

Good Morning, My name is Sarah Hawkins and I am an Assistant Regional Director for White Deer Run.

The White Deer Run Treatment Network includes 16 centers throughout Pennsylvania that provides an array of treatment services for adults with substance use and co-occurring mental health conditions. White Deer Run offers a full spectrum of treatment services, including detoxification, residential rehabilitation, partial hospitalization programs (PHP), intensive outpatient programs (IOP), traditional outpatient programs (OP), and level of care assessment. The network also includes two halfway houses, one for men and one for women. Through this service network, White Deer Run provides treatment to over one thousand citizens of Pennsylvania each day.

I want to thank you for the opportunity to provide testimony today on this important topic of access to care. Today I will be discussing the following points:

- The impact of inadequate reimbursement rates
- Access barriers related to commercial insurance policy deductible and copay amounts
- Utilization review practices that limit length of stay in treatment

The White Deer Run treatment network is in a unique position to provide testimony regarding access to care for a variety of individuals with various methods of paying for their services. Our system serves individuals who are able to self-pay for their care, those with private insurance, those accessing Medicaid and individuals who are uninsured. However, approximately 80% of the Pennsylvanians we serve are currently utilizing Medicaid for their health insurance coverage. Therefore, we would like to bring your attention to how the lack of an adequate Medicaid reimbursement rate affects access to care in our state.

In the current system, publicly funded reimbursement rates are established through an RFP process in which providers are able to annually submit their rates for review and approval by the Single County Authorities and the Managed Medicaid entities. The rate setting process only allows providers to include the basic costs of patient care, but establishes a cap on administrative costs, which prevents the provider from even getting close to the true cost of doing business. Furthermore, it is not unusual for some Managed Medicaid entities to provide reimbursement rates that fall even below the reduced cost of care rates established by the RFP process through the Single County Authorities. In addition, rates for longer term residential care programs are frequently even lower than short term, although the regulatory requirements of services to be provided and the costs associated with providing such services are equal to short term residential care. As a result, the availability of such programs throughout the state is rather limited.

In order to effectively explain how the rate structure further affects access to care, we would ask that you consider access being more than just an available bed or outpatient slot within the system of care and instead consider it to include access to high quality, effective treatment for all. As providers, we are aware that the best outcomes are achieved through the provision of care that is evidence based and appropriately matched to the individuals' needs. Some examples of this type of care includes use of certain modalities of therapeutic approach such as

motivational interviewing or motivational enhancement therapy, the ability to provide integrated physical and behavioral healthcare, the ability to provide access to medications that aide in recovery, such as Vivitrol and lengths of stay that are appropriate to the level of need. These are just a few examples of interventions that are known to be effective in achieving the best possible outcomes for individuals. Use of such interventions, however, requires a certain level of competency, training and infrastructure to ensure fidelity to the model and availability of resources. For providers that are primarily serving the Medicaid population, absorbing the higher costs of care associated with these treatment modalities can jeopardize the financial viability of the provider, as the reimbursement rate is already below the cost of doing business. As a result, it can be reasonably expected that individuals will continue to need to access higher cost levels of care, such as detoxification, on a more frequent basis, which will reduce access to these levels of care overall, further necessitating the addition of new beds into the system of care.

In this time, more than ever, it is extremely important that programs are funded at a capacity that enables the provision of high quality, evidence based and effective treatment at appropriate lengths of stay, to improve long term outcomes and reduce high utilization of certain levels of care.

As previously mentioned, the White Deer Run Treatment Network also serves individuals with private commercial insurance policies. Through the ACA and the MHPAEA, the majority of these individuals now have a benefit that covers treatment for substance use disorders. Unfortunately, those benefits are frequently unable to be accessed due to extremely high deductible or copay amounts. It has not been unusual to encounter plans that include \$4000-\$6000 deductibles before the cost of any treatment will be covered by the plan. These are plans for which the individual has paid their portion of the monthly premium and yet are still unable to use the coverage for which they have already paid without causing financial destitute to their families. In our experience, we are also seeing a great deal of young adults who carry this coverage under their parents, but are estranged from their families and are themselves not working and have no established credit or resources from which to borrow the cost of the deductible. These types of plans have rendered access to the very benefits that the MHPAEA intended to expand nearly impossible.

For those that do not have difficulty meeting the deductible or copay obligations of their health plans, the medical necessity review processes required to preauthorize treatment are creating additional barriers for individuals seeking care. The criteria used to determine the need for treatment is inconsistently applied across insurers, with some companies denying detoxification services for opiate addiction altogether. For other insurers that do authorize detoxification, the rehabilitation length of stay is often authorized at substantially shorter time periods than what is needed for the individual to develop the skills necessary to prevent relapse. We have consistently experienced these denials and shorter lengths of stay to be even more frequent for those who are experiencing their first time in treatment, whose families are still supportive and intact, who may not yet have become involved in the criminal justice system or lost their employment. However, as we know that the disease of addiction is progressive and often fatal,

reducing access to intensive early intervention only leads to further development of the disease and additional human and economic costs to the individual, their families and society.

I want to thank you again for the opportunity to provide testimony today on this very important topic of access to care.