

## **UPMC Health Plan Testimony on HR 590 Treatment Access, Barriers and Resources**

### **Introduction**

My name is Dr. James Schuster and I am the Chief Medical Officer of Medicaid and Behavioral Services and Vice President of Behavioral Integration for the UPMC Insurance Division and the Chief Medical Officer of Community Care Behavioral Health Organization, which resides within the division.

I am pleased to provide testimony on HR 590 and agree that an assessment of all strategies to increase access to treatment for addictions is warranted. There is no doubt that, unfortunately, individuals can sometimes not access care at the moment of greatest interest or need. The reasons for this are complex.

Our own data indicates that there has been substantial growth in the number of our members receiving facility, community based, and medication assisted treatment services during the past three years. This growth is undoubtedly related to both the growing addiction crisis and the expansion of insurance coverage pursuant to the ACA and Mental Health Parity, including both for exchange and Medicaid products. We at UPMC and Community Care have worked diligently to ensure all our products meet all parity provisions and, in fact, do very few medical necessity denials of payment for services. We have made significant efforts to increase screening, identification and referral for both behavioral health and substance use disorders, including through our Community team, our HEDDS UP program, our disease management protocols, and our Prescription for Wellness efforts, among other initiatives.

So if coverage restrictions are not to blame for access issues, what steps can we take to improve access and/or to reduce some of barriers to addictions treatment?

1. First, given the increase in the number of people experiencing issues with substance use, expanding appropriate assessment and early interventions in both hospitals and primary care settings are necessary, beginning with improved screening and engagement strategies. Medical professionals in many hospitals and community practices would benefit from increased competency in screening, assessment, and brief interventions for less severe disorders, and knowledge of referral sources and specialty care for individuals with more severe disorders.
2. While we agree that an increase in the number of residential settings is important, especially for individuals whose addictions are complicated with other behavioral or physical health conditions, it is clear that an enhanced spectrum of care, often known as a "recovery oriented system of care," including community based outpatient and other supportive programs is also necessary. Research from the National Institute of Drug Abuse and others indicates that at least 90 days of treatment is required to significantly improve an individual's likelihood of long-term recovery. Where the treatment occurs appears to be much less important than the length of treatment. In light of the great disparity between current resources and community needs, a substantial growth in community based

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programs is required to meet the needs of those individuals who can be treated in less intensive settings.

3. A continued expansion of medication-assisted treatment options for both opioid and alcohol addictions is also necessary. Methadone and buprenorphine are clearly the most effective treatments for opioid dependence (for which residential treatment is, unfortunately, not very effective) and the effectiveness of naltrexone for alcohol dependence has been demonstrated in studies over many years. The funding of 45 Opioid Use Disorder Centers of Excellence for Medication-Assisted Treatment in specialized settings is an excellent enhancement. Additional efforts to assist primary care physicians in integrating medication-assisted treatment into their routine practices (similar to the manner in which they have assimilated the use of antidepressants in their practices over the past three decades) is another opportunity to enhance individuals' access to the care they need.
4. Enhanced funding to accommodate the unmet need for services is also necessary. Only about 10% of those who would benefit from substance use treatment are currently accessing services. The current funding efforts to expand to treatment, including the funding of the new Centers of Excellence, are very welcome and necessary. They are, however, inadequate to address the access needs. We believe more funding is necessary, especially for prevention and early engagement (i.e. pre-treatment) activities.
5. We also feel strongly that improved strategies to better engage individuals who have entered treatment is also necessary. Community Care has been working with 24 providers statewide to enhance treatment models to improve individual follow-through, particularly with community-based treatment. Efforts include enhanced contact outside of scheduled appointments and enhanced appointment scheduling. Early indications are that these efforts have led to significant improvement in retention in care.
6. Family involvement in both assessment and treatment can significantly impact treatment outcomes. And, while family support for the individual struggling with addiction is critical, family members, too, require support to manage and deal with the emotional, mental and financial burdens associated with addiction. Unfortunately, to date, families have not always received the support and attention necessary.

We at the UPMC Insurance Division believe we have a responsibility to our members and to our communities to address the opioid crisis in innovative ways that go beyond treatment alone. We recognize that successful interventions will require a comprehensive response from all community stakeholders. Our collaborative efforts include participation on the regional committee led by U.S. Attorney David Hickton, and assisted by the University of Pittsburgh Institute of Politics, that is addressing the opioid epidemic and overdose prevention from multiple community perspectives. This task force released an updated report highlighting approaches for western Pennsylvania last week and we look forward to participating in multiple efforts to implement them.

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In late September, we co-sponsored a regional meeting with the University of Pittsburgh Institute of Politics that included representatives from the PA Department of Health, multiple county representatives, single county authorities, families, and medical and administrative leaders from several regional health systems. Together we reviewed actions in our region over the past two years and talked about the steps necessary going forward to address the opioid crisis. We are also actively working on an IOP committee seeking substantial grant funding for these activities.

Enhancing the quality of care delivered by existing providers is another strategy to improve the treatment system. We have successfully worked with providers to diminish the concurrent use of opioids and benzodiazepines among individuals in methadone treatment programs and are currently initiating a program to enhance the care of concurrent medical conditions at these sites.

The UPMC Comprehensive Pain Management Steering Committee aims to educate providers in means by which to more effectively manage pain without unwittingly putting patients at risk for prescription drug dependence. We have been active in these efforts and believe they are making substantial progress in reducing the use of prescription of opioid medications.

The Bridge-to-Hope family support program at the Passavant Foundation educates and provides support to families affected by a loved one's addiction or death from an overdose. It also trains and educates family members about the proper administration of naloxone. We have been active in this organization's work at Passavant Hospital and its efforts to initiate a new family group at UPMC East.

As part of our efforts to increase access to addiction treatment, we have provided substantial support to the Pregnancy Recovery Center at Magee Hospital, which offers medication-assisted treatment to women who are both pregnant and opioid dependent. This center, started about two years ago, is now planning significant expansion with the receipt of a Center for Excellence grant; we are involved in this planning process. We have also supported multiple efforts designed to enhance the knowledge and skills of physician staff in the UPMC Health System regarding substance use and dependence.

We have provided substantial support to efforts led by the Department of Drug and Alcohol Programs to provide naloxone to first responders. To enhance the distribution of naloxone, we have encouraged our providers to prescribe it for individuals who have or are at risk of opioid dependence.

Recognizing the need to enhance engagement among individuals in medical settings, we have participated in demonstration programs that include support from the PA Department of Human Services and Allegheny County to initiate peer services at several local UPMC Hospitals and at Community Care.

Pharmacists are often an untapped resource in our efforts to decrease the use of opioid medications. At UPMC Health Plan, we have implemented a number of formulary management interventions, which have led to substantial decreases in the prescriptions of opioids to our

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members. We are also exploring funding options to equip community pharmacists with tools to enhance competency in screening and intervention.

As above, we at the UPMC Insurance Division feel a strong responsibility to implement strategies to prevent addiction, make naloxone available, assist with linkage to services, and provide coverage for treatment for all those who have addictive disorders. We very much appreciate your attention to and interest in expanding access to care. We respectfully recommend that HR 590 be expanded to address the multitude of factors that, in addition to insurance coverage, affect access to treatment.

Thank you for offering us the opportunity to present today.