harder for providers to be successful. We need transparency and predictability in order to understand the rules under which we operate. These rules should be client-focused and weigh the administrative burden against how to maximize the likelihood of a client's successful long-term recovery.

**Managed Care Audit Challenges**

There is inconsistency between audit criteria between the different BH-MCOs that our COE programs work with; in fact, we often see differing audit criteria within the same BH-MCOs between different audits conducted over time with little consistency in terms of evaluation criteria or priorities. We received six different audits of our COE programs within the span of a few months with varying criteria each time. At times, the criteria varied within the same BH-MCO between different COE programs. Trying to comply with multiple and conflicting standards between and among BH-MCOs is burdensome and detracts from the effectiveness of the program while increasing the cost. We need to return to the original consistency experienced in the COE program's earlier years. COEs were expected to adhere to a standardized set of interpretations, had reasonable and predictable data requirements, and received consistent reimbursement for their COE programs regardless of which BH-MCO provided coverage for the particular client.

Appendix G was originally designed to determine how COE programs should operate.[1] Those standards made sense. BH-MCOs, however, regularly go above and beyond by creating additional requirements or creating conflicting interpretations of guidance or referencing criteria allegedly from Appendix G that do not align with the reality of what Appendix G actually says in terms of documentation requirements, staffing ratios, and timelines for documentation rules (*e.g.*, timelines for the submission of BARC-10 to measure the social determinants of health). With regard to recovery plan documentation, there is wide variability in required deadlines ranging from 30 to 90 days. The result is our COE programs end up defaulting to complying with the most restrictive and draconian requirement across our various BH-MCO relationships for each criteria.

We need one set of rules and standards that is easily understood and consistently applied across all BH-MCOs. Pyramid Healthcare's COEs are high-quality programs that meet and exceed standards; but it is essential to have one set of benchmarks to follow in order to ensure high quality care is provided to our clients and to build sustainable programs. We believe the DHS Office of Mental Health and Substance Abuse Services ("OMHSAS") Service Description for COEs as well as Appendix G should be the governing body for these services and interpretive guidance should conform to these principles. Ultimately, what is needed is a standardized set of guidelines or an operations manual implementing and instructing how to interpret Appendix G and the OMHSAS Service Description upon which both COEs and BH-MCOs can agree. Having one set of standards, guidelines, and interpretations of Appendix G and the OMHSAS Service Description will instruct providers how to collectively enact and enforce uniform guidelines for staffing, census, documentation requirements. This will increase quality by producing transparency and accountability while reducing administrative burden and confusion for providers resulting from varying processes, policies, and manuals across BH-MCOs.

[1] https://www.dhs.pa.gov/HealthChoices/HC-Services/Documents/PSR%20Appendices%201-1-2021.pdf.

**Data Collection Barriers & Administrative Burden**

Another significant area of concern is the overall administrative burden placed on COE providers – especially the onerous data collection requirements without sufficient access to the results and conclusions of that data. As mentioned, across our eight COE locations, we partner with many of Pennsylvania's BH-MCOs. Individual locations often have multiple payer contracts with several different BH-MCOs. We end up having to comply with the requirements and expectations of the most restrictive of these payer partners.

COE staff are under heavy burden from repeated and extended REDCap data administrative meetings. We have multiple meetings per week involving many hours of staff time spent away from client focused activities across our locations. These meetings are not centralized across BH-MCOs. We are required to have separate meetings with each of the BH-MCOs and REDCap in addition to monthly meetings as well as quality meetings and monthly trainings. This is in spite of the fact that Pyramid Healthcare has automated our REDCap data. Other COEs are still entering REDCap data manually and feel the burden even more acutely. Before we automated our processes for REDCap, in order to be in compliance with the over 200 lines of data entry per week, it took a full-time employee ("FTE") 20 hours per week to input the required REDCap data for all of our sites. That is 0.5 FTE just to perform data entry for the REDCap program. In addition, the process of converting manual to automated REDCap data processes is itself onerous and takes essential clinicians away from client care. In addition to the actual time it takes to enter the data into REDCap, there is extensive duplication of data entry. We have to chart in our integrated and unified electronic medical record ("EMR") system and then have to enter duplicate data back into REDCap. This is redundant duplication, which introduces chance for errors.

Data collection is essential to ensure proper client care. It is even more important to ensure providers are being good stewards of public funds. We understand and agree with the goals and objectives of data collection, however the data is siloed and not being used effectively. We report information to DHS as well as Pitt PERU and the BH-MCOs. That information is not being properly shared or digested between the various parties to ensure collaboration and communication.

However, the BH-MCO's do not have visibility into the data or how is it being used. Pitt PERU data is not shared with the BH-MCOs and BH-MCO data is not shared with Pitt PERU. COE providers and our clients are caught in the middle and are mandated to comply with these data requests or risk losing designation as a COE. Properly used, the data can be a useful tool in crafting appropriate responses, developing interventions, and rewarding high-quality providers. Improperly used, as is the case today, it is a drain in time, talent, and resources. We urge necessary data collection and reporting reforms to align information sharing between the BH-MCOs, Pitt PERU, and providers. The real focus of these data collection and reporting efforts should positively impact providers' quality improvement efforts and enhance clients' long-term recovery.

**Inconsistent Interpretation of the Guidelines & Unclear Purpose of the Program**

The administrative burden headaches faced by COEs such as Pyramid Healthcare result from both competing and conflicting interpretations of the guidelines as well as fundamental disagreement over the purpose of the COE program. In particular, it is troublesome when conflicting interpretations of the guidelines differ from how the regulators initially outlined the COE program, jeopardizing the program's integrity.

*Existential Purpose of the Program*

There is a tension between the BH-MCOs on whether the purpose of the COE program is to address immediate crises or prioritize and incentivize long-term retention to ensure long-term stable recovery. Engagement and retention were the original goals of the COEs since it is well known that the longer someone engages in treatment and recovery activities, the better their changes are in sustaining long-term recovery. Some of the BH-MCOs do not seem to agree. The reality is that the nature of the disease of addiction is that recovery takes time. That was

the original intention and philosophy of the program and it is being degraded when BH-MCOs base their audit tools and guidelines on a crisis intervention model.

Additionally, there is conflict among the BH-MCOs as to whether COE programs are supposed to be entities unto themselves or integrated parts of the facilities in which they are housed. Pyramid Healthcare's COEs are organized under our existing legal entities and Tax IDs and thus cannot be meaningfully separated—nor should they be since the purpose of the COE program is to facilitate connection to services that can assist in recovery such as access to clinicians approved to dispense medication-assisted treatment ("MAT")/medications for opioid use disorder ("MOUD").

*Day-to-Day Discrepancies in Interpretations Between BH-MCOs*
As a result of these fundamental disagreements over the purpose of the program, it is inevitable that day-to-day discrepancies result when trying to implement and enact these programs. In addition, the COEs have not been invited to the table to be active collaborators in developing these guidelines with the BH-MCOs. Rather, we have only been retroactively consulted or involved once the substantive work has already been completed and only able to provide feedback on what is essentially a finished product.

For example, changes to the admission and discharge criteria not only affect operations but also impact financial payment model results and we do not receive timely notice – let alone consultation – regarding these changes. If we are not consulted or informed of changes to the admission and discharge criteria, it is impossible for us to meet expectations on value-based payment models. Admission and discharge criteria were scheduled to be released in Fall 2023, but providers have yet to be granted access to these criteria. This delay and uncertainty makes it impossible to properly plan, budget, or make decisions about whether we want to continue as a COE designee. This could fundamentally alter whether every COE would want to continue providing services under the program and yet we remain in the dark.

*Staffing Requirements*
Another area of inconsistency between guidance from the BH-MCOs regards staffing ratios and requirements. Some BH-MCOs are trying to restrict the number of clients a CRS can serve while others are agnostic to staffing ratios and properly focused on whether the team is ensuring proper care for our clients. As a result, we end up having to comply with the most restrictive of our BH-MCO partner's expectations even if those expectations differ vastly from what our other funding partners are requiring.

**Financial Obstacles & Payment Models**
Our final challenge is competing and conflicting payment models and financial arrangements between the various BH-MCOs with whom we collaborate. Because of our scope and our eight COE facilities across the commonwealth, we deal with financial arrangements with five of the BH-MCOs. In addition, each one of our COE locations may have contract relationships with multiple BH-MCOs, which increases the financial complexity exponentially, as well as extending the administrative burden to comply with the various and often conflicting requirements of each BH-MCO. This is another example of how a standardized rulebook will help create consistency in terms of operations and activities performed with our clients.

Among the BH-MCOs with whom we have value-based payment arrangements, some prioritize objectives around client retention and others emphasize crisis intervention services. Those are both important goals but they also conflict with one another in terms of which interventions a provider should prioritize. We have had BH-MCOs lower our reimbursement rate while adding additional audit and reporting requirements noted above.

We believe we provide high-quality care and outcomes for our clients that lead to successful long-term recovery. As such, we are very interested in exploring value-based payment relationships with our funding partners. These

partnerships should reward positive treatment outcomes and not just get the provider to par. We are interested in creative payment arrangements that highlight the high-quality care we are providing, however, the base reimbursement rate needs to be sustainable to allow us to operate. Providers cannot take downside risk on base rates that are already unsustainable. As with the other areas of reform, providers need predictability in operations in order to do long-range financial planning to keep the programs in operation.

Thank you for your support of mental health, behavioral health, and substance use disorder treatment providers and for considering our policy proposals and recommendations on behalf of Pyramid Healthcare. If we can provide any additional information or materials, please contact Collan Rosier, Pyramid Healthcare's Vice President of Government Relations, at 667-270-1582 or crosier@pyramidhc.com. In addition, we invite you to reach out and schedule a visit to one of our locations to learn more about our programs and services.

Sincerely,

Jessica Barr, CADC
Regional Director of Operations
Pyramid Healthcare, Inc.

**CC: Imogen Wright, Executive Director, House Human Services Committee**
**Annmarie Robey, Republican Executive Director, House Human Services Committee**