

## **Testimony for House Resolution 590 – Difficulties with Access to Drug and Alcohol Treatment**

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Thank you Secretary Tennis and Lt. Governor Stack for allowing me the opportunity to provide testimony on the House Resolution 590 - Difficulties with access to drug and alcohol treatment.

My name is Paula Ruane, and I am the Central Region Director with Gaudenzia, Inc. Gaudenzia, a non-profit provider of drug and alcohol treatment services in Pennsylvania and the largest provider for Medicaid eligible individuals. Gaudenzia has been providing treatment services in PA since 1968. Today, we have 78 locations and over 150 programs in the Commonwealth. Annually, Gaudenzia provides treatment services for over 20,000 individuals.

It is well-documented that this nation is in one of the worst opiate epidemics we have ever encountered. In 2014, Pennsylvania lost 2,500 people to drug-related overdoses and in 2015, those numbers increased to 3,500 overdose deaths. It is anticipated to be even higher this year. The overdose crisis has created a disproportionate need for drug and alcohol treatment services related to available treatment slots. Particularly, there is a significant shortage of detoxification beds for those needing this service. There is difficulty securing short term and long term residential treatment beds and a shortage of dual diagnosis services.

I would like to discuss one of the greatest barriers to access of treatment which has been haunting the provider system since the 1960's. It is a Federal statute known as the IMD Exclusion. The IMD stands for the Institution for Mental Diseases and it restricts federal Medicaid match for treatment of mental illness and addiction treatment to facilities with 16 beds or less. This 16 bed limit makes it impossible for addiction treatment providers to survive in light of the state licensing and accreditation requirements for staffing and coverage. This is especially true for community-based detoxification which requires round the clock nursing coverage. The IMD exclusion is in direct conflict with the overburdening need for drug and alcohol treatment.

The IMD exclusion imposes an arbitrary 15 day monthly cap on residential addiction treatment for Medicaid managed care. For someone in the throes of an opiate addiction, 15 days of treatment will surely lead to their death due to a premature discharge from treatment and a subsequent return to their drug of choice. Statistics will bear out that recovery occurs when the individual receives an adequate length of treatment in the right level of care. If we are ever to make any inroads in this opiate epidemic, it is time to change, revise or amend the IMD exclusion as it applies to drug and alcohol treatment.

Act 106 of 1989 requires all commercial group health plans and HMO's to provide comprehensive treatment for alcohol and other drug addictions. It establishes minimum coverage benefits for detoxification, residential, outpatient and partial hospitalization. Medical

necessity, under Act 106, established only one lawful prerequisite for an insured to obtain treatment: a certification and referral from a licensed physician or licensed psychologist.

If the company is self-insured and Act 106 is not applicable, the insurer simply denies care. There is no recourse. In some cases, insurance companies frequently cite failure to meet medical necessity criteria. These insurance companies have developed their own medical necessity criteria which they refuse to share with the treatment providers.

Here is one such instance. Megan was admitted into the facility for opiate detoxification. She had private insurance which authorized 5 days of detoxification treatment but denied all further inpatient treatment due to medical necessity. This client had been using heroin and methamphetamines daily for 3-4 years with only two small interruptions for inpatient detoxification treatment during that time. It was clear that 5 days of detoxification treatment would not provide her with enough stability and clean time to sustain her recovery, especially after she had tried that before twice and been unsuccessful. After 2 appeals with the insurer, they continued to deny her inpatient rehabilitation. We were able to secure funding through her home county's drug and alcohol commission but this is a good example of insurance companies denying treatment that was clearly necessitated.

We have one particular insurance company that has routinely denied care at the outpatient, the least restrictive level of care. That leaves the provider stuck with absorbing the loss. Add to this the low cost of reimbursement for services from insurers, treatment providers continue to be on the losing end where expenses track higher than revenues.

If an insurance company certifies that treatment is needed, they often have a required fail-first policy; meaning the patient must fail (which means that the patient relapses) at the outpatient level of care before residential will be recommended. In light of this opiate epidemic, one relapse could be the last. There can be no first-fail requirements when death may be likely outcome. When the outpatient program tries to refer the client to residential due to medical necessity, the insurance program will often deny short term residential treatment if detoxification is not needed.

Zachary was to be admitted for treatment into our facility for opiate detoxification. Upon his arrival at the facility, it was clear that he had overdosed on a substance, which was later found to be heroin. Our nursing staff gave him prompt medical attention including administering Narcan. He was revived and taken, by ambulance, to Harrisburg Hospital. Later that day, he was returned to our facility to begin his detoxification treatment. When the nursing staff attempted to secure authorization from insurer for his treatment, their request was denied due to medical necessity. Later, they approved 1 day, but only one day, after which, all further detoxification treatment was denied. It was very clear, from our perspective, that this client needed further inpatient treatment. We always seek other means of funding for our clients so we were able to secure funding through his home county's drug and alcohol

commission for the days that were denied. This is a good example of managed care organizations denying treatment for clients who need it.

Treatment programs encounter difficulties with insurance companies at the point of the initial authorization and at continued stay reviews. The continued stay reviews are lengthy, sometimes taking up to an hour per client and taking much needed time away from direct client service. Some insurance companies play the game of requiring continued stay reviews every day for detox and every few days for long term residential treatment. Insurance companies routinely deny authorization for the Intensive Outpatient level of care.

Insurance companies often require treatment providers to send the entire medical record for payment to be initiated. This requirement violates 42 CFR, Part 2, Confidentiality and the Pennsylvania Code 255.5 disclosure rules which protect the medical records of our most vulnerable patients. There has been little progress in the reduction of stigma surrounding this disease. Even those suffering from the throes of addiction are too ashamed to admit they have a problem. If access to the patient's personal, clinical information is breached, it could irreparably damage the patient and their families. And, the insurance companies have no re-disclosure provisions and no guarantees that future medical benefits will not be denied based on prior existing conditions.

The Affordable Care Act was designed to provide insurance coverage to the working poor or otherwise non-insured. Through the Insurance Exchange Market Place, insurance companies are offering reduced benefits, increased co-payments and unreasonable deductibles as a way to maneuver around their requirements to cover treatment. This has made treatment unaffordable for many. We have witnessed co-payments as high as \$100.00/day for outpatient and intensive outpatient inclusive with deductibles of upwards of \$5,000.00. Essentially, this is out of pocket payment for treatment. In some instances, we have sought alternate funding through the Single County Authorities to help provide treatment or help offset these ridiculous costs although this is not always an option. Here is a prime example of insurance company cost-shifting.

There are other numerous access barriers that client's routinely grapple with including issues with the legal system. Clients routinely are pulled from treatment by judges, probation or parole officers who either make length of stay treatment decisions or otherwise interfere with the client's ability to complete treatment.

Tim, a 35 year old man who was making good progress and was committed to treatment. He completed a short term residential stay and was referred by his counselor to long term treatment. The judge decided that the client needed to face his charges and he was remanded to prison right in the middle of his treatment.

James was scheduled to be admitted to our facility for opiate detoxification treatment. On the day he was to be admitted, his Probation Officer detained him and he was later incarcerated. This client had been actively using heroin by injection and had been for an

extended period of time. We did not have a bed available when he first called the facility, but were able to schedule him for admission for the following day. It is our belief that the Probation Officer was aware that he had a bed reserved at our facility and did not take that into consideration when making his decision to detain this client.

The outpatient programs report a significant need for psychiatric services when medication management is required after the client is discharged from residential and returns to the outpatient level. Lack of community-based psychiatric follow up for those identified seems to contribute to relapse.

Gaudenzia provides a full array of treatment services and supports Medication Assisted Treatment as an adjunct to treatment services. When discussing the benefits of Vivitrol with clients who are opiate addicted, we experience problems in finding community-based doctors to prescribe Vivitrol. If we can locate a doctor, they charge upwards of \$150.00 for providing the shot. For those on Suboxone, our experience has been that the doctor keeps the client in their clinic for education about the MAT and often fails to refer them for the required drug and alcohol counseling.

Another significant barrier to access of treatment is the lack of transportation. Gaudenzia operates an outpatient within the city of Harrisburg. If the client lives on Allison Hill, he must take no less than 3 different bus lines to arrive at outpatient. Of course, the cost becomes prohibitive for the client. Transportation is a particularly acute problem when the treatment program is located within a suburban or rural area where there is no public transportation. Teens are most seriously impacted by the lack of transportation to treatment.

My hope is that these hearings may help resolve some of the barriers of access to treatment. Thank you for inviting me to share some of the most critical elements impacting this access.