Legislative Budget and Finance Committee

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Drug and Alcohol Treatment Services in a Managed Care Environment

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Report Summary and Recommendations

In response to concerns voiced by substance abuse treatment advocates and service providers, the Legislative Budget and Finance Committee directed its staff to undertake a study of the impact of managed care on the treatment services provided to persons with substance abuse dependency. Of particular concern was the perceived lack of compliance with Act 1989-106, which provides for certain minimum benefit requirements for persons certified as having a substance abuse dependency.

Although this report does not address all the issues raised during our interviews, such as concerns over specific regulatory requirements, we did expand the scope of the study to include organizational issues within the Commonwealth's substance abuse treatment delivery system that we became aware of during the study.

According to the Robert Wood Johnson Foundation, $238 billion is spent annually on problems related to alcohol and other drug use and dependency. Substance abuse is related to criminal activity, losses in wages, losses in productivity, health problems, increased health care utilization, mental retardation, mental health problems, and mortality. In Pennsylvania, according to the National Institute of Drug Abuse (NIDA), total state spending linked to substance abuse was $3.5 billion, or 14.5 percent of the total state budget. Only a relatively small amount of this, however, is for treatment related services, approximately $304 million in FY 2001-02.

Several State Agencies Oversee and Fund Drug and Alcohol Treatment Services, Creating Inefficiencies and Hindering Clear Policy Direction

Pennsylvania's drug and alcohol treatment service system is complex and involves multiple funding streams and regulatory agencies. Although the Bureau of Drug and Alcohol Programs within the Department of Health (DOH) is the designated lead agency to coordinate the various public programs, the growth of HealthChoices—Pennsylvania's Medicaid managed care program—in the Department of Public Welfare (DPW) and expanded funding for treatment services within the Department of Corrections (DOC) and the Pennsylvania Commission on Crime and Delinquency (PCCD) has resulted in the development of several different treatment "systems," each with its own funding streams, rules, and requirements.

Services provided through private commercial insurers are not directly affected by these multiple systems, but many service providers treat both public and private clients, and clients often move between private and public programs. As a result, we found it difficult to separate the concerns expressed over the impacts of

managed care, particularly for providers who treat large numbers of HealthChoices clients, from these broader organizational and structural issues.

Areas we found problematic include:

- *Administrative Complexity.* The Department of Health has one bureau that licenses drug and alcohol services; another bureau that sets policy and funds Single County Authorities (SCAs), the county agencies that provide substance abuse services to the uninsured; and a third bureau that monitors commercial managed care plans. DPW interacts with drug and alcohol service providers primarily through the Office of Mental Health and Substance Abuse Services, which licenses community mental health programs and manages the HealthChoices behavioral health contracts, the Act 152 drug and alcohol program, and the Behavior Health Services initiative. DPW's Office of Medical Assistance Programs has retained responsibility for substance abuse services for Medicaid-eligible clients still enrolled in the fee-for-service program. The Department of Corrections and PCCD also provide major funding for drug and alcohol treatment services. Other involved agencies include the Department of Education, the Insurance Department, and the Board of Probation and Parole. With so many agencies and programs involved, it is difficult to develop, promote, and implement a coordinated statewide strategy for the prevention, intervention, and treatment of substance abuse disorders.

- *Cost Shifting.* Cost shifting for substance abuse treatment services occurs at several levels. If commercial managed care organizations deny care or provide an inadequate level of care, costs are often shifted to a public program. The SCAs cited such cost-shifting—often as the result of the client losing his or her job—as a major reason why virtually all SCAs must ration the care they provide so they do not run out of money before the end of a fiscal year. People who receive inadequate services through a commercial behavioral health care organization (BHCO) may also end up on Medicaid or in the criminal justice system. Cost shifting also occurs at the county level, with clients being enrolled in a county mental health program, which is a mandated service, rather than a more appropriate drug and alcohol program, which is an optional service for persons who do not qualify for Medical Assistance. Costs are also shifted to other county human service programs, such as county children, youth and families programs. Medicaid also shifts at least some costs to the SCAs, which receive only limited funds to provide services to HealthChoices-eligible clients during the 30-day period it takes to enroll in the HealthChoices program. A more streamlined administrative structure would help reduce some of the cost shifting that occurs between programs, thus allowing the time and money now

spent on shuffling clients between programs to be directed to treatment services. While cost shifting is a concern to the SCA directors, we should note that their primary concern is over the level of base funding they receive, which is inadequate for the services they are expected to provide.

- *Dual Licensure/Dual Diagnosis.* National estimates are that over one-third of persons with substance abuse problems also have an underlying mental health problem, known as a dual diagnosis or co-occurring disorder. We spoke to one major HealthChoices provider who estimated that as many as 70 percent of its clients have a dual diagnosis. Despite this close relationship, drug and alcohol programs are licensed and regulated by the Department of Health whereas mental health programs are separately licensed and regulated by DPW. As a consequence, it can be difficult and costly for providers to be licensed to provide both types of services. Also, much effort is spent enrolling, disenrolling, and then reenrolling clients as they move between the two systems.

- *Confidentiality Requirements.* Under Act 1998-68, managed care organizations are responsible for maintaining confidentiality of pertinent records. The Act also implies that information necessary for a managed care organization to determine coverage, review complaints or grievances, conduct utilization review, or facilitate payment of a claim is to be made available to the MCO. The PA Drug and Alcohol Abuse Control Act, however, allows disclosure only if the patient gives his/her consent and only to medical personnel exclusively for purposes of diagnosis and treatment. Department of Health regulations (§255.5) further limit disclosure to five specific points of information. Substance abuse treatment providers can thus be placed in the position of either violating DOH regulations or being denied payment for services because the managed care firm does not receive the information it believes necessary to determine medical necessity. Furthermore, these requirements may jeopardize clients' receipt of services. In 1997, DOH issued a letter of interpretation to clarify the type of information that could be provided to a BHCO, but the letter did not resolve the problem. DOH, with input from stakeholders, has begun reviewing the language of its interpretation of its confidentiality regulations to address these issues. The Department anticipates issuing a second letter to address at least some of the outstanding concerns early in 2003.

- *Separate Service and Outcome Databases.* Collecting uniform, standardized service and outcome data, a challenge under the best of circumstances, is made even more difficult because the drug and alcohol system is so fragmented. The Departments of Health and Public Welfare have recently applied for a federal grant to integrate their two separate data

systems, but the federal government has yet to respond to the proposal. Other discussions to integrate data systems among Pennsylvania's publicly funded programs have not advanced very far. Moreover, there is virtually no sharing between public and private systems because data is payer driven and does not track clients as they move from one system to another. Without such information, it is difficult to measure program effectiveness and monitor accountability. Some stakeholders have called for mandated reporting of more specific data, and several bills were introduced last legislative session that address these concerns.

For these and other reasons, virtually everyone we spoke to during this study agreed that the current system for delivering drug and alcohol treatment services should be restructured. The *Pennsylvania Community Providers Association* has taken the position that the Bureau of Drug and Alcohol Programs should be moved from DOH to DPW and elevated to the Office of Drug and Alcohol Programs (ODAP). PCPA also advocates moving the Division of Drug and Alcohol Licensing, currently in DOH, and the Substance Abuse Services portion of DPW's Office of Mental Health and Substance Abuse Services to the newly created ODAP. ODAP and the re-named Office of Mental Health would be charged to work in concert with the Office of Medical Assistance programs to develop a seamless service delivery system for persons with co-occurring disorders.

The *Drug and Alcohol Service Providers of Pennsylvania* (DASPOP) advocates restoring the Governor's Council on Alcohol and Drug Abuse and consolidating funding for addiction treatment by moving Behavioral Health Services Initiative (BHSI), HealthChoices, and Medicaid fee-for-service funds to the Bureau of Drug and Alcohol Programs to be administered by the Single County Authorities. The Bureau would be located within DOH for administrative purposes but would report to the Council. The Council, in turn, would report directly to the Governor.

The *Pennsylvania Association of County Drug and Alcohol Administrators*, the association representing the Single County Authorities, advocates creating a cabinet-level position for substance abuse services that would be responsible to develop and implement a statewide strategy for substance abuse prevention, intervention, and treatment; to coordinate these programs; to establish policies and priorities for allocating federal and state funds to support such programs; and to evaluate the effectiveness of programs and, if necessary, change strategies as needed.

We also spoke to several providers who believe that all drug and alcohol and mental health regulatory functions should be located in one office within DPW. The providers expressing this opinion tended to serve high percentages of Medicaid recipients and cited the difficultly of dual licensure and the paperwork burdens created by the need to be constantly shifting clients between drug and alcohol and mental health programs as reasons for consolidation.

Commercial Managed Care Has Resulted in Clients Receiving Different and Fewer Treatment Services

Annual surveys conducted by the National Association of Psychiatric Health Systems found the average length of stay for alcohol and drug abuse patients in psychiatric hospitals decreased from 14 days in 1993 to 7.7 days in 1996. Although using apparently different methodologies over time, data reported by Mutual of Omaha shows a similar trend: the average length of stay for substance-abuse only patients in residential treatment declined from 19.0 days in 1990 to 11.0 days in 1995 and 8.9 days in 2001.

Comprehensive, statewide longitudinal data is not available for Pennsylvania. Yet, there is some indication that PA appears to have mirrored this national trend. One Pennsylvania provider submitted data for its commercial BHCO substance abuse clients showing that the average length of stay for inpatient nonhospital rehabilitation fell from 15.4 days in 1992 to 6.2 days in 2001, a 60 percent decrease. Average treatment duration also fell for partial hospitalization (from 15.3 days in 1992 to 7.8 days in 2001) and intensive outpatient (from 17.0 sessions in 1992 to 9.9 sessions in 2001). The provider's data also shows a dramatic increase in the number of clients receiving intensive outpatient treatment, from 99 cases in 1992 to 701 in 2001. According to the provider, the emphasis on partial hospitalization and intensive outpatient services was a direct result of the behavioral health plan's emphasis on the need to develop alternatives to inpatient care.

This provider's 2001 data closely tracks the broader data we received from several other commercial BHCOs operating in Pennsylvania. We also obtained data from the HealthChoices program and from the Single County Authorities. Comparisons between programs and firms are difficult and must be viewed with caution because the data is not collected or reported uniformly across behavioral health plans. Nevertheless, the data do allow some general observations:

- *Average lengths of stay are reasonably similar for inpatient detoxification for public and private payers, but public programs allow much longer lengths of stay for inpatient rehabilitation.* Average lengths of stay for inpatient nonhospital rehabilitation exceeded 25 days in all the public programs for which we had data. In contrast, the average length of stay for this service for the two behavioral health firms under contract with private insurers was 8.4 and 7.3 days respectively.
- *Several factors may account for the longer lengths of stay in public programs.*
  - To some extent, the longer lengths of stay for clients in public programs may be due to their being more severely affected and to difficulty in finding an appropriate home to which the client can be released. Clients with private insurance are more likely to have jobs,

families, and homes and therefore can be more readily placed in an outpatient program. Additionally, under the HealthChoices waiver, Medicaid clients are eligible to receive inpatient care in nonhospital facilities, a service which is not included in fee-for-service programs.

  - HealthChoices plans and the Single County Authorities must use standardized medical necessity criteria, the Pennsylvania Client Placement Criteria, when evaluating and placing a client. The PCPC identify specific criteria typically used by BHCOs under contract with private sector MCOs. The PCPC also includes specific criteria for when to discharge a patient, whereas the ASAM criteria provide more general guidelines.

  - Public programs are held accountable for the services they provide through oversight by the counties and DOH for Single County Authorities and DPW for HealthChoices and fee for service programs. In contrast, BHCOs under contract with commercial managed care organizations may or may not be held accountable for their treatment decisions.

  - To some extent, the difference in average length of stay may also be due to legitimate differences in interpretation of the effectiveness of various treatment modalities. Although most of the research shows a positive correlation between longer treatment and better outcomes, it is less clear how the intensity of treatment (e.g., inpatient versus intensive outpatient) affects outcomes. This issue is discussed further in Finding II.F.

- *Penetration (utilization) rates are much higher for HealthChoices clients.* The percent of covered lives receiving a service are much higher for HealthChoices clients for all services (except hospital-based inpatient rehabilitation) than for clients of private insurance. Substance abuse is a particularly prevalent problem among the poor, and penetration rates can be expected to be higher for Medical Assistance clients than the general population.

- *Public sector programs provide significantly more outpatient sessions than the BHCOs under contract with commercial insurers.* For example, the HealthChoices program (Southeast and Southwest) had an average of 63.4 units of intensive outpatient treatment per client in 2001, compared to 11.1 and 12.0 for the two BHCOs under contract with private MCOs. Again, the differences can be attributed to differences in the severity of the client's problems, Pennsylvania Client Placement Criteria (PCPC) versus ASAM criteria, and the level of oversight exercised by the organization holding the contract with the BHCO.

Several advocates noted that even if the efficacy of longer lengths of stay has not been proven conclusively, state law (Act 1989-106) requires insurers to provide

minimum coverage of 7 days inpatient detoxification and 30 days inpatient treatment annually (28 days and 90 per lifetime, respectively). Based on the data we obtained from three commercial BHCOs, it is clear that the average lengths of stay for residential treatment (all less than 9 days) do not begin to approach the 30-day minimum coverage provisions set forth in Act 106.

When asked about this discrepancy, one BHCO official responded that, as with other health plan benefits, the Act 106 benefits only apply if the BHCO determines the services to be medically necessary. If that determination is made, the benefits are provided using ASAM placement criteria. Advocates disagree with this interpretation, citing the language of Act 106 that provides for a physician or licensed psychologist to certify an individual as having a substance abuse disorder and then having the authority to directly refer that individual for appropriate treatment. The BHCO official also noted that it might not be in the members best interest to use a full-year's benefit (30 days) all at one time and that some members may have short lengths of stay because they have exhausted their annual or lifetime benefits.

We reviewed the Act 106 requirements with officials in the Department of Health, Insurance Department, and the Office of Attorney General to obtain their interpretation of the act and to determine what steps have been taken to enforce the act's provisions. Although Act 106 does not specifically charge any one agency with enforcement responsibility, the Insurance Department does have overall responsibility to enforce the Commonwealth's insurance statutes. However, the Insurance Department targets its enforcement efforts to those areas it deems problematic based on the number of formal complaints it receives. According to the Department, although it has received five complaints related to alcohol and drug treatment under Act 68, it has never received a formal complaint regarding Act 106 benefits and therefore has not taken any specific actions to enforce Act 106. A November 2002 letter from the Insurance Department's Chief Counsel does, however, reinforce that a patient's treating physician controls over a managed care physician regarding the need, level, and length of care, so long as the appropriate clinical criteria are met.

The Department of Health also looks to complaints to guide its enforcement actions. According to the Department, it has received only five grievances pertaining to substance abuse services since 1999. In two of those grievances, the Department ruled in favor of the client. A third grievance was decided in favor of the managed care firm, and decisions are pending in the remaining two cases.

The Office of Attorney General has established a Health Care Unit to help citizens of the Commonwealth with problems related to health care services, including drug and alcohol treatment. The Unit reports it receives about 100 complaints annually regarding drug and alcohol services. However, the Attorney General does not have authority under an insured's policy or Act 68 to file a complaint or

grievance on the consumer's behalf. Under Pennsylvania's Unfair Trade Practices Act, the Attorney General's Office could initiate an investigation and, possibly, litigate a case if it believed a managed care organization or subcontractor was engaged in a pattern of violations. However, the Office does not comment on such investigations or mediations unless it results in a legal action, and, to date, the Attorney General has not filed any such legal suits.

Drug and Alcohol Treatment Providers Are Struggling to Cope With Multiple Layers of Oversight and Regulation

As noted above, Pennsylvania's drug and alcohol treatment providers must comply with requirements of multiple public and private agencies. DOH's Bureau of Community Program Licensure and Certification must license all drug and alcohol treatment providers. If they receive monies through the Single County Authority, they must also comply with county contracts and the requirements of the Bureau of Drug and Alcohol Programs. Most providers also serve Medical Assistance clients, which means they must abide by the requirements of DPW's Office of Mental Health and Substance Abuse Services and Office of Medical Assistance Programs.

In addition to these state and county requirements, managed behavioral health care organizations impose additional certification and monitoring requirements. One drug and alcohol provider we spoke to said that during the course of a year his organization may have more than ten on-site reviews by public and private agencies, including DOH, DPW, SCAs, Community Behavioral Health (Philadelphia), and private certification and private insurers. According to this and other providers, these reviews are often redundant with the reviewers typically focusing on patient records and whether various patient forms have been properly completed, with relatively little attention given to the nature or quality of the hands-on care being provided.

Difficulties created by confidentiality constraints, preapprovals and retrospective denials, and delayed payments also contribute to the burdens placed on providers. While all acknowledge that some administrative requirements are inevitable, many providers believe these administrative burdens have become truly unreasonable and are seriously jeopardizing their ability to provide quality patient care.

Pennsylvania's Process for Filing Complaints and Grievances Against Commercial Managed Care Organizations Is Difficult, Especially for Individuals With Drug and Alcohol Problems

Act 1998-68 created a process whereby non-emergency complaints and grievances must go through a two-stage process within the managed care organization—an initial review to be completed within 30 days of receiving a complaint or grievance followed by a second-level internal review to be completed within 45 days of receiving the request to reconsider the initial review—before the complaint can be appealed to the Insurance Department. The Department of Health assigns third-level grievances to an independent review organization. The external review can take another 60 days.

While many complaints and grievances get resolved early in the process, advocates cited the lengthy grievance process as one reason why only five formal drug and alcohol grievances had been filed at the state level between January 1999 and September 2002. They also note that drug and alcohol clients are often in denial of their condition and will not dispute, for example, a BHCO decision that inpatient services are not necessary. The number of complaints made to the Attorney General's Health Care Unit—estimated to be approximately 100 annually—also suggests that the low number of complaints and grievances is more indicative of the procedural difficulties in filing complaints than it is to the lack of problems with managed care treatment decisions.

New Approaches Are Emerging to Overcome Some of the Difficulties in the Traditional Managed Care Model

New models of managed care for behavioral health services are evolving to address some of the problems created by the traditional for-profit BHCOs. These models typically involve more stakeholders in decision-making capacities and may include providers assuming some degree of risk. Three such models operate in Pennsylvania. In one model (Community Behavioral Healthcare Network of Pennsylvania), treatment providers are represented on the Board of Directors and have a wide degree of latitude to provide the services they believe appropriate without prior approval in exchange for assuming a degree of risk. CBHNP reports high levels of satisfaction from both consumers and providers, with the cost savings from reduced administrative oversight being redirected to improved care. The other two models take advantage of a HealthChoices provision that allows counties to reinvest savings to address gaps in services, including drug and alcohol services. HealthChoices also includes consumer satisfaction teams, provider satisfaction surveys, and stakeholder advisory committees to enhance involvement in managed care decisions.

Recommendations

We recommend:

1. **The Commonwealth's organizational structure for regulating and administering substance abuse treatment programs should be streamlined and strengthened.** While widespread agreement exists that the Commonwealth's current organizational structure for drug and alcohol programs is inefficient and hinders the development of a strong policy direction, far less agreement exists on how the programs should be restructured. Some advocates believe a cabinet-level agency reporting directly to the Governor is necessary; others believe it more important to improve coordination between substance abuse and mental health services, perhaps by combining them under one office within DPW. A key concern among those who oppose a consolidated mental health/substance abuse office is that mental health, the larger of the two programs, will overshadow substance abuse programming. One association advocates a compromise solution: two separate offices, one for substance abuse and one for mental health, but both within the Department of Public Welfare.

2. **The Department of Insurance should promulgate regulations to reinforce Act 106's provisions.** A recent letter from the Insurance Department's Chief Counsel addresses several key issues pertaining to the authority of a patient's treating physician in authorizing drug and alcohol treatment services. While treatment advocates are cautiously optimistic that this letter may constitute a breakthrough in clients receiving the services mandated by Act 106, regulations would have greater permanence and authority. In developing these regulations, consideration should also be given to establishing a separate process (i.e., separate from the Act 68 process) for resolving Act 106 complaints and grievances and to prohibit managed care firms from denying treatment simply because the insured is under court supervision.

3. **If the Department of Health's upcoming letter does not resolve the confidentiality dilemma, it should revise its regulations to allow greater disclosure flexibility.** In 1975, the Department of Health promulgated regulations that limit the type of information treatment providers can disclose to managed care firms and others. Many advocates believe such restrictions are appropriate given the stigma, and often criminal nature, of substance abuse addictions. As a result, however, providers are placed in the difficult position of having to choose between violating the Department's confidentiality regulations or possibly being denied payment for not providing the medical records the managed care firm believes it needs to determine whether the services are medically necessary. The Department plans to reissue a 1997 letter interpreting the regulations in an attempt to address this problem. If this letter does not resolve the dilemma, we recommend the Department consider new regulations to allow, with patient

consent, greater flexibility in the type of information that can be disclosed to a managed care organization.

4. **If primary responsibility for mental health and substance abuse services remains in separate departments, additional efforts should be made to better coordinate the two programs.** With many substance abuse clients also having a mental health disorder, the two programs need to closely coordinate their efforts. The current process, whereby clients need to enroll and disenroll in the two programs, is inefficient and drains scarce dollars from treatment services. The Departments of Health and Public Welfare have initiated several pilot projects to better integrate these two services. We recommend they use the information learned from these projects to better coordinate services and reduce administrative costs.

5. **The Department of Public Welfare should reduce the 30-day "gap" period for HealthChoices enrollment.** DPW contracts with HealthChoices managed care organizations allow for a 30-day gap between when a person is deemed eligible for Medicaid and when he/she must select a managed care plan and become officially enrolled in a HealthChoices plan. During this period, the Single County Authorities are responsible to provide substance abuse services if needed. While DPW provides some funds for services during this gap period, the funds are not adequate to meet the demand and therefore reduce funds intended for SCA clients. We recommend, and DPW has agreed, that the Department explore ways to reduce, if not eliminate, this gap period.

6. **The Department of Health, together with the Department of Public Welfare, should initiate a task force to guide development of an outcomes-based database.** The Departments have applied for federal discretionary funds to merge service data for the drug and alcohol programs they administer and to collect information on treatment outcomes, but the funds have not yet been approved. However, even if funded, this initiative would not include data from PCCD, DOC, CHIP, or private insurers. Such information is necessary to monitor and evaluate services and to formulate cost-effective policy decisions. The Tennessee Department of Health has contracted with the University of Memphis to evaluate its substance abuse services and outcomes in a program that has become a national model. The Institute of Research, Education and Training in Addiction (IRETA), a federally funded, Pittsburgh-based drug and alcohol policy group, is one of several organizations that could possibly serve a similar function in Pennsylvania. The Pennsylvania Health Care Cost Containment Council, which provided some of the data used in this report, or a university-based organization might also be able to serve this function.

7. **The General Assembly should consider requiring private insurers to report encounter and outcomes data for substance abuse services.** Because substance abuse results in a high demand for a variety of state services, the

Commonwealth has a direct interest in monitoring the availability and efficacy of the treatment services funded by both public and commercial insurers. As recommended in Recommendation 6 above, ideally the Commonwealth would develop a comprehensive database that would be able to track clients and the services they receive as they move between the public and commercial insurance systems. If this is not feasible for private-sector insurers, we recommend the General Assembly consider requiring commercial insurers to provide detailed, aggregated information on the substance abuse services they provide, including at a minimum, the number of clients served in each type of treatment, average duration of treatment, number of complaints received, and the resolution of these complaints.

8. **The Insurance Department should take additional steps to reduce commercial managed care payment delays.** The Insurance Department reports having assessed penalties of over $2.5 million against HMOs for noncompliance with Act 68, including violations of the Act's prompt payment provisions. However, despite these efforts, in FY 2001-02, the Department completed nine market conduct examinations of health maintenance organizations where all nine were cited for prompt payment violations. In one case, the Department attributed most of the responsibility for making late payments to the company's behavioral health subcontractor. This high rate of noncompliance suggests that additional steps beyond the scheduled market conduct reviews are warranted. We also note that HealthChoices has a higher standard for claims payment.

I. Introduction

In response to concerns voiced by legislators and substance abuse treatment advocates, in October 2001 the Legislative Budget and Finance Committee (LB&FC) directed its staff to conduct a study of the impact of managed care on the delivery of drug and alcohol treatment services. Of particular concern was the perceived lack of compliance by behavioral health managed care firms of the benefits mandated by Act 106 of 1989. We began work on this project in the spring of 2002.

Audit Objectives

1. To identify key statutory, regulatory, and program requirements regarding access to drug and alcohol treatment services.
2. To assess the efforts made by the Departments of Health, Insurance, and Public Welfare to ensure compliance with the identified statutory, regulatory, and program requirements.
3. To assess the availability of appropriate drug and alcohol treatment services for individuals in public and private health care plans, including the types (inpatient, intensive outpatient, outpatient) and frequency of services provided.

Methodology

To identify legislative, treatment service provider, and consumer concerns, we attended public hearings held by various legislative committees in Bethlehem, Harrisburg, Hershey, and York. We reviewed state and federal statutes and regulations pertaining to drug and alcohol treatment as well as state and federal proposals to enact or amend legislation that could affect treatment services. We also administered questionnaires to Single County Authorities and interviewed state officials, including legislators and legislative staffers.

To determine type and duration of services being provided by managed care organizations, we met with several BHCOs and collaboratively developed a request for treatment data for the HealthChoices (Medicaid managed care) program from three commercial type behavioral health managed care organizations, the Pennsylvania Employees Benefits Trust, and the Pennsylvania Health Care Cost Containment Council (hospital data only). In addition, the data we obtained from the commercial BHCOs was provided on the condition that the report would not specifically identify what data came from which BHCO, a stipulation to which we agreed. We reviewed the data provided and sought clarifications where necessary, but we did not independently audit the accuracy of the data.

We also reviewed grievance and complaint information filed by clients and providers with the Departments of Health and Insurance and annual reports on internal grievance filings with the managed care entities.

To get a first-hand experience of treatment services and to hear the concerns of providers in the field, we visited and observed treatment facilities, met with providers and advocacy groups individually, and held three provider focus groups. We also meet with representatives from several academic, research, and technical assistance entities.

Acknowledgements

We wish to thank the Secretaries of Health and Public Welfare, the Insurance Commissioner, and the Attorney General and their staffs for the excellent cooperation and assistance afforded us during this audit. Additionally, we would like to acknowledge the assistance provided by the many SCAs, providers and provider organizations, and managed care organizations who worked with us to identify key issues and concerns, and also provided data for this study.

Important Note

This report was developed by Legislative Budget and Finance Committee staff. The release of this report should not be construed as an indication that the Committee or its individual members necessarily concur with the report's findings and recommendations.

Any questions or comments regarding the contents of this report should be directed to Philip R. Durgin, Executive Director, Legislative Budget and Finance Committee, P.O. Box 8737, Harrisburg, Pennsylvania 17105-8737.

II. Findings and Conclusions

A. Several State Agencies Oversee and Fund Drug and Alcohol Treatment Services, Creating Inefficiencies and Hindering Clear Policy Direction

Responsibility for licensing, regulating, and monitoring Pennsylvania's public drug and alcohol treatment system is shared principally between two state agencies: the Department of Health (DOH) and the Department of Public Welfare (DPW). Several other state agencies, particularly the Department of Corrections (DOC), the Pennsylvania Commission on Crime and Delinquency (PCCD), and the Pennsylvania Insurance Department are also involved in funding and overseeing treatment programs and services.

Nearly everyone we spoke to believes that the system needs to be streamlined and restructured to reduce inefficiencies and allow for a clearer policy direction, with some suggesting that a separate cabinet-level agency, reporting directly to the Governor, be created to develop statewide strategies and to oversee the various funding streams.

State Agencies Involved in Drug and Alcohol Treatment Services

As shown in Table 1, four state agencies spent approximately $305 million for publicly funded drug and alcohol treatment related services: DOH ($65 million), DPW ($200 million), DOC ($26 million), and PCCD ($15 million). The Pennsylvania Department of Education, Insurance Department, and Board of Probation and Parole also provide significant funding for drug and alcohol prevention, intervention, and treatment services.

Table 1

Public Drug and Alcohol Treatment Related Funding in Pennsylvania*
($000)

Funds	Administrator	Identified Population	Estimated[a] Annual Expenditures
MA Fee for Service	DPW	Federal Poverty	$ 19,900
MA HealthChoices Managed Care	DPW	Federal Poverty	125,900[b]
SCA State Base	DOH/SCA[c]	General	25,100
SCA Federal[d]	DOH/SCA	General	39,600
Act 35 – BHSI	DPW/SCA	MA Eligible Nonhospital-Based Treatment Per	36,800[e]
Act 152	DPW/SCA	Non-MA eligible State	17,400[f]
PCCD	PCCD/DOC/DOH SCAs	Offenders Offenders	13,500[g]
DOC	DOC	Incarcerated	24,200[h]
CHIP	Insurance	Low Income Families	1,200
Total			$303,600

*These dollars should be viewed as estimates.

[a]Estimates are for recent but different years, depending on the funding stream, and are rounded. They are, for example, FY 2001-02, FY 2002-03 or a similar federal fiscal year.

[b]Excludes approximately $14 million in administrative costs.

[c]SCAs are DOH contracted entities.

[d]Includes SAPT block grant directed toward treatment and adult offender treatment; excludes $5.4 million in administrative costs and $1.1 million in Governor's Discretionary Funds used primarily for prevention and intervention in the Student Assistance Program.

[e]Excludes approximately $2.6 million in administrative costs.

[f]Excludes approximately $800,000 in administrative costs.

[g]Adjusted to exclude estimated PCCD-funded DOC drug and alcohol programming in order to avoid double counting.

[h]Excludes DOC estimated administrative costs of approximately $1.3 million.

Source: Developed by LB&FC staff from agency documents and conversations with agency officials.

PA Department of Health

The Department of Health licenses both publicly and privately funded drug and alcohol treatment services through its Bureau of Community Programs Licensure and Certification, and the Bureau of Drug and Alcohol Programs oversees services administered through Single County Authorities (SCAs). A third bureau, the Bureau of Managed Care, coordinates with the Pennsylvania Insurance Department to issue HMO certificates of authority, certifies utilization review entities, and hears consumer complaints regarding quality of care.

Bureau of Community Programs Licensure and Certification. The Bureau's Division of Drug and Alcohol Program Licensure issues licenses for specific substance abuse treatment services. Facilities may be licensed to provide more than one service. Exhibit 1 summarizes the licenses in force as of December 2001.

The Division conducts annual on-site inspections and issues licensing alerts to highlight deficiencies found most frequently during these inspections. Deficiencies in psychosocial evaluation records (primarily in the completeness of the evaluation notes) were the most frequently cited deficiencies in 1999, occurring at 399 facilities (45 percent). The on-site audits also found problems with the disclosure of confidential information to managed care plans and other third party payers (see Finding II.C).

Exhibit 1

Licensed Drug and Alcohol Treatment Services

Service	Number	Description
Outpatient	532	Counseling or psychotherapeutic services on a regular and predetermined schedule
Inpatient Nonhospital Rehabilitation	176	Residential rehabilitation in a non-hospital facility
Partial Hospitalization	134	Psychiatric, psychological, social, and other therapies on a planned, regular schedule (more intensive than outpatient but not 24-hour inpatient care)
Hospital Detoxification	73	Inpatient care to eliminate the intoxicating substance or dependency factors by metabolic means
Inpatient Nonhospital Detoxification	34	Elimination of the intoxicating substance or dependency factors by metabolic means in a non-hospital facility
Methadone Maintenance	28	Pharmacological treatment of opiate addiction with counseling
Hospital Rehabilitation	14	Residential rehabilitation in a hospital-based program
Intake, Evaluation, and Referral	12	Intake and referral by a facility designated to perform such services for two or more facilities in a SCA
Others	26	Psychiatric detoxification, psychiatric rehabilitation, transitional living, methadone detoxification

Source: Information provided by the Division of Drug and Alcohol Program Licensure, PA Department of Health.

Bureau of Drug and Alcohol Programs (BDAP). Reorganization Plan No. 4 of 1981 officially transferred the powers, functions, and duties of the Governor's Council on Drug and Alcohol Abuse to the Pennsylvania Department of Health, thereby making the Department the lead agency for developing a state plan

to control and prevent drug and alcohol abuse and dependence problems.[1] The plan includes provisions for:

- coordination of effort for all state agencies;
- encouragement of local agencies and coordinating councils;
- development of model control plans and educational materials;
- establishment of training programs and educational courses;
- coordination of research and investigation of drug testing methodology;
- treatment and rehabilitation for adult and juvenile offenders;
- standards for the approval of private and public facilities; and
- evaluation of programs and publication of statistics.

The Bureau of Drug and Alcohol Programs coordinates its efforts primarily through Single County Authorities, which were established in the state plan. SCAs are locally controlled entities established by the counties. They receive federal and state funds through the Bureau and other sources to provide a continuum of drug and alcohol services to individuals without private insurance or who do not quality for Medical Assistance benefits. SCA funding is presented in Table 1 and is further discussed in Finding II.D.

The Residential Rehabilitation for Pregnant Addicted Women and Women with Dependent Children program is also administered by the Bureau of Drug and Alcohol Programs. Act 1993-65 authorizes the Department of Health to establish and fund residential drug and alcohol treatment programs for pregnant women and women with dependent children. Block grant dollars are allocated to the SCAs to implement this program. Programs are designed for women with children and include a variety of training, therapy, and rehabilitation. During FY 1999-2000, there were 15 residential programs with approximately 300 beds for women and over 500 beds for children. Four halfway house programs were in operation, with additional programs for women only.

Bureau of Managed Care. The Bureau of Managed Care coordinates with the Insurance Department to issue HMO certificates of authority. It determines whether the applicant has the potential to assure the availability, accessibility, and quality of health care services provided on a prepaid basis. Managed care plans must file quarterly and annual reports with the Bureau. In 2002, the Bureau undertook an audit of complaints and grievances reported as overturned or upheld at each review level to determine the accuracy of the reports, but the results were not available as of December 2002.

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[1]Initially, the Governor's Council on Drug and Alcohol Abuse was created by the Drug and Alcohol Abuse Control Act to be the lead agency but this was restructed by statute, with all of the Council's duties transferred to DOH by Reorganization Plan No. 4 of 1981. The Council continued to exist as an advisory body to DOH. Conforming changes were made to the act in 1985. As an advisory body, the Council provided advice to the Department of Health regarding drug and alcohol issues, including the state drug and alcohol plan, promulgating regulations, drug and alcohol funding priorities and allocations, and policies regarding data collection and dissemination. The Council went out of existence pursuant to sunset legislation on December 31, 1991.

Managed care plans often contract with specialized entities to manage behavioral health benefits. The Commonwealth does not regulate such entities as managed care plans per se. Although behavioral health organizations must be certified as review entities (CREs) by the Bureau of Managed Care to perform delegated functions, the managed care plans themselves remain ultimately responsible for compliance with the laws and regulations governing such functions.

PA Department of Public Welfare (DPW)

The Department of Public Welfare is involved in the administration and funding of drug and alcohol services primarily for medical assistance-related clients through its Office of Mental Health and Substance Abuse (OMHSAS) and the Office of Medical Assistance Programs.

Office of Mental Health and Substance Abuse Services. OMHSAS oversees the Commonwealth's mental health hospitals, community-based mental health services, Behavioral Health Services, the behavioral health component of the HealthChoices (Medicaid managed care) program, and programs funded through Act 1988-152.

Community Mental Health. Community mental health services are administered by a county or county joinder and are generally provided through contracts with private, nonprofit organizations and agencies. These services are available to low-income persons who are not eligible for Medical Assistance, Pennsylvania's Medicaid program. County community-based mental health services typically do not include substance abuse services. (For non-Medicaid-eligible clients, these services are provided through the SCAs.) The Office of Mental Health and Substance Abuse Services licenses mental health services providers; many are also licensed by the Department of Health to provide drug and alcohol services.

BHSI. Since FY 1996-97, OMHSAS has assumed responsibility for the Behavioral Health Services Initiative created by Act 1996-35. The Behavioral Health Services appropriation is intended to provide funding for both drug and alcohol and mental health services for persons who have lost eligibility for services rendered through Medical Assistance as a result of welfare reform legislation. OMHSAS allocates the portion of these funds dedicated to drug and alcohol services directly to the 49 SCAs.

HealthChoices. In February 1997, DPW initiated the HealthChoices Medicaid managed care initiative for both physical health and behavioral health services. The behavioral health component, which includes substance abuse, was assigned to OMHSAS. As shown in Exhibit 2, HealthChoices was initially implemented in the Southeast, then expanded to the Southwest and the Lehigh/Capital area. DPW expects to implement HealthChoices in the remaining counties by 2006. OMHSAS has the responsibility for contract development, implementation, negotiation, and

monitoring of all HealthChoices behavioral health contracts. A major advantage of the HealthChoices Medicaid waiver initiative in the behavioral health area is that nonhospital inpatient drug and alcohol services, not included under the Medicaid fee-for-service program, are covered services under the waiver.

Exhibit 2

HealthChoices Participating Counties and Implementation Date

Southeastern PA February 1997	Southwestern PA January 1999	Lehigh Valley/Central PA October 2001
Bucks	Allegheny	Adams
Chester	Armstrong	Berks
Delaware	Beaver	Cumberland
Montgomery	Butler	Dauphin
Philadelphia	Fayette	Lancaster
	Greene	Lebanon
	Indiana	Lehigh
	Lawrence	Northampton
	Washington	Perry
	Westmoreland	York

Source: Developed by LB&FC staff using information provided by the Department of Public Welfare.

Act 1988-152. OMHSAS administers funding for the Act 152 drug and alcohol treatment program. Because the intent of Act 152 was to provide state funds for nonhospital inpatient drug and alcohol services for Medicaid clients, which are not eligible for reimbursement under the fee-for-service Medicaid program but are eligible under the HealthChoices waiver, Act 152 funds have been reduced in HealthChoices counties. This funding accompanies the client when the service becomes covered under HealthChoices. Since FY 1997-98, the funds provided under Act 152 have been allocated directly to the 49 SCAs.

Office of Medical Assistance Programs. The Office of Medical Assistance Programs (OMAP) has retained responsibility for drug and alcohol treatment services provided to Medicaid-eligible clients still served under the fee-for-service program. While much smaller than in the pre-HealthChoices years, the fee-for-service program spent approximately $20 million in FY 2001-02 on drug and alcohol treatment services.

EPSDT. As part of its HealthChoices responsibilities, OMAP also oversees the Early and Periodic Screening, Diagnosis and Treatment program that was enacted by Congress in 1967 to provide comprehensive preventive health and treatment services to Medicaid eligible children under age 21. The EPSDT program can be used to provide screening and treatment of alcohol and other drug problems of children and their parents.

Pennsylvania Insurance Department

The Bureau of Company Licensing and Financial Analysis, together with the Department of Health, issues HMO certificates of authority and reviews the rate and form filings of HMOs, Preferred Provider Organizations (PPOs), and commercial and nonprofit insurers. The Bureau of Enforcement focuses on compliance with statutory requirements. The Market Conduct Division in the Bureau of Enforcement examines insurers' records to determine whether their business practices reflect compliance with statutes and regulations intended to protect consumers. The division conducted a series of follow-up examinations in FY 2001-02 to determine HMOs' compliance with prior recommendations and Act 68 provisions. (See Finding II.E for a discussion of the results.)

Children's Health Insurance Program. Families with children ineligible for Medicaid or other health insurance may obtain coverage through the Children's Health Insurance Program (CHIP) if their family income does not exceed the levels established in Act 1998-68. CHIP coverage has included substance abuse treatment at the levels cited in Act 1989-106 since September 1999.

The CHIP enrollment process differs from the centralized HealthChoices system. Insurers with CHIP contracts are responsible for enrolling the eligible members within their respective regions but their membership cards may identify them only as members of a group plan, not as CHIP beneficiaries. CHIP coverage has included substance abuse treatment since September 1999. The coverage, based on Act 1989-106, limits inpatient detoxification to seven days per year and a lifetime maximum of four inpatient admissions. Residential treatment has a 30-days-per-year limit with a maximum of 90 days, and the outpatient limit is 30 full-session visits per year with a maximum of 120 sessions.

Department of Corrections

Drug and alcohol treatment providers also receive significant funding through the Pennsylvania Department of Corrections. The Department reported it released 10,486 inmates in 2001, approximately 70 percent of whom had been identified as having drug or alcohol problems when they entered prison. In FY 2001-02, the Department will spend approximately $25.5 million for drug and alcohol treatment services for inmates. Most of these services are provided by contracted private treatment providers.

Pennsylvania Commission on Crime and Delinquency (PCCD)

PCCD funds substance abuse treatment programs under Act 2000-41, the County Intermediate Punishment Act, which repealed the similarly named Act 1990-193. The act provides for restrictive intermediate punishment (RIP) as an

alternative to incarceration for nonviolent offenders. Funding for drug and alcohol treatment in county RIP programs totaled approximately $14.5 million in FY 2001-02.

Other PCCD-funded programs include:[2]

- The Substance Abuse Violators Effort (SAVE), another alternative to incarceration, places parolees with significant addiction problems in Eagleville Hospital, where they receive intensive substance abuse treatment. They gradually return to regular parole supervision after treatment.
- The Residential Substance Abuse Treatment (RSAT) program is similar to SAVE in that it provides an alternative to long-term recommitment for technical parole violators with substance abuse problems. Phase I consists of six months in a therapeutic community at a state prison. While there, offenders participate in group meetings and receive individual counseling. Phase II is a six-month placement in a community corrections center where offenders attend intensive outpatient treatment. Offenders are then reparoled and have an intensive case-plan to assist them in staying drug and alcohol free and maintaining a crime-free lifestyle. They are placed on an enhanced level of supervision consisting of at least one face-to-face contact with the parole agent per week, along with frequent urinalysis and electronic monitoring, as deemed appropriate.
- Guidelines for the Violent Offender Incarceration/Truth in Sentencing program allow the DOC to use up to 10 percent of a U.S. Department of Justice grant to support drug testing, intervention, and sanctions. The DOC used approximately $1.5 million for outpatient services at four prison-based therapeutic communities and a standardized alcohol and drug curriculum in 2000. Therapeutic communities provide between 6 and 12 months of full-time rehabilitation therapy.
- The State Correctional Institution at Chester opened as a facility dedicated to substance abuse treatment in 1998. Inmates with significant problems may receive one year of intensive therapeutic treatment at Chester as they near the end of their minimum sentences. They receive six months of aftercare as residents of community corrections centers or supervised parolees after release.

Proposals for Administrative Restructuring

While it was not our original intent to assess the organizational structure of the Commonwealth's drug and alcohol programs, we found it difficult to separate the concerns expressed over the impacts of managed care--particularly for providers who treat large numbers of HealthChoices clients--from these broader

[2]Act 2002-198, signed by the Governor on December 9, 2002, creates the Substance Abuse Education and Demand Reduction Fund to be administered by the PCCD. Grants to counties and organizations fighting substance abuse through prevention, intervention, training, treatment, and education services will be available through the Fund. Under the new law, anyone convicted of a drug-related or DUI offense will be assessed a mandatory $100 fee to support the Fund. An additional $200 fine will be imposed if a DUI offender is found to have a blood alcohol content of .15 percent or higher within two hours of arrest.

organizational issues. Examples of problems created or exacerbated by the current organizational structure include:

- administrative burdens on drug and alcohol treatment providers (Finding II.C),
- cost-shifting among private and public payers (Finding II.D),
- inefficiencies created by the need for dual licensure to treat clients with dual diagnoses (Finding II.C);
- problems in sharing confidential information (Finding II.C); and
- lack of consistent data on services and outcomes (Finding II.F).

Various proposals have been advanced for how the Commonwealth's drug and alcohol treatment programs could be streamlined and restructured to improve efficiency and allow for a more unified policy direction. These include:

Pennsylvania Community Providers Association (PCPA)

The PCPA believes that the current administrative structure for mental health and drug and alcohol services has not kept pace with changes in the mental health and drug and alcohol fields, resulting in a dramatic under-funding and under-representation of drug and alcohol services in Pennsylvania as well as a lack of an integrated treatment structure for persons with co-occurring disorders. To address these problems, PCPA recommends that drug and alcohol and mental health programs be equal, independent entities under the same administrative department. These two programs should then be charged to develop a seamless system of service delivery. To do this, PCPA recommends the following changes:

- move the Bureau of Drug and Alcohol Programs from the Department of Health to DPW and elevate it to the Office of Drug and Alcohol Programs;
- move Substance Abuse Services from the OMHSAS to the newly created ODAP;
- move the Division of Drug and Alcohol Licensing from the Department of Health and put it under the new ODAP;
- rename the Office of Mental Health and Substance Abuse Services the Office of Mental Health;
- maintain the mental health licensing functions in DPW;
- have both the Office of Drug and Alcohol Programs and the Office of Mental Health work to develop a seamless system of service delivery for persons with co-occurring disorders; and
- request the Secretary of Public Welfare to organize a special commission to create a long term, comprehensive plan to address drug and alcohol problems across multiple systems.

Drug and Alcohol Service Providers Association of Pennsylvania (DASPOP)

The DASPOP supports the concept of a freestanding council reporting directly to the Governor on issues of drug and alcohol treatment policy. DASPOP

believes that the demotion of the original Governor's Council over the years has diminished effectiveness and authority. DASPOP also notes that funding for alcohol and drug addiction treatment is dispersed among multiple agencies, creating duplicate administration. DASPOP recommends restoring the drug and alcohol council, which would report directly to the Governor. This agency would be responsible to:

- continue to fund consumer organizations for people in recovery and for families with loved ones touched by drug and alcohol disorders;
- ensure the representation of families and people in recovery on advisory councils, boards, and ad hoc committees that consider policy in regard to alcohol and other drug prevention and treatment;
- complete a comprehensive statewide needs assessment and estimate of the prevalence of alcohol and drug addiction and abuse and develop a needs based budgeting plan; and
- streamline and consolidate funding for addiction treatment by moving BHSI, HealthChoices, and Medicaid dollars to the Bureau of Drug and Alcohol Programs and SCAs to administer.

The Pennsylvania Association of County Drug and Alcohol Administrators, Inc. (PACDAA)

PACDAA supports the establishment of a cabinet-level position for substance abuse services to provide a long-term comprehensive state approach with a central point of accountability and authority regarding substance abuse services. This new agency would:

- develop, promote and implement a statewide strategy for substance abuse prevention, intervention, and treatment programs;
- coordinate these programs;
- establish policies and priorities for allocating federal and state funds to support these programs; and
- evaluate existing substance abuse prevention, intervention, and treatment strategies.

B. Commercial Managed Care Has Resulted in Clients Receiving Different and Fewer Drug and Alcohol Treatment Services

Managed care has changed the traditional relationship between health care providers and third-party payers. Indemnity systems had relied on physicians to make medical decisions as to whether patients needed the services, including specialty care, covered by their health insurance plans. Managed care organizations (MCOs) sought to control costs by imposing medical necessity criteria and having primary care physicians act as gatekeepers for services that previously had been directly accessible.

In behavioral health, determining medical necessity is often more difficult than for physical health. Therefore, managed care reviewers and medical directors have greater discretion when making a medical necessity determination, resulting in disagreement and frustration among drug and alcohol treatment providers, clients, and families. This is especially true if the insured (the patient) self-refers to a BHCO for treatment. Act 1989-106 has further complicated the matter because of the lack of an authoritative application of its benefit provisions. A November 2002 letter from the Insurance Department's Chief Counsel has, however, directly addressed this issue.

Behavioral Health Care Organizations

The development of managed care for behavioral health services, which includes both mental health and substance abuse services, has paralleled the growth of managed care for physical health. Of the estimated 250 million Americans with health insurance, approximately 164.1 million (66 percent) are enrolled in some type of managed behavioral health program. This represents a 148 percent increase over 1993, when approximately 66.3 million Americans were enrolled in some type of managed behavioral health program.[1] Substance abuse treatment represents a small fraction of the total spending for personal health care nationwide (1.3 percent in 1996). Although inpatient treatment can be costly, substance abuse treatment also accounts for only a small proportion of total spending on behavioral health care (16 percent in 1996).

The vast majority of behavioral health services for people with private insurance are administered through carve-out arrangements. Carve-out administrators are behavioral health care organizations (BHCOs) typically hired by an insurer to manage specialized mental health and substance abuse treatment for enrollees independently from physical health care. The carve-out format is attractive to the

[1] *Open Minds,* October 31, 2002.

insurer in that it entails the potential advantage of offering more highly specialized treatment and personnel than if the care was managed directly by the MCO. A potential disadvantage of such an arrangement is that BHCOs do not stand to benefit from the medical savings that can accrue from prompt, appropriate mental health or substance abuse services. Critics note that this lack of financial incentives can lead to BHCOs promoting less costly short-term approaches over ones that could effect a more beneficial long-term outcome.

Magellan Behavioral Health Services is the nation's largest BHCO, with 30 percent of market share. The top three vendors--Magellan, Value Options, and United Behavioral Health--represent slightly over 50 percent of the market. Nationally, ten companies control approximately 75 percent of the market.

In Pennsylvania, the Department of Health (DOH) had certified ten BHCOs to perform utilization reviews for managed care plans as of February 2002.[2] Approximately 5.6 million Pennsylvanians were enrolled in managed care plans as of June 2002 and had their behavioral health benefits managed as follows:

- 55.5 percent by Magellan Behavioral Health Services;
- 24.6 percent by other behavioral health subcontractors;
- 19.4 percent through the Department of Public Welfare (DPW) HealthChoices carve-out; and
- 0.5 percent directly by their managed care plans.

Utilization Review and Medical Necessity

Utilization review, the process used by MCOs and BHCOs to authorize services, is key to the concept of managed care. Pennsylvania's Act 68 defines utilization review as "a system of prospective, concurrent or retrospective utilization review performed by a utilization review entity of the medical necessity and appropriateness of health care services prescribed, provided or proposed to be provided to an enrollee." Exhibit 3 shows the timeliness standards for each category of review.

[2]Pennsylvania does not certify BHCOs per se. It certifies them as utilization review entities under Act 68.

Exhibit 3

Act 68 Timeliness Standards for Utilization Review

Review	Definition	Timeliness Standard
Prospective	Review to approve or deny payment occurs before service is rendered.	Notification of decision within 2 business days of receiving the necessary information.
Concurrent	Review to approve or deny payment occurs during course of treatment or hospital stay.	Notification of decision within 1 business day of receiving the necessary information.
Retrospective	Review to approve or deny payment occurs after service has been rendered.	Notification of decision within 30 business days of receiving the necessary information.

Source: Compiled by LB&FC staff from Act 1998-68.

Act 68 requires that the Department of Health certify all entities conducting utilization reviews, including BHCOs. Neither Act 68 nor department regulations defines the term "medical necessity."[3] The MCOs develop their own definition of medical necessity. DOH regulations, however, do require a managed care plan to use the same definition of medical necessity throughout its "provider contracts, enrollee contracts, and other materials used to evaluate appropriateness and to determine coverage." A managed care plan thus has broad latitude in adopting and maintaining a definition, as long as it is used consistently. (This does not apply to HealthChoices managed care organizations, which are required by the Department of Public Welfare to use standardized drug and alcohol medical necessity criteria.)

This latitude has allowed MCOs and BHCOs to shift the focus of medical necessity away from established clinical practice standards and onto studies showing the benefits of specific procedures for general populations.[4] Thus, it is increasingly common in Pennsylvania and across the nation for services to be based on level of care placement criteria, standardized treatment planning methods, and evidence-based treatments. MCOs and BHCOs contend that such systems help ensure that only appropriate and necessary care is delivered and that it is delivered in the least restrictive settings and by qualified professionals.

Because treatment plans are more standardized under this approach, the provider's knowledge of a patient's individual circumstances becomes less relevant.

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[3]By contrast, for example, Act 1990-6, which created a peer review system to evaluate automobile insurance claims involving health care services provided to injured persons, relies on the health care provider to make the determination. It defines "necessary medical treatment and rehabilitative services" as those determined necessary by a licensed health care provider unless they have been determined unnecessary by a state-approved Peer Review Organization. Also, the 2002 RFP for the Children's Health Insurance Program (CHIP) calls for medical necessity determinations to be "appropriate and consistent with the diagnosis and in accordance with generally accepted standards of medical practice."

[4]Sara Rosenbaum, David M. Frankford, Brad Moore, and Phyllis Borzi, "Who Should Determine When Health Care Is Medically Necessary?" *The New England Journal of Medicine*, Vol. 340(3), Jan. 21, 1999, pp. 229-232.

Such changes have raised concerns about the adequacy of the clinical and policy research to support them. [5]

The Impact of Commercial Managed Care on Type and Duration of Treatment

Although we were unable to find data to document conclusively the impact of managed care on lengths of stay and services provided, the data and studies we reviewed indicate that over the past ten years clients receiving inpatient treatment through commercial managed care have much shorter lengths of stay and that treatment programs rely more heavily on group-based outpatient counseling than inpatient treatment. Managed care organizations acknowledge the reduced lengths of stay, particularly for residential treatment, but believe that the longer lengths of stay prior to managed care were largely the result of fee-for-service reimbursement systems that would pay for inpatient care until benefits were exhausted, rather than any assessment of what the patient needed or best practices.

National Studies

Annual surveys conducted by the National Association of Psychiatric Health Systems found the average length of stay for alcohol and drug abuse patients in psychiatric hospitals decreased from 14 days in 1993 to 7.7 days in 1996. Although using apparently different methodologies over time, data reported by Mutual of Omaha shows a similar trend: their average length of stay for substance abuse only patients in inpatient treatment declined from 19.0 days in 1990 to 11.0 days in 1995 and 8.9 days in 2001.

A 1998 *Journal of Mental Health Policy and Economics* article reported that the switch from unmanaged indemnity care to managed carve-out care for drug and alcohol and mental health patients was followed by a 75 percent drop in inpatient days and a 40 percent drop in outpatient visits per 1,000 members, despite an increase in minimum benefit levels. Another published study found a dramatic shift in the category of service being provided as management of care shifted from HMOs to the carve-out. The use of inpatient services per 1,000 members decreased from 10.6 in the first year, 1995, following the change to the carve-out and continued to decrease to 2.25 in the second year, 1996. Outpatient service utilization followed a similar pattern, decreasing from 45.7 under the HMO to 15.7 in the first carve-out year and 12.1 in the second.

An unpublished 1998 study conducted by the Hay Group for the American Society of Addiction Medicine appears to confirm these trends. The Hay report found that, while the value of general health benefit expenditures declined by 11.5

[5]Appendix A includes various scientifically based approaches to drug addiction treatment as published by the National Institute on Drug Abuse.

percent between 1988 and 1998, substance abuse benefit values declined by 74.5 percent. According to the report, the single most important factor responsible for driving down plan values is that the types of plans offered have substantially changed. In 1987, 92 percent of employers reported fee-for-service plans as the most prevalent plan type. By 1998, various forms of managed care plans were most prevalent, with PPOs (34 percent) being most common followed by HMOs (24 percent), point of service plans (22 percent) and fee-for-service (20 percent). This study suggests that, while managed care plans are somewhat less generous in providing general health benefits, they are much less generous in providing substance abuse benefits.

Pennsylvania-Specific Data

Pennsylvania's experience appears to mirror the national trends. Although statewide longitudinal data is not available, one major Pennsylvania provider of drug and alcohol services provided us with data on its experience since 1992. The data shows that the average length of stay for inpatient nonhospital rehabilitation fell from 15.4 days in 1992 to 6.2 days in 2001, a 60 percent decrease. Average treatment duration also fell for partial hospitalization (from 15.3 days in 1992 to 7.8 days in 2001) and intensive outpatient (from 17.0 sessions in 1992 to 9.9 sessions in 2001). Appendix B shows the number of cases and range of stays for various treatments in 1992 and 2001.

The data also shows a dramatic increase in clients receiving intensive outpatient treatment, from 99 cases in 1992 to 701 in 2001. According to the provider, the emphasis on partial hospitalization and intensive outpatient services was a direct result of the behavioral health plan's emphasis on the need to develop alternatives to inpatient care.

Tables 2 and 3 present service and treatment duration data we collected from several behavioral health firms operating in Pennsylvania serving both public and private clients.[6] Aggregated HealthChoices data from the southeast and southwest and SCA data are also presented.

Comparisons between firms are difficult and must be viewed with caution because the data is not collected or reported uniformly across behavioral health plans. Additionally, although we reviewed the data and sought clarifications where necessary, we did not independently audit the data.[7] Nevertheless, the data do allow some general observations:

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[6]The data we obtained from the commercial BHCOs was provided on the condition that we would not specifically identify what data came from which BHCO, a condition we agreed to.

[7]See Appendix C for further information on our data collection techniques and data constraints.

Table 2

Incidence of Inpatient/Residential Drug and Alcohol Services*

Hospital Based Inpatient Detox	Covered Lives		Members In-Service		Penetration Rate		Average Length of Stay (Days)	
	2000	2001	2000	2001	2000	2001	2000	2001
Public:								
HealthChoices – Southeast/Southwest	910,687	759,838	886	875	0.10%	0.12 %	4.2	4.5
BHCO-A[a, b]	--	128,656	--	280	--	0.22	--	4.6
BHCO-B[a, c]	--	--	--	82	--	0.25	--	3.4
SCA[d]	NA	NA	2,023	2,226	NA	NA	4.5	4.1
Private:								
BHCO-X[a]	(See Nonhospital Detox)							
BHCO-Y[a, b]	--	6,321,139	--	878	--	0.01	--	3.9
PEBTF[e]	(See All Services Below)							

Hospital Based Inpatient Rehab	Covered Lives		Members In-Service		Penetration Rate		Average Length of Stay (Days)	
	2000	2001	2000	2001	2000	2001	2000	2001
Public:								
HealthChoices – Southeast/Southwest	910,687	759,838	232	192	0.03%	0.03%	9.7	11.5
BHCO-A[a, b]	--	128,656	--	13	--	0.01	--	8.0
BHCO-B[a, c]	--	--	--	40	--	0.12	--	13.5
SCA[d]	NA	NA	1,064	1,184	NA	NA	14.8	16.7
Private:								
BHCO-X[a]	(See Nonhospital Rehab)							
BHCO-Y[a, b]	--	6,321,139	--	740	--	0.01	--	5.0
PEBTF[e]	(See All Services Below)							

Nonhospital Detox	Covered Lives		Members In-Service		Penetration Rate		Average Length of Stay (Days)	
	2000	2001	2000	2001	2000	2001	2000	2001
Public:								
HealthChoices – Southeast/Southwest	(See Nonhospital Rehabilitation)							
BHCO-A[a, b]	--	128,656	--	625	--	0.49%	--	4.3
BHCO-B[a, c]	--	--	--	170	--	0.51	--	3.3
SCA[d]	NA	NA	6,573	8,562	NA	NA	4.6	4.5
Private:								
BHCO-X[a, f]	NA	NA	NA	NA	NA	NA	5.1	5.4
BHCO-Y[a, b]	--	6,321,139	--	502	--	0.01	--	6.8
BHCO-Z[a]	(See Nonhospital Rehab)							
PEBTF[e]	(See All Services Below)							

*Important Note: Please note that the data presented in this table has been provided by the identified source and has not been independently verified by LB&FC staff. The various notes in the table have been developed by LB&FC staff through analysis and conversation with source data persons. Penetration rates and "average lengths of stay" for HealthChoices were calculated by LB&FC staff in consultation with DPW.

Table 2 (Continued)

Nonhospital Rehab	Covered Lives 2000	Covered Lives 2001	Members In-Service 2000	Members In-Service 2001	Penetration Rate 2000	Penetration Rate 2001	Average Length of Stay (Days) 2000	Average Length of Stay (Days) 2001
Public:								
HealthChoices – Southeast/Southwest[g]	910,687	759,838	9,623	10,437	1.06%	1.37%	39.2	39.0
BHCO-A[a, b]	--	128,656	--	1,293	--	1.01	--	25.2
BHCO-B[a, c]	--	--	--	209	--	.63	--	26.0
SCA[d]	NA	NA	14,716	15,873	NA	NA	31.5	31.5
Private:								
BHCO-X[a, b]	NA	NA	NA	NA	NA	NA	7.2	8.4
BHCO-Y[a, b]	--	6,321,139	--	4,230	---	0.07	--	7.3
BHCO-Z[a, h]				252				8.7[i]
PEBTF[e]	(See All Services Below)							

Halfway House	Covered Lives 2000	Covered Lives 2001	Members In-Service 2000	Members In-Service 2001	Penetration Rate 2000	Penetration Rate 2001	Average Length of Stay (Days) 2000	Average Length of Stay (Days) 2001
Public:								
HealthChoices – Southeast/Southwest	(See Nonhospital Rehab)							
BHCO-A[a, b]	--	128,656	--	334	--	0.26%	--	64.1
BHCO-B[a, c]	--	--	--	101	--	.31	--	36.5
SCA[d]	NA	NA	175	194	NA	NA	60.2	57.8
Private:								
BHCO-X[a]	NA	NA	NA	NA	NA	NA	NA	NA
BHCO-Y[a, b, j]	--	6,321,139	--	2	--	0.0	--	9.0
PEBTF[e]	(See All Services Below)							

All Services	Covered Lives 2000	Covered Lives 2001	Members In-Service 2000	Members In-Service 2001	Penetration Rate 2000	Penetration Rate 2001	Average Length of Stay (Days) 2000	Average Length of Stay (Days) 2001
PEBTF	285,445	287,330	176	201	.06%	.07%	--	--

[a]Behavioral Health Organization which functions with its contracted insurer as a managed care organization.

[b]Data based on authorizations, not actual claims.

[c]Data is annualized from October 2001 – September 2002.

[d]SCA data is by fiscal year.

[e]Pennsylvania Employees Benefit Trust Fund reported information based on managed care model. Although PEBTF serves public commonwealth employees, it functions as a private entity and uses a managed care approach to its behavioral health benefits.

[f]These average length-of-stay numbers represent at least 90 percent nonhospital services. The remainder could be hospital-based.

[g]These numbers include HealthChoices nonhospital rehab, nonhospital detox, and halfway house. DPW's data system does not separate them. Philadelphia County is included in this data and is 42.2 and 41.3 days for 2000 and 2001 respectively.

[h]August 2001 – July 2002.

[i]Includes both inpatient detox and rehabilitation from August 2001 – July 2002 and may include some hospital based services.

[j]For BHCO-Y, this category is called "supported housing."

Source: Derived from information reported by state agencies and selected behavioral health organizations.

Table 3

Incidence of Outpatient Drug and Alcohol Services*

Partial Hospitalization	Covered Lives		Members Who Received Service		Penetration Rate		Average Units of Service[a]	
	2000	2001	2000	2001	2000	2001	2000	2001
Public:								
HealthChoices – Southeast/Southwest[b]	--	--	--	--	--	--	--	--
BHCO-A[c]	--	128,656	--	245	--	0.19%	--	25.4
BHCO-B[c, d]	--	--	--	24	--	0.07	--	44.3
SCA[e]	NA	NA	2,819	3,142	NA	NA	43.0	45.3
Private:								
BHCO-X[c]	NA	NA	NA	NA	NA	NA	NA	NA
BHCO-Y[c]	--	6,321,139	--	4,358	--	0.07	--	10.5
BHCO-Z[c, f]				229				6.5
PEBTF[g]	(See All Services Below)							

Intensive Outpatient	Covered Lives		Members Who Received Service		Penetration Rate		Average Units of Service[a]	
	2000	2001	2000	2001	2000	2001	2000	2001
Public:								
HealthChoices – Southeast/Southwest[h]	910,687	759,838	15,991	17,389	1.76%	2.29%	45.6	63.4
BHCO-A[c]	--	128,656	--	332	--	0.26	--	16.0
BHCO-B[c, d]	--	--	--	94	--	0.28	--	59.2
SCA[e, h]	NA	NA	21,142	22,836	NA	NA	85.3	82.0
Private:								
BHCO-X[c]	NA	NA	NA	NA	NA	NA	11.0	11.1
BHCO-Y[c]	--	6,321,139	--	2,023	--	0.03	--	12.0
PEBTF[g]	(See All Services Below)							

Outpatient	Covered Lives		Members Who Received Service		Penetration Rate		Average Units of Service[a]	
	2000	2001	2000	2001	2000	2001	2000	2001
Public:								
HealthChoices – Southeast/Southwest	(See Intensive Outpatient Above)							
BHCO-A[c]	--	128,656	--	2,304	--	1.79%	--	42.4
BHCO-B[c, d]	--	--	--	1,098	--	3.32	--	10.6
SCA[e]	(See Intensive Outpatient Above)							
Private:[i]								
BHCO-X[c]	NA	NA	NA	NA	NA	NA	4.9	5.5[j]
BHCO-Y[c]	--	6,321,139	--	3,013	--	0.05	--	35.2
PEBTF[g]	(See All Services Below)							

Table 3 (Continued)

All Services	Covered Lives		Members Who Received-Service		Penetration Rate		Average Units of Service	
	2000	2001	2000	2001	2000	2001	2000	2001
PEBTF	285,445	287,330	176	201	.06%	.07%	--	--

*Important Note: Please note that the data has been provided by the identified source and not independently verified by LB&FC staff. The various notes in the table have been developed by LB&FC staff through analysis and conversation with source data persons.

[a]A unit of partial hospitalization is typically four hours at least four times per week; a unit of intensive outpatient is typically two to three hours several times per week in a group setting; a unit of outpatient is typically an hour per week and is generally on an individual basis.

[b]HealthChoices partial hospitalization data is included in another category of DPW's data system and is not included here.

[c]Behavioral Health Organization which functions with its contracted insurer as a managed care entity.

[d]Data is annualized from October 2001 – September 2002.

[e]SCA data is by fiscal year.

[f]August 2001 – July 2002.

[g]Pennsylvania Employees Benefit Trust Fund reported information based on managed care model. Although PEBTF serves public commonwealth employees, it functions as a private entity and uses a managed care approach to its behavioral health benefits.

[h]The data for HealthChoices and SCA outpatient is included under Intensive Outpatient. Both DPW's and DOH's data systems do not separate them.

[i]BHCO-Z is not included here because for the BHCOs outpatient services, each practitioner is tabulated separately preventing aggregated units of service data.

[j]The BHCO reports that outpatient is typically delivered one session (hour) per week. It classifies more hours of treatment per week as Intensive Outpatient.

Source: Derived from information reported by state agencies and selected behavioral health organizations.

- Penetration rates--the percent of covered lives receiving a service--are much higher for HealthChoices clients for all services (except hospital-based inpatient rehabilitation) than for clients of private insurance. Substance abuse is a particularly prevalent problem among the poor, and penetration rates can be expected to be higher for Medical Assistance clients than the general population.
- Average lengths of stay are reasonably similar for inpatient detoxification for public and private payers, but public programs allow much longer lengths of stay for both hospital and nonhospital inpatient rehabilitation. Average lengths of stay for nonhospital rehabilitation exceeded 25 days in all the public programs for which we had data. In contrast, the average length of stay for nonhospital rehabilitation for the three behavioral health firms under contract with private insurers were all less than 9 days. Several factors may account for the longer lengths of stay in public programs:
  - To some extent, the longer lengths of stay for clients in public programs may be due to their being more severely affected and to the difficulty in finding an appropriate home to which the client can be released. Clients with private insurance are more likely to have jobs, families, and homes and therefore can be more readily placed in an outpatient program.
  - HealthChoices providers and the Single County Authorities must use the Pennsylvania Client Placement Criteria when evaluating and placing a client. The PCPC identify specific criteria to supplement the American Society of Addiction Medicine (ASAM) criteria typically used by BHCOs under contract with private sector MCOs. The PCPC also include specific criteria for when to discharge a patient, whereas the ASAM criteria allow greater discretion because they provide only general guidelines. (See Appendix D.)
  - Public programs are held accountable for the services they provide through oversight by the counties and by the Department of Health (for SCAs) and the Department of Public Welfare (for HealthChoices and the fee-for-service program). However, state-level oversight of BHCOs under contract with commercial managed care organizations is limited to case-by-case reviews of complaints and grievances by the Department of Health and the Insurance Department. As described in Finding II.C, the Insurance Department also conducts market studies, but these studies review business practices rather than medical necessity or treatment decisions.
  - To some extent, the difference in average length of stay may also be due to legitimate differences in interpretation of the effectiveness of various treatment modalities. Although most research has found that duration in treatment is positively correlated with improved outcomes,

it is less clear that the intensity of treatment is a factor. In short, it appears important that the client remain involved in some form of a treatment program, ideally for a several-months period, but that does not necessarily mean that a multi-week stay in an inpatient treatment facility is the most cost effective approach. This issue is discussed further in Finding II.F.

- Public sector programs provide many more outpatient sessions than do the BHCOs under contract with commercial insurers. For example, the HealthChoices program (Southeast and Southwest) had an average of 63.4 units of intensive outpatient treatment per client in 2001, compared to 11.1 and 12.0 units of service for the two BHCOs under contract with private MCOs. Again, the differences can be attributed to differences in the severity of the client's problems, Pennsylvania Client Placement Criteria (PCPC) versus ASAM criteria, and the nature of oversight exercised by the organization holding the contract with the BHCO.

Hospital Inpatient Data

Table 4 summarizes CY 2001 hospital inpatient data from a special report prepared for us by the Pennsylvania Health Care Cost Containment Council (HC4) on substance abuse treatment. It shows that hospital inpatient lengths of stay are 5.5 days for DRG 435 and 14.8 days on average for the relatively few who receive inpatient rehabilitation therapy. (See Appendix E for a statement regarding the use of HC4 data.)

Table 4

CY 2001 Hospital Admissions for Drug and Alcohol Abuse or Dependence

	Diagnosis-Related Group	Number of Admissions	Percent of Total	Average Length of Stay (Days)
DRG 435	Detox or other symptomatic treatment without complications or comorbidities	13,153	53.7%	5.5
DRG-434	Detox or other symptomatic treatment with complications or comorbidities	5,657	23.1	4.7
DRG 433	Patient left against medical advice	3,692	15.1	2.9
DRG 436	Rehabilitation therapy	995	4.1	14.8
DRG-437	Combined detox and rehab therapy	977	4.0	15.6
	Totals	24,474	100.0%	5.7

Source: Pennsylvania Health Care Cost Containment Council.

The HC4 also provided admissions data by payer categories: Medicaid, Medicare, and commercial. Table 5 shows the average lengths of stay for the commercial subcategories and the Medicaid subcategories combining the data for

the five diagnosis-related groups. The table also shows comparative figures for CY 2000 inpatient chemical dependency services as reported by the New York State Department of Health. Overall, it shows that private commercial average lengths of stay were less than for Medicaid, albeit only slightly for managed care in Pennsylvania.

Table 5

Inpatient (Hospital) Average Lengths of Stay (in Days)
(Combined DRGS)

Payer	Drug & Alcohol Abuse in Pennsylvania, CY 2001	Chemical Dependency in New York, CY 2000
Commercial		
Fee for service	4.3	5.2
Managed care plans	5.2	5.7
Others[a]	4.2	[b]
Medicaid		
Fee for service	7.6	6.6
Managed care plans	5.5	7.1

[a]Primarily third party administrators and risk-assuming BHCOs.
[b]Not reported.

Source: Pennsylvania Health Care Cost Containment Council and *A Report on Managed Care Performance*, Office of Managed Care, New York State Department of Health, March 2002.

The HC4 report also contained information on readmissions by the same commercial payer for drug and alcohol diagnoses. As Table 6 shows, by March 2002, there were 26 readmissions with either a primary or secondary substance abuse diagnosis per 100 patients treated in FY 2000-01.

Table 6

Readmission Rates for FY 2000-01 Commercially-Insured Inpatients

Category of Diagnosis	Readmissions per 100 Inpatients (cumulative)		
	3 Months	6 Months	9 Months
Alcohol or drug use and alcohol or drug-induced organic mental disorders	8.8	13.5	16.8
Mental diseases and disorders with any secondary diagnosis or procedure codes relating to drug and alcohol addiction treatment services	5.2	7.3	9.1
Total Readmissions	14.0	20.8	25.9

Source: Pennsylvania Health Care Cost Containment Council.

Interpretation and Enforcement of Act 106 Requirements

Act 1989-106, 40 P.S. §908-1 et seq., requires specific coverage of drug and alcohol treatment services in certain group insurance policies or contracts.[8] Mandated coverage for alcohol abuse treatment services was originally provided for by Act 1986-64, which was amended in 1989 by Act 106 to extend coverage to include drug abuse within the mandate. For the different services, the act provides as follows:

> *Inpatient Detoxification Treatment.* There is no required minimum, and inpatient detoxification treatment may be subject to a lifetime limit of four admissions of seven days each (or the equivalent).
>
> *NonHospital Residential Drug and Alcohol Treatment Services.* Act 106 states that the treatment under this section "shall be covered for a minimum of thirty (30) days per year" and may be subject to a lifetime limit of ninety (90) days.
>
> *Outpatient Alcohol or Other Drug Services.* Treatment "shall be covered . . . for a minimum of 30 outpatient, full-session visits per year" or in the alternative coverage may be for "equivalent partial visits per year." There may be a lifetime limit of 120 full-session visits or the equivalent partial visits.
>
> *Outpatient Treatment Exchanged for Inpatient.* The act allows for outpatient or partial hospitalization sessions to be exchanged on a two-to-one basis to secure up to 15 additional residential treatment days.

The act requires that for nonhospital residential and outpatient services to be covered, the insured must be referred by a physician or licensed psychologist.

Interpretation

Based upon the data shown above, it is clear that the average lengths of stay for inpatient rehabilitation for the three BHCOs under contract with private MCOs (all less than nine days) do not begin to approach the minimum coverage provisions (30 days) set forth in Act 106. When asked about these differences, a major BHCO stated that Act 106 does not require that insurers authorize full coverage limits for each client. The BHCO contends Act 106 allows it to determine the appropriate type of service and duration based upon its determination of medical necessity and in conjunction with American Society of Addiction Medicine placement criteria.[9]

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[8]The requirements of Act 106 do not apply to Medicare or Medicaid supplemental contracts or limited coverage accident and sickness policies. Additionally, under the federal Employee Retirement Income Security Act of 1974, employers are allowed to self-insure many of the benefits they offer employees. These ERISA benefits under self-insured plans are only subject to federal law.

[9]When Act 106 was being considered, the Insurance Commissioner commented that the bill did not require a determination of medical necessity, raising the question of creating entitlement to the maximum length of treatment, rather than for the period of medical necessity. The Pennsylvania Health Care Cost Containment Council recommended language be added to the bill that medical necessity be a requirement for use of any Act 106 benefits. However, no change was made to the language of the bill to address this issue.

The BHCO also reported it feels obligated to safeguard a portion of a member's annual benefit in case additional care is needed within a given benefit year.

Because Act 106 provides for a minimum coverage of 30 days for residential treatment, advocates believe the average lengths of stay should be longer than the 7-9 days currently provided by commercial BHCOs. Since the actual intensity and frequency of treatment is not specified by Act 106, it is left to be determined on a case-by-case basis by a physician or licensed psychologist. Therefore, the important issue in the discussions is who determines the necessary intensity and frequency of the treatment.

Act 106 states that before a person can receive benefits required by the act,[10] "a licensed physician or licensed psychologist must certify the insured as a person suffering from alcohol or other drug abuse or dependency and refer the insured for the appropriate treatment." Some interpret this to mean that the treating physician or psychologist is to do the certifying and referral to a specific level and duration of treatment, while others believe that any doctor or psychologist can make the determination as to whether the individual is suffering from substance abuse or dependency and refer him/her for appropriate treatment, including an off-site physician or psychologist employed by the BHCO.

Both the Pennsylvania Office of Attorney General and the Pennsylvania District Attorneys' Association have taken the position that the certifying physician or psychologist is to be the treating physician or psychologist. The District Attorneys' representative stated it is implicit that the physician or psychologist certifying the patient would have to have seen the patient, so there is no need for a reference in the act to "treating" physician.

Managed care representatives, on the other hand, hold that "a" physician or psychologist means "any" physician or psychologist, including the BHCO's physician or psychologist, and that the physician or psychologist does not have to see the patient to be able to certify whether or not the person is suffering from substance abuse or dependency and to refer him/her for appropriate treatment.

Although Act 106 does not specify which doctor is to be the certifying physician, this issue is addressed in a letter (see Appendix F) dated November 21, 2002, by the Chief Counsel for the Insurance Department. In the letter, the Chief Counsel interprets Act 106 to allow the managed care physician to determine whether care should be provided, the appropriate level of care, and the appropriate length of stay, "provided that a knowledgeable treating physician does not make a recommendation that an otherwise denied treatment or service should be covered based upon compliance with appropriate clinical criteria." The letter goes on to state that "should a treating physician contest the medical [managed care physician's]

[10]This requirement applies only to nonhospital residential and outpatient alcohol or other drug services.

decision . . . the treating physician's certification that the clinical criteria have been complied with should control as long as all other legitimate coverage requirements (i.e., other than medical necessity) have been met by the patient/insured."[11] Although the letter appears clear, it will take time to determine what effect, if any, it has on BHCO treatment decisions.

Additionally, we note that under Pennsylvania's Statutory Construction Act, statutes are to "be liberally construed to effect their objects and to promote justice,"[12] and case law generally supports construction of insurance statutes in favor of coverage. [13] Accordingly, we believe any lack of clarity as to how Act 106's mandated coverage applies would likely be resolved by the courts in favor of providing coverage.

Enforcement

Given the controversy over the requirements of Act 106, we reviewed the statutory authority to enforce Act 106 given to the Insurance Department, the Department of Health, and the Attorney General's Office. We then asked each agency to provide us with their interpretation of the Act's requirements and what steps they have taken or could take to better enforce the law.

Act 106 grants no specific enforcement responsibilities to the Departments of Insurance or Health or the Office of Attorney General. Act 106 does, however, grant authority to the Insurance Commissioner and the Secretary of Health to "jointly promulgate those rules and regulations as are deemed necessary for the effective implementation and operation" of the act. The Insurance Department promulgated regulations in 1988 to implement the predecessor to Act 106. These regulations did not address the "treating vs. certifying" issue currently in debate and were not modified after 1989 to reflect the new provisions of Act 106.

The Department of Insurance is established and charged to enforce all Pennsylvania insurance laws, including Act 106. The Insurance Department licenses and oversees the insurance industry and can revoke a company's certificate to do business in the state if it concludes that a company is violating insurance laws. Pennsylvania's Unfair Insurance Practices Act also allows the Insurance Department to investigate unfair or deceptive insurance practices.

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[11]The Chief Counsel concludes that "Act 106 requires only 'a licensed physician or licensed psychologist' to certify the need for such care, a requirement which is met by certification by a treating physician. A health insurer or managed care plan cannot, under Act 106, require that their medical director or the medical director of a carve-out contractor be the only one empowered to made [sic] such a certification."

[12]1 Pa. C.S.A. §1928(c)

[13]The Pennsylvania Superior Court has held that "in close or doubtful insurance cases, the court should resolve the meaning of insurance policy provisions or the legislative intent [of insurance statutes] in favor of coverage for the insured." Danko v. Erie Insurance Exchange, 428 Pa.Super. 223, 630 A.2d 1219 (1993).

For its part, the Department of Health approves HMO provider contracts and grievance resolution systems and can penalize HMOs for inadequate care and contract violations. The Department of Insurance monitors advertising misrepresentations. A representative of the Department also noted that they have a role in standardizing and approving assessment and placement tools for the industry, but they have only been asked to do this in one situation some years ago. Finally, the Office of Attorney General has the ability to act against unfair trade practices under Pennsylvania's Unfair Trade Practices and Consumer Protection Law.

Both the Department of Health and the Insurance Department told us they investigate and respond to the formal complaints and grievances they receive and that this information is used to assist in gauging compliance. The Insurance Department also noted that it uses proactive measures, such as market conduct exams and market surveillance reviews, to enforce the insurance laws. As addressed in Finding II.E, the Department of Health reported receiving only five grievances pertaining to drug and alcohol services since 1999. In two of those grievances, the independent review entities assigned by the Department of Health ruled in favor of the client. A third grievance was decided in favor of the managed care firm, and decisions are pending in the remaining two cases. The Insurance Department reported that as of January 1, 2003, it had received five complaints related to drug and alcohol treatment services that fall under the Insurance Department's Act 68 jurisdiction. However, no complaints have been filed with the Insurance Department specifically regarding Act 106 coverage.

To respond to general concerns about unfair health care practices, in February 2000, the Office of Attorney General established a Health Care Unit that now receives about 2,000 calls annually, approximately 5 percent of which pertain to drug and alcohol services. The unit assists consumers in mediating resolutions to situations involving health care insurance, but does not have authority under an insured's policy or Act 68 to file a complaint or grievance on the consumer's behalf. The Deputy Attorney General in charge of the Health Care Unit said that, if they believed a managed care organization or subcontractor was engaged in a pattern of violations, they could initiate an investigation and, possibly, litigate the case. The Attorney General's Office does not, however, comment on such investigations or mediations unless they result in a legal action. To date, the Attorney General has not filed any such legal suits.

Our review of Pennsylvania case law found no cases pertaining to the substance abuse benefits mandated by Act 106, and hence, no judicial interpretation of the act has been made. The Counsel to the Insurance Department indicated that, until a body of case law is developed, the extent to which the rights and responsibilities outlined in Act 106 can be enforced will remain uncertain.

C. Managed Care Imposes Additional Requirements on Treatment Providers Who Are Already Struggling Under a Burdensome System

Many of the drug and alcohol treatment providers we spoke to during this study reported they are struggling to meet the demands of a variety of federal, state, county, and private organizations. These include federal and state licensing, regulatory, and confidentiality requirements; county and SCA contracting requirements; and managed care utilization review and billing procedures. While all acknowledge the inevitability of such administrative requirements, many providers believe the burden has become truly unreasonable and is seriously jeopardizing their ability to provide quality patient care.

While we were not able to address all of the concerns raised by the provider community,[1] listed below are several of the more significant administrative and policy issues brought to our attention. While not all of these issues pertain directly to managed care, they do impact the ability of providers to deliver efficient and effective treatment services. Many of these issues are also of concern to insurers and public program administrators.

Clients With Both Substance Abuse and Mental Health Issues

From one-third to over one-half of clients with drug and alcohol problems also have a mental health diagnosis, known as a dual diagnosis or co-occurring disorder.[2] One HealthChoices (Medicaid) provider told us that in their program as many as 70 percent of clients have such a dual diagnosis. However, despite the prevalence of co-occurring disorders, barriers exist between the two treatment systems--substance abuse and mental health--that create inefficiencies and can negatively affect patient care.

National

In 1997, the National Dialogue on Co-occurring Mental Health and Substance Abuse Disorders reported that up to 10 million people in the country have co-occurring mental health and substance-related disorders in any given year.

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[1]In particular, we did not attempt to address the myriad of specific programmatic issues—such as the Department of Health's regulations on the types of drugs that can be used to treat heroin addiction—that were beyond the scope of this study.

[2]The terms "dual diagnosis," "dual disorder," or "co-occurring disorder" refer to the coexistence of a mental health disorder and alcohol or other drug problems. Common examples include the combinations of major depression with cocaine addiction, alcohol addiction with panic disorder, alcoholism and polydrug addiction with schizophrenia, and borderline personality disorder with episodic polydrug abuse. Studies show that patients with mental disorders have an increased risk of drug and alcohol disorders and patients with drug and alcohol disorders have an increased risk for mental disorders.

While no definitive data exists, national estimates are that between one-third and one-half of persons with substance abuse problems have a co-occurring mental health disorder.

Obtaining professional help for persons with dual disorders can be difficult, especially given the problems resulting from their disorders, such as frustration, denial, or depression. The 1997 National Dialogue reported a number of structural barriers to providing effective treatment for dually diagnosed persons, including that substance abuse, mental health, and primary care systems often work independently of each other. Each system has its own treatment philosophies, administrative structures, and funding mechanisms. Each system also typically maintains its own service data, and the licensing and certification mechanisms reflect different training and experience requirements.

Pennsylvania

As in many states, Pennsylvania's mental health and substance abuse services are largely bifurcated, with the Department of Public Welfare overseeing mental health treatment providers and the Department of Health being the lead agency for licensing and regulating providers of substance abuse treatment services.

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) states that such a bifurcated system can result in mislabeling, rejecting, failing to recognize or automatically transferring patients with dual disorders. This, in turn, can result in inadequate treatment or patients simply falling between the cracks. The symptoms of disorders often fluctuate in intensity and frequency, with the client's current symptoms reflecting only a short-term change in the course of the overall disorders. The American Society for Addiction Medicine (ASAM) also reports that, historically, without coordinated services, either the psychiatric or the addictive disorder was assumed to be "primary" or "underlying," and the co-occurring disorder was expected to subside when the primary disorder was successfully treated. However, if one disorder was treated without treating the other, the patient often failed to respond to treatment or relapsed.

Department of Public Welfare. DPW licenses and regulates mental health service providers and administers state laws pertaining to the care, prevention, early recognition and treatment of mental illness. Chapter 20 of the Public Welfare Code sets forth licensing or approval requirements with which a mental health treatment facility must comply, including an annual inspection and fee. Subpart D of Chapter 20 describes the requirements for operating psychiatric outpatient clinics, partial hospitalization facilities, mental health intensive case management, and private psychiatric hospitals. The regulations define the application and re-view process; program standards; staffing patterns, qualifications, and supervision;

treatment policies and procedures; records to be maintained; and quality assurance standards.

Department of Health. DOH licenses and regulates substance abuse service providers and is the lead agency charged to coordinate substance abuse services throughout the Commonwealth. DOH is also responsible for the development of a State Plan for control, prevention, intervention, treatment, rehabilitation, research, education, and training aspects of drug and alcohol abuse and dependence problems. Chapters 701-711 of the Health and Safety Code describe regulations for drug and alcohol treatment services, including staffing qualifications and requirements, facilities standards, and licensing procedures. There are detailed standards for freestanding treatment activities; intake, evaluation and referral; residential treatment and rehabilitation; short-term detoxification; partial hospitalization; and outpatient activities. A facility providing integrated treatment service for a dually diagnosed patient must comply with both sets of regulations and licensing requirements.

Efforts to Improve Coordination. SAMHSA supports the development, delivery, and evaluation of integrated service models for treating people with severe co-occurring disorders. Likewise, ASAM recommends that physicians and other health professionals carefully evaluate for co-occurring disorders and incorporate attention to all disorders in formulating a treatment plan. Moreover, ASAM recommends that if staff expertise is not adequate dual diagnosis patients should be referred to appropriate services or the treatment setting should develop cooperative treatment arrangements with other treatment facilities.

In 1997, DPW's Office of Mental Health and Substance Abuse Services and the Department of Health's Bureau of Drug and Alcohol Programs jointly sponsored a statewide Mental Illness and Substance Abuse (MISA) Consortium to examine integrated approaches to working with dually-diagnosed persons. Based on the Consortium's recommendations, OMHSAS and BDAP sought county interest in establishing MISA pilot projects. The objectives of the MISA Pilot Program are:

1. To identify, develop, and implement effective and efficient methods of engagement, assessment, and treatment models for persons with co-occurring substance abuse and mental illness disorders.
2. To create meaningful partnerships, particularly between public mental health and substance abuse systems, for the purpose of establishing more effective and efficient community-based treatment.
3. To identify and evaluate key program and partnership elements in successful programs so that these efforts can be replicated.
4. To incorporate the information gained through the project to enable the provision of integrated services throughout the state.

The pilot projects are being evaluated to determine the impact of integrated treatment and systems of care on client outcomes; the impact on client satisfaction; the potential of specialized MISA integrated treatment and support services; best practice models of system integration representing a variety of strategies for adult and adolescent services that can be replicated.

In August 2001, the state awarded the counties of Beaver, Berks, Blair, Mercer, and Washington seed money to develop the MISA pilot projects. The projects are to demonstrate the potential of specialized mental health and substance abuse integrated treatment and support services as a cost-effective alternative to traditional services and to create best practice models of treatment systems integration. The counties are expected to design model programs that coordinate mental health and drug and alcohol treatment for individuals with co-occurring disorders. The projects will receive funding from both mental health and drug and alcohol for two years with an additional year for evaluation. As of January 2003, the projects were in the second of two years approved for the pilot. As of February 2003, both DOH and DPW officials had recommended continuation of the project through the end of 2004, depending on funding availability. Project goals for each county are set forth below:

- *Washington County* – to have a dually licensed continuum of care at several facilities and proposes to increase the number of places where MISA screening is done, and provide mobile MISA screening, assessment, crisis services, and intensive case management. The county will establish a MISA Oversight Committee, task force, halfway house, and therapeutic community housing.
- *Blair County* – to integrate care from several treatment facilities and develop a central point of contact to "welcome" consumers into treatment. The county will designate a MISA project coordinator, policy and assessment teams, and a triage/outreach counselor. The county will also provide intensive case management.
- *Beaver County* – to have Gateway Rehabilitation Center provide integrated treatment for county criminal justice clients. The county will designate a forensic case manager, require MISA training for its provider network and focus on community support services.
- *Mercer County* – to provide a MISA mobile assessment team, create a MISA interagency subcommittee, create three new positions for MISA case managers, and designate a MISA coordinator. The county plans to integrate service from three treatment facilities within the county.
- *Berks County* – to convene a workgroup to include families and other stakeholders to plan and implement the MISA project for adolescents. The county will add a MISA coordinator and case manager positions; train intake staff and providers beyond core requirements; and add integrated intensive outpatient to complete the continuum of integrated treatment.

Confidentiality Constraints

Pennsylvania's drug and alcohol confidentiality regulations are much stricter than federal requirements and have created problems between substance abuse treatment providers and mental health providers and behavioral health care organizations (BHCOs) regarding how much client identifying information can and should be shared. As a result, substance abuse providers are placed in the difficult position of possibly being cited by the Department of Health for violating confidentiality restrictions or risking the BHCO denying services by claiming they have received insufficient information to justify the need for treatment.

Some advocates believe strict confidentiality provisions are necessary because of the stigma attached to substance abuse and because admitting a substance abuse problem can be a tacit admission of criminal behavior. Several treatment providers we spoke to also believe BHCOs seek confidential information with the real goal of finding a reason to deny or limit treatment. BHCOs, however, claim insufficient information is released under the state regulations to allow for complete evaluations of a patient's condition in making clinical assessments for appropriate treatment authorization.

State Statutory and Regulatory Provisions

PA Drug and Alcohol Abuse Act. The Pennsylvania Drug and Alcohol Abuse Control Act, 71 P.S. §1690.101 et seq., requires that all patient records remain confidential, subject to the following exceptions:

- disclosure may occur with the patient's consent, but only to medical personnel exclusively for purposes of diagnosis and treatment of the patient, or
- to government or other officials exclusively for the purpose of obtaining benefits due the patient as a result of his drug or alcohol abuse or drug or alcohol dependence (except emergency medical situations).

The act also provides that a complete medical, social, occupational, and family history must be obtained as part of the diagnosis, classification, and treatment of a patient pursuant to this act. Copies of all pertinent records from other agencies, practitioners, institutions, and medical facilities must be obtained in order to develop a complete and permanent confidential personal history for purposes of the patient's treatment.

Department of Health regulations (4 Pa. Code §255.5) further clarify the information that can be released on persons receiving drug and alcohol treatment services. Section 255.5 restricts the information that can be released (upon client consent) to an insurance company or health or hospital plan to the following five items:

- Whether the client is or is not in treatment.
- The prognosis of the client.
- The nature of the project.
- A brief description of the progress of the client.
- A short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse.

In 1997, it was brought to the attention of the Department's Division of Drug and Alcohol Program Licensing that its licensing inspectors were identifying treatment facilities that were violating confidentiality regulations in annual field reviews. The providers complained, noting that at the second level appeal of a denial, managed care organizations often require the patient's full charts and/or medical records to continue the process. If the substance abuse provider does not supply this information, services could be denied or the BHCO could later refuse to pay for the services provided.[3]

In an attempt to remedy this situation, in July 1997, the Department's Deputy Secretary for Quality Assurance issued a letter of interpretation stating as follows:

> *Whether the Client Is or Is Not in Treatment* – Information may be released as to how long the client has been in treatment; how long the client is expected to stay in treatment; and the attendance patterns of the client.
>
> *Client's Prognosis* – Information may be released as to the client's prognosis/ diagnosis; how treatment will or will not benefit the client; and whether the client should continue with the project.
>
> *Nature of the Project* – Information may be released as to the purpose and philosophy of the project; program structure, methodology of treatment and the treatment models that are utilized by the project; and services that are being offered to an individual client.
>
> *Brief Description of the Client's Progress* – Information may be released as to the client's denial or lack of denial and client's progress in coming to terms with his/her addiction; the client's cooperation or lack of cooperation with treatment plan and the facility's rules.
>
> *Short Statement as to Whether the Client Has Relapsed Into Drug or Alcohol Abuse and the Frequency of Such Relapse* – Information may be released that provides a short statement as to whether the client has relapsed into drug or alcohol abuse and the frequency of such relapse; and results of urine tests.

[3]We were also told that confidentiality requirements are routinely compromised in some drug courts. One provider indicated they maintain separate files on disclosed confidential information that can be removed when representatives of the Department of Health review the files.

As discussed below, however, this letter has done little to resolve the problem, in part because the language in Act 1998-68 would appear to permit broader disclosures.

Act 68. Act 1998-68 provides that a managed care plan shall adopt and maintain procedures to ensure that all identifiable information regarding enrollee health, diagnosis, and treatment is adequately protected and remains confidential in compliance with all applicable federal and state laws and regulations and professional ethical standards. The act goes on to provide, however, that nothing in the confidentiality section is to prevent disclosure by the MCO of the information "necessary to determine coverage, review complaints or grievances, conduct utilization review or facilitate payment of a claim."

Discussion. Magellan Behavioral Health, through its counsel, has sought clarification from thee Department of Health as to the interpretation and applicability of regulation at §255.5 in light of the newer provisions of Act 68. Magellan's position is that the restrictions of §255.5 prevent them from obtaining sufficient information to comply with the newer requirements of Act 68, such as (1) making determinations of "medical necessity," (2) being able to timely address complaints and grievances, (3) undertaking quality improvements, and (4) report on their activities to the Department. Magellan concludes that §255.5 is superceded either by Act 68 or, at a minimum, is no longer workable in light of the managed care structure of health care and actually impedes the organized management of care. No response to the Magellan request for clarification had been issued by the Department as of December 2002.[4] The Department began meeting with stakeholder groups in 2002 to work on issues relating to §255.5 and anticipates issuing a new letter of interpretation in 2003.

In addition to the conflicts created between substance abuse providers and BHCOs, the confidentiality requirements make integrated care more difficult to provide for the dually diagnosed. For example, a Philadelphia facility reported that it may use two providers to treat the same clients for mental illness and substance abuse, but communication between the different providers is, at least technically, a violation of the confidentiality restrictions. One suggested solution was to exempt clients with certain co-morbidities from the confidentiality restrictions.

One group of utilization review coordinators we spoke with stated they generally comply with 4 Pa. Code §255.5(b) when they release patient information to BHCOs. They make only the five approved items available for utilization review but share complete information with other health care treatment providers. Utilization reviewers may, however, look at the patient's charts on site. Other providers

[4]We met jointly with DPW and DOH in mid-2002. They were continuing their discussions as of December 2002, but they had not completed their plans to address this matter.

indicated that they need to disclose confidential information before the BHCO will decide on medical necessity and approve treatment.[5]

Federal Provisions

With certain exceptions, federal confidentiality laws and regulations prohibit disclosure of information about patients who have applied for or received any alcohol or drug abuse-related services. Federally regulated or assisted drug and alcohol functions must maintain the confidentiality of all records of identity, diagnosis, prognosis, or treatment of any patient.[6] Disclosure[7] may be made as follows:

- with prior written client consent for purposes set forth in regulation; and
- without client consent to (1) medical personnel for a bona fide medical emergency; (2) qualified personnel for scientific research, management audits, financial audits, or program evaluations, as long as individual information is not disclosed; and (3) based on court orders.

The federal requirements do not preempt state laws or regulations. Therefore, a more restrictive state requirement regarding confidentiality will take precedence over a less restrictive federal requirement.[8]

Federal HIPAA Regulations

In August 2002, the U.S. Department of Health and Human Services issued the first-ever comprehensive federal regulation that gives patients extensive privacy protections for their medical records. The HIPAA privacy rule applies to health plans, health care clearinghouses, and those health care providers who conduct certain financial and administrative transactions electronically. Under the new regulation (effective on April 14, 2003), patients are guaranteed access to their medical records and are given more control over how their health information is used and

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[5]DOH reported, however, that it has not issued citations for failure to comply with confidentiality regulations.
[6]A "patient" is any individual who has applied for or been given diagnosis or treatment for alcohol or drug abuse at a federally assisted program and includes any individual who, after arrest on a criminal charge, is identified as an alcohol or drug abuser in order to determine eligibility to participate in a program. A "diagnosis" includes any reference to an individual's alcohol or drug abuse or a condition caused by that abuse made for treatment or referral. "Treatment" includes management and care of a patient suffering from alcohol or drug abuse, a condition caused by that abuse, or both to reduce or eliminate adverse effects upon that patient.
[7]A "disclosure" refers to a communication of patient identifying information, the affirmative verification of another person's communication of patient identifying information, or communication of any information from the record of a patient who has been identified. "Patient Identifying Information" means name, address, social security number, fingerprints, photograph, or similar information by which the identity of a patient can be determined with reasonable accuracy and speed either directly or by reference to other publicly available information. It does not include a number assigned to a patient by a program.
[8]Federal regulations do permit exceptions for certain audit and evaluation activities or entities conducting audits on behalf of a state governmental agency that either provides financial assistance to the program or is authorized by law to regulate the program's activities.

disclosed, with recourse if their medical record privacy is violated. The rule provides that:

- patients must give specific authorization before covered health care entities could make non-routine use or disclosure of protected information;
- covered health care entities must give notice to patients of privacy practices and patients' rights;
- covered entities must get patient authorization before sending them marketing materials;
- covered entities cannot use business associate agreements to circumvent the rule's marketing prohibitions; and
- patients can generally access and request corrections to their medical records.

Covered entities, including most, if not all, substance abuse treatment providers, must comply with the new privacy regulations by April 14, 2003. However, federal regulations stipulate that if a state has imposed more rigorous requirements, the state requirements take precedence. Thus, Pennsylvania's state confidentiality requirements are stricter than HIPAA.

Preapprovals and Continuing Stay Reviews

As a strategy to hold down costs and to exert control over the level and amount of care provided to their members, managed care firms often require that providers obtain authorization, or preapproval, before starting treatment services and then require further continuing stay reviews before authorizing additional days of service. This approach has also been adopted by most, but not all, of the behavioral health organizations operating in Pennsylvania.

We were not able to obtain information on how frequently commercial behavioral health firms operating in Pennsylvania denied care to a substance abuser who was entitled to benefits or authorized a lower level or fewer days of care than may be necessary.[9] We did, however, hear from many providers of the time they spend on telephone calls and other types of correspondence with commercial behavioral health firms attempting to obtain authorization for services and meeting other managed care service requirements. Concerns included difficulty in getting through to a BHCO benefit manager, particularly on weekends; inability to obtain authorization for treatment more than a day or two in advance of the first treatment session; authorizing inpatient treatment in only one- or two-day increments; requiring patients to fail in outpatient treatment as a prerequisite for admission to inpatient treatment,[10] and requiring that face-to-face family sessions be held within 72 hours of admission, even if the clinician believes such a session might be counterproductive. Providers note that such barriers are particularly harmful when

[9]The information we obtained on level of care and duration of service can be found in Finding II.B.
[10]The practice of "treatment failure" by managed care organizations has been documented, and criticized, by the American Society of Addiction Medicine.

detoxification treatment is needed, where delays can result in the patient going into withdraw and leaving the facility to resume alcohol or drug use.

Multiple Onsite Reviews

One of the issues that also concerns providers is the amount of time they must spend preparing for and participating in the many review and monitoring activities of various managed care organizations and licensing and accrediting bodies. Providers are subject to licensure review by the Department of Health and, if also a mental health provider, the Department of Public Welfare. Additionally, SCAs, managed care insurers, both public and private, and accreditation agencies typically require some sort of onsite review of patient and facility records. Exhibit 4 summarizes these reviews.

The Department of Health conducts annual on-site licensure reviews of all drug and alcohol treatment providers. These reviews typically involve one evaluator and vary from one day for a standard outpatient facility of moderate size up to a week for a large residential facility. For problem facilities (those with questionable incidents or one under a provisional license), a team of two performs the evaluation. The reviewers evaluate each type of treatment service according to standards for each. Unlike mental health, only one license is issued, regardless of how many services a facility offers. However, if an organization has multiple facilities, each must be reviewed for its own license. A written report is done for each review citing the deficiencies found and the actions that need to be taken. A provider has 15 days to respond to deficiencies and develop a plan of correction.

Many drug and alcohol providers are also licensed by the Division of Program Standards and Licensing within the Department of Public Welfare to provide mental health services. This licensing process also involves an annual on-site inspection. These reviews typically involve a team of one to six evaluators and take from one to three days. The size of the review team depends on the size of the facility and how many licenses it has; each mental health service is licensed separately. The reviewers inspect a facility's records; complete a survey form, designed to ensure that the facility is abiding by regulations; and conduct an exit interview. A survey report is prepared for each review, which includes comments that can recognize areas of excellence at the facility; suggestions, which are optional; and recommendations, which the facility must act on to address a deficiency. Mental health providers are also subject to the possibility of unannounced on-site inspections in addition to the annual visit.

Exhibit 4

Drug and Alcohol Provider Requirements and Reviews by Outside Entities

Department of Health Licensing – Licensed Treatment Services

- Annual site review by one reviewer, lasting from two days for a standard outpatient facility of moderate size to a week for a large residential facility.
- Reviews of facilities with prior problems, or a complex facility might have two reviewers.
- Review according to standards for each type of service.
- Review based on standards for each type of service, e.g. staffing, physical plant, records, policies/procedures.

SCAs (Single County Authorities)

- Site visits twice yearly.
- Record reviews at each visit with follow-up as needed.
- Review for clinical appropriateness, billing accuracy, accurate client liability, policies/procedures, staff credentials.

JCAHO (Joint Commission on Accreditation of Healthcare Organizations)

- Conducts surveys on a three-year cycle.
- Accreditation based on JCAHO standards.
- Length of survey and number of surveyors depends on the types and volume of services provided.
- Site visits include discussions with the director/manager of the facility, conversations with staff, tour of the facility, review of case records and conversations with consumers and/or families as appropriate.

Magellan

- Site visits of high volume providers.
- Check on primary data sources (e.g., the national practitioner data bank) of all providers where possible to verify the accuracy of the information that is presented.
- Site visits typically a combination of reviewing treatment records and verifying basic safety and contract compliance (e.g., having the patient's rights and responsibilities posted).
- Site visits are done between each credentialing cycle, three years for most contracts.

UBH (United Behavioral Health)

- Site visits to high volume providers or those providers not accredited by JCAHO.
- Typically one reviewer for one day, possibly two.
- Site visits typically include record reviews; contract compliance, policy, and procedure reviews; and clinical and treatment plan reviews.

CBH (Community Behavioral Health)

- Site visits to all providers, who can be credentialed for six, 12, or 24 months
- Number of reviewers and length of review depends on the size of the facility.
- Considers its criteria to be more stringent than other managed care entities.
- Is considering accepting JCAHO accreditation in lieu of site-visits.

Exhibit 4 (Continued)

CCBHO (Community Care Behavioral Health Organization)

- Site visits only if provider is not accredited by JCAHO, CARF, or COA.
- Site visits to non-accredited providers are less stringent than licensure visits and average one person in the facility for several hours. Visit is based on an approximately 37-38 item checklist.
- Concerned with how provider records are kept and their format, the physical facility, as well as policies and procedures; examine sample records.
- Facilities credentialed every three years.

CBHNP (Community Behavioral HealthCare Network)

- Site visits if the provider is not accredited by JCAHO, CARF, or COA. Otherwise, CBHNP might do a site visit to find out more about a particular organization.
- Typically one to three people perform site visit, depending on the size of the facility.
- Recredential every two years.
- Concerned with space, licensing, confidentiality, accessibility, policies, and procedures. Record reviews are not done, but they do look at the type of paperwork that providers complete.

Additionally, if also a mental health provider,[a] the following applies:

Department of Pubic Welfare – Mental Health Licensure

- A provider would only receive a site visit and review from DPW if it also offered mental health services as well and drug and alcohol treatment.
- A typical visit lasts one day, possibly two, with the number of reviewers depending on the size of the facility. A team of five to six might visit a particularly large facility for three days.
- Four main areas: treatment planning, grievance procedures, confidentiality, and commitment procedures
- Each service a facility offers must be licensed separately.
- Also subject to possible unannounced on-site inspections.
- Certain programs require letters of agreement with the county program.

[a]If solely a mental health provider, various other reviews are also applicable.

Source: Developed by LB&FC staff.

SCA personnel also frequently conduct site reviews twice per year although the Department of Health requires only one site visit per year. They go to provider sites to examine such areas as contract compliance, clinical appropriateness, accuracy of billing, correct applicability of client liability, policies and procedures, and staff credentials. Some counties review credentials only for assessors, for which they have developed a special credential, relying on the licensure review for all other staffing requirements. One SCA performs an annual focused review by examining a specific issue, for example, billing, children's services, or PCPC compliance.

Additionally, drug and alcohol treatment providers that serve Medicaid HealthChoices clients are subject to annual inspections by the HealthChoices behavioral health organizations. Although most times, BHCOs that cover both public and private clients have only one such inspection, Community Behavioral Health (CBH) in Philadelphia is an exception. Philadelphia providers are therefore subject to an additional visit from CBH, which acknowledges that its credentialing procedures are more rigorous than most.

BHCOs that have commercial contracts also conduct site reviews. One BHCO informed us that they conduct site visits of their high volume providers as part of its three year credentialing cycle. Site visits typically include a combination of reviewing treatment records and verifying basic safety and contract compliance. This organization checks primary data sources, e.g., the national practitioner data bank, of all providers where possible to verify the accuracy of the information presented by providers. Another BHCO informed us that they also conduct site visits of their high volume providers. It also reviews providers that are not accredited by the JCAHO. These reviews typically involve one reviewer for one or two days.

Drug and alcohol providers may also be accredited by one or more national accreditation agencies, such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). JCAHO conducts site visits on a three-year cycle to assess compliance with applicable standards through staff interviews, on-site observation, and document reviews. The Center for Accreditation of Rehabilitation Facilities (CARF) conducts on-site inspections of drug and alcohol providers that also are licensed as hospitals or specialty rehabilitation facilities every one to three years.

Aside from the time and resources required to respond to the requests of these review teams, providers expressed frustration at the attention focused on the "paperwork"—whether all required forms are included in the patient records and whether those forms have been fully completed—and how little attention is focused on the quality of care being delivered to patients. Providers also noted inconsistencies in the standards used by the various review teams; for example, some BHCOs will accept JCAHO accreditation in lieu of a site visit; at least one BHCO's requirements are more stringent than the licensure reviews performed by the Department of Health. Several providers indicated that they have begun to accept the fact that they will never be able to comply with all the various requirements and are willing

to accept being cited for administrative deficiencies as long as it does not jeopardize their licensure status.

Claim Denials and Payment Delays

Behavioral health care organizations also conduct retrospective reviews. They can deny claims if during these reviews they conclude the services were not medically necessary even though they had been authorized, which puts providers at an enhanced financial risk. Providers note that the managed care organizations often fail to explain why the ASAM (American Society of Addiction Medicine) criteria were not met or they ignore clinical data that would indicate the care was appropriate. We were also informed that claims can be denied because there was no face-to-face family session within 72 hours of admission or, as discussed above, because the provider refused to send in the patient's full medical records.

Providers also identified payment delays of commercial behavioral health care organizations as a concern during a focus group meeting held with LB&FC staff. Act 1998-68 requires insurers and managed care plans to pay health care providers' clean claims for services within 45 days of receiving them.[11] Failure to pay clean claims and interest on overdue claims were the most frequently cited non-compliance violations under Act 68 in FY 2001-02. The Insurance Department completed nine market conduct examinations of health maintenance organizations for compliance with Act 68, and all nine were cited for failing to make timely payments. Eight also failed to pay the required interest. In one case, the Department attributed most of the responsibility for making late payments to the company's behavioral health subcontractor, who, as a subcontractor, was not subject to the Department's authority to issue citations or penalties. The Department reported that in such instances, it issues penalties and restitution assessments upon the managed care plans, as the licensed entity over which the Department has jurisdiction.

The Insurance Department also noted that it has committed substantial resources to the overall enforcement of Act 68, including compliance with Act 68's prompt payment provisions. Specifically, the Department reported it has examined all HMOs currently operating in the Commonwealth twice. To date, these exams have resulted in the assessment of penalties of over $2.5 million against non-compliers and have obtained over $1.6 million of restitution for health care providers. A major focus of these reviews has been examination of claims payment data for prompt payment violations.

[11] A clean claim has "no defect or impropriety," such as a lack of supporting documentation or other circumstance preventing timely payment.

D. Cost Shifting Is Prevalent for Substance Abuse Treatment Services

Table 7 shows the public funding streams available for drug and alcohol treatment services in Pennsylvania. The cost of treatment services, however, represents only a small portion of the total cost of substance abuse. A January 2001 report by the National Center on Addiction and Substance Abuse (NCASA) estimated that states spent about $81.3 billion to deal, either directly or indirectly, with substance abuse and addiction, or 13.1 percent of total state spending. These costs include $30.7 billion for criminal justice, $16.5 billion to address problems related to substance abuse in the education system, $15.2 billion in health-related costs, $7.7 billion for child and family assistance services and $5.9 billion in mental health and developmentally disabled services.

Table 7

Service Types and Responsible Administrator for Public D&A Treatment Related Funding in Pennsylvania*

Funds	Source	Administrator	Identified Population	Estimated[a] Annual Expenditures ($000)
MA Fee for Service....	Federal/State	DPW	Federal Poverty	$ 19,900
MA HealthChoices .... Managed Care	Federal/State	DPW	Federal Poverty	125,900[b]
SCA State Base.....	State	DOH/SCA[c]	General	25,100
SCA Block Grant[d].....	Federal	DOH/SCA	General	39,600
Act 35 – BHSI	State	DPW/SCA	MA Eligible Nonhospital-Based Treatment Per Non MA eligible	36,800[e]
Act 152.....	State	DPW/SCA	State	17,400[f]
PCCD.....	State/Federal	PCCD/DOC/DOH	Offenders	13,500[g]
	Federal	SCAs	Offenders	
DOC.....	State	DOC	Incarcerated	24,200[h]
CHIP	Federal/State	Insurance	Low Income Families	1,200
Total				**$303,600**

*These dollars should be viewed as estimates.

[a]Estimates are for recent but different years, depending on the funding stream and are rounded. They are, for example, FY 2001-02, FY 2002-03 or a similar federal fiscal year.

[b]Exudes approximately $14 million in administrative costs.

[c]SCAs are DOH contracted entities.

[d]Includes SAPT block grant directed toward treatment and adult offender treatment; excludes $5.4 million in administrative costs and $1.1 million in Governor's Discretionary Funds used primarily for prevention and intervention in the Student Assistance Program.

[e]Excludes approximately $2.6 million in administrative costs.

[f]Excludes approximately $800,000 in administrative costs.

[g]Adjusted to exclude estimated PCCD-funded DOC drug and alcohol programming to avoid double counting.

[h]Excludes DOC estimated administrative costs of approximately $1.3 million.

Source: Developed by LB&FC staff from agency documents and conversations with agency officials.

The report estimated that, in Pennsylvania, total spending linked to substance abuse was $3.5 billion, or 14.5 percent of the state budget in 1998. The NCASA considers these estimates conservative in that they did not include federal or local spending or the private costs that resulted from lost productivity or premature death. The report noted that only 4 cents of every dollar was spent on substance abuse and addiction prevention and treatment programs.

Cost Shifting From Private to Public Payers and From One Public Payer to Another

In addition to such macro-level cost shifting, we also found that significant cost shifting is occurring among payers within the drug and alcohol treatment system. While no specific data is available to quantify the extent of such cost shifting, the comments we received indicate that cost shifting occurs at several levels:

- *From Managed Care Organizations to Substance Abuse Providers.* Several substance abuse treatment providers told us that they provide "scholarship" care to clients who are denied treatment by behavioral health care organizations (BHCOs) or whose authorized treatment plans are inadequate. However, these funds are limited and are intended for clients who are destitute, not the insured. One provider representative estimated that as many as 5 to 10 percent of clients receive such scholarship care. Others, however, reported they simply do not have the resources to provide scholarships. As discussed in Finding II.C, BHCOs can also shift costs to providers by retroactive denials--denying payment for claims even when services were preauthorized.

- *From Private Managed Care to Single County Authorities (SCAs).* A more indirect form of cost shifting occurs if an insured individual loses his or her job (reportedly sometimes as a result of inadequate treatment services) and then turns to the publicly funded SCA system. The SCAs do not maintain data on the extent to which this occurs, but report that it is an ongoing issue. Also, when BHCOs deny treatment or provide only very limited treatment services, clients may seek services through their county's publicly funded SCAs. However, several SCA directors we spoke to stated that, while in the past SCAs frequently provided services for people who had been denied treatment by their managed care plan, this practice has been curtailed in recent years.

- *From Medicaid to SCAs.* Under the Medicaid HealthChoices program, a period of time (approximately 30 days) elapses between an applicant being declared eligible for Medicaid and when he or she is actually enrolled in the HealthChoices program. During this period, which is often when clients require intense services, drug and alcohol services are paid for through the Single County Authority, not HealthChoices. The SCAs receive funds from the Department of Public Welfare through Act 152 and

the Behavioral Health Services Initiative[1] to provide services during this "gap" period, but often these funds are insufficient. When the SCA runs out of Act 152 and BHSI funds, they must either suspend inpatient treatment services or use other funds to support these HealthChoices-eligible clients. This, of course, reduces the funds available to non-HealthChoices-eligible clients.

The 30-day lag time is due to the original design of the HealthChoices program. The 30 days is to ensure that consumers have enough time to both select an HMO for physical health and to meet with an enrollment specialist. DPW recognizes that the lag time is a problem for behavioral health services and is exploring ways to reduce or eliminate the gap period.

- *From Private and Public Payers to the Criminal Justice System.* The criminal justice system is, in effect, the substance abuse treatment provider of last resort. Department of Corrections (DOC) officials estimate that approximately 78 percent of their inmates have a drug or alcohol problem. Last year, DOC reported 16,100 inmates in treatment systemwide.

  We were told that some parents who are frustrated over lack of treatment options have resorted to having their children arrested to take advantage of court-ordered treatment programs. BHCOs, however, may refuse to pay for court-ordered substance abuse treatment, including through newly established Drug Courts, if they believe that such treatment is not medically necessary.[2] Such persons are then treated using the various public funds available to the SCAs.

  To address this and other problems in Minnesota, in 2001 the Minnesota Attorney General entered into a settlement agreement with Blue Cross and Blue Shield of Minnesota (BCBSM) which, among other provisions, requires BCBSM to pay for court-ordered benefits if the order is based on an evaluation by a physician, licensed psychologist, licensed alcohol and drug dependency counselor, or a certified chemical dependency assessor.[3]

- *From Private and Public Substance Abuse Programs to Other Human Service Programs.* Substance abuse clients are also often clients of county mental health or county children, youth, and family programs. As counties are

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[1]Although the BHSI funds may be used, SCAs must ensure that there is enough for the population targeted by these funds. See discussion later in this finding regarding resultant shortages in Act 152 and other funds.
[2]HB 2808 (2001-02 legislative session) would prohibit this practice.
[3]Other provisions included that the BCBSM must: (1) ensure sufficient number of appropriate providers for treatment within a medically appropriate period of time (not more than 10 days); (2) upon a denial for medical necessity, BCBSM must inform patient what treatment will be paid for; (3) ensure that its network offer reasonable access and coverage for treatment for chemical dependency, and BCBSM "recognizes the medical necessity of treatment for these conditions, including 28-day inpatient treatment for chemical dependency"; and (4) not sanction providers for providing medically necessary benefits and not provide any incentives for denying coverage by claims reviewers.

mandated under state law to provide mental health and children and youth services, these programs are often used to provide services that would otherwise be provided through a substance abuse program. No data is available on the extent that this happens, but providers reported it is a common practice. A November 2002 Pennsylvania Joint State Government Commission report on services to children and youth addresses this issue. It reports that untreated drug and alcohol abuse and addiction is believed by many to be the largest single common denominator at work in the caseloads of the children and youth services delivery system, with several advisory committee members who head county agencies estimating that it is present in 70 percent to 80 percent of their cases. Costs can also sometimes be shifted to other public programs, such as for AIDS, vocational rehabilitation, or mental retardation.

- *From Behavioral Health to Physical Health.* Substance abuse can cause serious physical problems, thereby increasing physical health costs. One common manifestation of this is increased emergency room costs, where substance abuse clients are often seen for medical problems. Untreated substance abuse problems can also result in expensive medical procedures such as a liver transplant. One of the criticisms of contracted behavioral health care organizations is that they do not have the inherent financial incentive that an integrated physical/behavioral health insurer has to provide robust substance abuse treatment services so as to avoid such physical health costs.

Single County Authority Funding Concerns

It would be misleading to imply that cost shifting is the only, or even the primary, concern in funding drug and alcohol treatment services. The SCA directors we spoke with indicated that, while cost shifting from public and private managed care organizations has exacerbated the problem, the primary dilemma they face is the inadequate level of base funding for the services they are expected to provide. Over the past three years, Department of Health allocated SCA federal and state funds, for example, increased by only 1.6 percent, from $90.0 million to $91.4 million.[4]

To assess the impact of funding constraints on SCA services, we surveyed ten SCAs regarding their allocation method, funding shortages, and experiences with cost shifting. As Exhibit 5 shows, many SCAs allocate a set amount of funds, either on an annual or monthly basis, for inpatient treatment. Once those funds are exhausted, the SCAs are only able to provide outpatient treatment until the new month (or year) begins. Without such limits, costly inpatient treatment programs would deplete all the SCA's funding before the end of the fiscal year. Even with such limits, nearly all SCAs reported they had to limit or suspend both inpatient and outpatient services before the end of the 2001-02 fiscal year. In FY 2000-01, only three of the ten SCAs reported having exhausted all their funding before the end of the fiscal year, while four SCAs limited or suspended service.

[4]Excludes state administrative expenses, but includes SCA administrative costs.

Exhibit 5

Selected Single County Authority Funding Information

SCA	Allocation Method	Lack of Funding FY 2000-01 and FY 2001-02	Cost Shifting	Impact of Lack of Funding
Allegheny	Annual allocation at start of fiscal year, based on level of service (fee for service).	Depleted state funding each year by end of third quarter. Funding streams depleted based on degree of restrictiveness, BHSI and Act 152 being the most restrictive. Have not suspended services. Service projections enable SCA to see gaps/surpluses. Some providers willing to continue after utilizing allocation; others may have excess capacity.	Special priority status to specific populations; computer systems algorithm that matches client with funding stream; collaboration with health and human services entities to coordinate funding and support services for clients.	Women with children, adolescents, intravenous drug users, HIV and Hepatitis-C patients, and the homeless increasing while dollars are shrinking, resulting in lost work time and additional health care and corrections costs.
Chester	Annually, allocate to ambulatory services first and then residential. Currently using monthly targets to avoid long suspension period at end of year.	In FY 2001-02, exhausted residential funding (Act 152, BHSI, IGT, state base, and federal block grant) at end of third quarter and then suspended residential admissions. In FY 2000-01 did not exhaust funds due to having closed admissions during last quarter of FY 1999-00.	Likely those unable to access D&A treatment will need medical or psychiatric services or appear in the criminal justice system. Commercially insured individuals denied treatment access through dependency/delinquency placements or criminal justice system, requesting SCA funds.	Impacts on medical services, family stability, crime, and corrections. Destabilizes the treatment system.
Dauphin	Mostly fee for service contracts. Only prevention services are program funded. Set budget around these funding streams.	Exhausted Act 152 funds every year in the last decade except FY 2000-01 and projected to run out of Act 152 dollars in FY 2002-03. Service not suspended.	Will utilize BHSI, IGT or base funds or provider will continue services in hopes there will be sufficient funds.	Not all identified targeted populations adequately funded--youth in the criminal justice system in need of D&A treatment, pregnant women and women with children (childcare, food, transportation, health care).
Delaware	Contract with providers annually. Dollars distributed based on actual expenditures.	Exhausted funding from all sources, BHSI first. Suspended services 6/01 and 4/02 due to lack of funding.	Reinvestment and county base dollars used to offset deficit.	Services suspended.
Erie	Fee for service.	Exhausted funding from all sources in FY 2001-02. Service suspended in June. No previous lack of funding.	None.	Clients waited until July for admission to treatment.

Exhibit 5 (Continued)

SCA	Allocation Method	Lack of Funding FY 2000-01 and FY 2001-02	Cost Shifting	Impact of Lack of Funding
Lackawanna	Allocations for programs/services determined annually. Funds disbursed monthly based on actual expenses.	Avoided exhausting funds by designating monthly reserve on fund expenditures and limiting services to priority populations. Outpatient service costs capped contractually.	Mid-year analysis results in budget modifications to cover shortfalls and reduce other categories.	Unable to expand services and providers; difficult to maintain current level of services; unable to initiate innovative treatment alternatives; increased wait list; excessive staff turnover due to non-competitive compensation.
Lancaster	First come, first serve basis. Allocate annually, and preauthorize all placements into residential treatment.	Suspended placements in rehab and halfway houses 4/01 and 12/01 due to lack of funding.	Detox and outpatient open all year, although money may be taken from other cost centers. No other cost shifting.	Continued addiction, homelessness, lack of jobs, increased crime and disease.
Northumberland	Contract basis based on historical needs. Modify during year.	For FY 2001-02, exhausted BHSI funding in June. Never suspended services.	Cost shifting within the primary allocations-- OMSAS, BDAP, IGT.	Diverted to lesser level of care with no detriment to client.
Philadelphia	Allocation Review Committee annually engages in extensive process in which each contract agency is fully reviewed from the perspective of both programmatic and fiscal components. For BHSI allocation, agencies reimbursed through this mechanism on a fee for service basis.	BDAP funds allocated on a program-funded basis, and providers precluded from overspending (or must make it up). Did not exhaust BSHI funding in FY 2000-01 and FY 2001-02 through imposition of cost controls and some additional funding sources used to support treatment services for criminal justice clients. BHSI admissions/ readmissions not suspended but significantly curtailed in February/March each year.	Shifted PCCD funding for BHSI to provide treatment services to CJS clients. Forced to cost shift regularly and implement cost controls.	Reduced client length of stay and restricted others requiring additional treatment to one or two treatment continua.
Westmoreland	Funding qualifier sheet determines which funding stream matches client eligibility for treatment.	Did not run out of Act 152 money in FY 2000-01. Exhausted funding in FY 2001-02 by May 2002. Did not suspend services.	Shift cost by using BDAP base 110 monies to fill gap.	Trends indicate it will worsen, unless lag time getting clients qualified for HealthChoices is reduced significantly.

Source: Developed by LB&FC staff from SCA provided data.

E. Pennsylvania's Commercial Managed Care Grievance and Appeal Process Is Difficult, Especially for Clients With Drug and Alcohol Problems

Consumers must have a means of expressing their concern if they think they are not receiving the health care services they need. Traditional indemnity plans enable dissatisfied patients to see more than one provider, but managed care plans may limit their enrollees' choices to one primary care physician who controls their access to a network of providers following the same practice guidelines. Visits to providers outside the network might not be economically feasible for many enrollees.

The alternative to going outside a managed care's provider network is to formally dispute the decision of the managed care plan. The formal process involves requesting a review of the decision to deny a service the plan does not consider part of the benefit package or deems medically unnecessary or inappropriate.

Act 68 defines two types of dispute resolution procedures. A *complaint* is an unresolved dispute about "a participating health care provider or the coverage, operations or management policies of a managed care plan." A *grievance* is a request to have a managed care plan or certified review entity (CRE) "reconsider a decision solely concerning the medical necessity and appropriateness of a health care service." Filing a written grievance initiates the review process to resolve a dispute about a decision to:

- disapprove full or partial payment for a requested health care service, or
- approve a service of lesser scope or duration than requested, or
- approve payment for an alternative to the requested health care service.

Act 68 provides for a two-stage internal review process before enrollees may file formal appeals to the Department of Health or the Insurance Department. Exhibit 6 shows the process for reviewing complaints.[1]

Exhibit 6

The Complaint Process Under Act 68

Stage	Reviewers	Timeliness Standard
Initial Internal Review	One or more employees of the managed care plan	Review completed within 30 days of receiving the complaint; written notification within 5 business days
Second Level Internal Review	Three or more persons (at least 1/3 nonemployees) who did not participate in the initial review	Review completed within 45 days of receiving the request; written notification within 5 business days
Appeal	Department of Health or Insurance Department	Complaint files forwarded within 30 days of the department's request

Source: Compiled by LB&FC staff from Act 1998-68 and Department of Health regulations.

[1]The HealthChoices appeal process differs and is described in Appendix G.

HealthChoices members may use the MCO's complaint and grievance system and/or the Department of Public Welfare's fair hearing process for appropriate issues. The Office of Mental Health and Substance Abuse Services has established a Division of Grievance and Appeals to monitor the complaint and grievance system and to provide training to consumers, providers and MCOs.

Complaints – Insurance Department

The Insurance Department cited five of 10 companies for failing to complete reviews of complaints within the Act 68 time frames, based on its FY 2001-02 market conduct reports. Although the act does not specify a time period within which the departments must complete their reviews of appeals, managed care plans must forward the complaint files in question within 30 days of receiving a request from one of the departments. The original filing date remains in effect for determining compliance if the Insurance Department transfers an appeal to the Department of Health. As of January 1, 2003, the Insurance Department reported having received only five complaint files relating generally to drug and alcohol treatment services.[2]

Grievances – Health Department

Grievances must go through a two-stage internal process before enrollees may request external reviews. The request for the review may come from an enrollee or a provider with an enrollee's written consent, but the act prohibits an enrollee from filing a separate grievance after giving such consent. Exhibit 7 shows the review process.

Exhibit 7

The Grievance Process Under Act 68

Stage	Reviewers	Timeliness Standard
Initial Internal Review	One or more persons who did not participate in denying payment for the requested service	Review completed within 30 days of receiving the complaint; written notification within 5 business days
Second Level Internal Review	Three or more persons who did not participate in denying payment for the requested service	Review completed within 45 days of receiving the request; written notification within 5 business days
External Review by an Independent CRE	One or more licensed clinical peer physicians or psychologists or board-certified specialists	Written decision to managed care plan, enrollee, and provider within 60 days of the filing date

Source: Compiled by LB&FC staff from Act 1998-68.

The grievance review at each internal level must include a licensed physician or, where appropriate, an approved licensed psychologist, "in the same or similar specialty that typically manages or consults on the health care service." Act 68 also requires an expedited process to be available if the enrollee's life, health, or ability

[2]These are complaints filed pursuant to the Act 68 process. The Insurance Department has jurisdiction to consider complaints of contract exclusions, non-covered benefit disputes, and potential violations of Insurance statutes. See Finding II.B specifically regarding complaints relating to Act 106 coverage.

to regain maximum function might be jeopardized. The managed care plan must notify the enrollee and the provider of its expedited decision within 48 hours.

Act 68 allows enrollees 15 days to file their requests for external reviews after receiving second level denials. Managed care plans have five business days to notify the Department of Health that they have received such requests. The Department must assign CREs to external reviews on a rotational basis within two business days of such notification, or the managed care plans may designate CREs to conduct the reviews.[3]

A CRE may not be designated if it has a conflict of interest such as a proposed or actual contract to do utilization review for the plan or any other affiliation with the plan. The plan must pay the fees and costs, excluding attorneys' fees, of the external grievance process if an enrollee files the request. The nonprevailing party pays if the filer is a health care provider.

Low Incidence of Appeals Related to Drug and Alcohol Services

Internal Plan Review. DOH regulations require managed care plans to submit annual reports of their activities, including the total number of complaints and grievances and the number relating to behavioral health services. The report format does not, however, require separate reporting for substance abuse complaints and grievances.

We reviewed the annual reports from plans that were not serving predominantly or exclusively HealthChoices clients to determine how many of their grievances related to behavioral health services.[4] Not all plans showed the data for such cases separately. Seven plans, accounting for 73 percent of managed care enrollees in Pennsylvania, reported their behavioral health complaints and grievances separately, showing 394 behavioral health grievances out of 6,164 for all services.

External Review. Health care providers or managed care plan members filed 521 appeals for CRE external reviews from January 1999 through December 21, 2002. They included 116 mental health grievances, but only nine drug and alcohol grievances. Providers initiated more than one half of the appealed grievances related to mental health services, but no providers initiated action for drug and alcohol services. Provider-initiated grievances overturned the initial decision in about 50 percent of the mental health services related cases; 32 percent of the member-initiated grievances succeeded in overturning decisions.

CREs had completed seven external reviews of appealed grievances for substance abuse treatment denials, and the Department of Health had made an administrative determination on a third complaint as of September 2002. The other two appeals were pending. One CRE reversed a denial of inpatient detoxification services, and another upheld a denial of inpatient treatment. The administrative

[3]Eight CREs were approved for all external grievance appeals, including behavioral health cases, and one CRE was approved only for behavioral health reviews as of February 2002.
[4]HealthChoices clients have the option of pursuing grievances through an alternative Medicaid process.

determination in the third case required the managed care plan to provide coverage and reimbursement for inpatient care, which involved services rendered by an out-of-network facility. The department cited the plan's failure to determine whether the requested services were necessary and, if so, available through network providers.

Provider advocates believe the existing grievance processes under Act 68 do not work well for drug and alcohol addicted clients and that this is why there are so few grievances filed by drug and alcohol clients. They argue that a client is often in denial of his/her condition and wants to hear that, for example, inpatient services are not necessary or that shorter lengths of stays will provide sufficient treatment services. They also note that it is impractical for providers to submit grievances, in part, because of the long time frames allowed under Act 68 and because providers are dependent upon the BHCOs for clients and do not want to establish a confrontational relationship with them. DOH officials, however, believe the existing Act 68 process is adequate and that clients and providers should be more willing to use the process before suggesting that new grievance procedures are needed.

Role of the Office of Attorney General. In February 2000, Pennsylvania's Office of Attorney General established a Health Care Unit (HCU) as a specialized division within its Bureau of Consumer Protection. The HCU assists consumers in mediating resolutions to situations involving health care insurance. The HCU addresses healthcare problems on behalf of consumers on issues such as insurance coverage denials, quality of care, ancillary services and billing, and deceptive and fraudulent practices in the healthcare industry.

The HCU handles approximately 2,000 complaints per year, with approximately 5 percent of those relating to drug and alcohol treatment services. Most of the HCU drug and alcohol cases involve the denial of treatment services in contradiction of the recommendation of the treating physician. The OAG does not have authority under an insured's policy or under Act 68 complaint and grievance procedures to bring action in these situations but can mediate these cases pursuant to its authority under the Unfair Trade Practices and Consumer Protection Law, 73 P.S. §201-1 et seq. In the course of such mediations, a pattern of practice or conduct may be revealed that leads to an investigation and/or litigation, as appropriate. The HCU does not comment on mediations or investigations in which it is involved, unless legal action is initiated.

Expedited Internal Grievance Process

Pennsylvania law requires, and Department of Health regulations clarify, that a managed care plan must make an expedited review procedure available to its enrollees, which the enrollee may request at any stage of the review process as long as there is a jeopardy to the enrollee's life, health, or ability to regain maximum function caused by the delay of the regular review process. The enrollee's physician must certify to this in writing. The expedited review then proceeds as if it is a second level review, except with expedited time periods. A plan must conduct

the expedited review and issue its decision within 48 hours of request. The decision must include the plan's basis for the decision, the clinical rationale, and an explanation of the procedure for an external expedited review. The enrollee then has two business days to file a request for the external review, which involves the assignment of a CRE by the Department of Health to review the matter. Within 24 hours of seeking the external review, the MCO must forward the request to DOH, which is to assign a CRE within one business day. The CRE then has another two business days to issue a decision.

DOH explained this process has not been used with respect to drug and alcohol grievances. The Department's only requirement in accordance with Department regulations is that a physician certify in writing that the client's life, health, or ability to regain maximum function would be placed in jeopardy by the delay of the review process. The certification must also contain a clinical rationale and facts to support the physician's opinion.

Legislative Initiative

In the 2001-02 legislative session of the Pennsylvania House of Representatives, House Bill 1823 (PN 2361), referred to committee in June 2001, proposed new grievance procedures for drug and alcohol treatment services. Under the bill, the Department of Health's Bureau of Drug and Alcohol Programs (BDAP) must "establish a grievance procedure to handle complaints and grievances regarding access to, denial of, and provision of drug and alcohol treatment services by health maintenance entities."[5] It would be a one-level, external procedure that would have to resolve complaints and grievances within 30 days of initiation. The new grievance procedure could be initiated by the consumer, the facility (or its designee), or a treatment program that is providing or has provided a service to a subscriber. The procedure must include, at a minimum, that:

- a case assigned for review must have all identifying matter removed, such as the patient's name, name of treatment program, and managed care entity's (MCE) name;
- the reviewing entity may not have a conflict of interest;
- there be a procedure for efficient assignment of the cases for review;
- all clinical reviews must use the PCPC or ASAM criterion;
- the final determination results of the reviewing entity must be reported to BDAP and to the parties;
- the parties must immediately comply with the decision; and
- the decision be binding upon the parties absent a gross abuse of discretion.

Under the bill, BDAP would be required to establish a registry of qualified drug and alcohol treatment clinicians, conduct grievance reviews, compile annual statistical reports on complaints and grievances, and promulgate rules and regulations to implement the new procedures.

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[5]The bill defines a "managed care entity" to be a health care system that integrates any financing and delivery of health care services, including, but no limited to, a health insurer, health plan, HMO, managed care firm, or third-party administrator. The bill does not specifically define a health maintenance entity.

F. The Lack of Service and Outcome Data Hinders Developing an Outcome-Based Approach to Substance Abuse Treatment Services

Health care providers and payers continue to debate the effects of managed care and behavioral health carve-outs on substance abuse treatment outcomes. While several studies have been conducted on the impact of managed care on treatment services and the effectiveness of various treatment approaches, confidentiality restrictions and the number of payers involved had made it difficult to collect the type of data necessary to allow broad scale outcomes monitoring. Without such data, it is difficult to assess the effectiveness of the Commonwealth drug and alcohol system and to identify potential problem areas.

Efforts have been made in Tennessee and elsewhere to use outcomes data to improve the service delivery system. In Pennsylvania, the Departments of Health and Public Welfare have applied for a federal grant to integrate the data systems maintained by the two departments with the goal of using outcomes-based measures to better manage the Commonwealth's substance abuse service delivery system.

National Drug Abuse Treatment Outcome Study[1]

The National Institute on Drug Abuse (NIDA) sponsored a nationwide Drug Abuse Treatment Outcome Study (DATOS) for patients who entered 96 treatment programs in 11 cities between 1991 and 1993. DATOS looked at four treatment programs: outpatient methadone, outpatient drug-free, long-term residential, and short-term (30 days or less) inpatient.[2] The study compared drug use and social behavior 12 months before and after treatment for approximately 3,000 randomly chosen patients.[3] The specific measures were:

- weekly and daily drug use,
- illegal acts (e.g., assault, robbery, burglary, and forgery),
- full-time employment (at least 35 hours per week), and
- attempts or thoughts of suicide (an indication of depression).

The study found a general reduction in drug use and improvement in social behavior for each of the four treatment programs. The short-term inpatient

[1]This finding discusses several key reports on Pennsylvania drug and alcohol treatment outcomes and describes the results of a few national outcomes studies. Appendix H contains additional annotated information on the results of selected other studies identified for us by stakeholders as important publications in the drug and alcohol treatment field.

[2]Michael D. Mueller and June R. Wyman, "Study Sheds New Light on the State of Drug Abuse Treatment Nationwide," *NIDA Notes*, Vol. 12, No. 5, September/October 1997.

[3]Clients still receiving outpatient methadone treatment were interviewed 24 months after admission.

programs produced significant declines in drug use even though the patients stayed no more than 30 days, a finding NIDA officials described as one of the most surprising. The DATOS also showed a significant decrease in the percentage of short-term inpatients that reported illegal acts and suicidal thoughts after treatment.

Outpatients and clients of long-term residential programs generally had significantly better outcomes if they stayed in their programs at least three months. The study identified the major predictors of the likelihood to remain in treatment as:

- high motivation,
- legal pressure to stay in treatment,
- no prior trouble with the law,
- psychological counseling while in treatment, and
- no other psychological problems, especially antisocial personality disorders.

Programs with high retention rates were found to have good client-counselor relationships, a wide range of services, and high client satisfaction with the program.

Later studies used the DATOS results to look more closely at the relationship between problem severity at intake, time in treatment, and outcomes. One study showed relatively high relapse rates for cocaine-dependent clients who had spent less than three months in long-term residential programs, the type of program which patients with the most severe problems were more likely to enter.[4]

The relapse rates in Table 8 highlight several trends:

- Long-term residential patients had better outcomes if they stayed in treatment at least three months.
- Long-term residential patients with the most severe problems had better outcomes than outpatients or short-term inpatients with the most severe problems if they stayed in long-term treatment at least three months.
- Outpatients and long-term residential patients had better outcomes than short-term inpatients if they stayed in treatment at least three months.
- Short-term inpatient and outpatient programs offered potentially cost-effective alternatives for short-retention clients with the least severe problems.

[4]D. Dwayne Simpson, George W. Joe, Bennett W. Fletcher, Robert L. Hubbard, and M. Douglas Anglin, "A National Evaluation of Treatment Outcomes for Cocaine Dependence," *Archives of General Psychiatry*, Vol. 56, June 1999, pp. 507-514.

Table 8

Patients Using Cocaine Weekly Within One Year After Treatment

Problem Severity Index (0-7 range)	Long-Term Residential Programs	Outpatient Drug-Free Programs	Short-Term Inpatient Programs
Short Retention Group[a]			
Low (0-3)	38%	19%	16%
Medium (4-5)	42	43	47
High (6-7)	38	27	43
Long Retention Group[b]			
Low (0-3)	10	13	22
Medium (4-5)	21	15	25
High (6-7)	15	29	38

[a]Less than 3 months for residential or outpatient programs, fewer than 21 days for inpatient programs.

[b]At least 3 months for residential or outpatient programs, at least 21 days for inpatient programs.

Source: D. Dwayne Simpson, George W. Joe, Bennett W. Fletcher, Robert L. Hubbard, and M. Douglas Anglin, "A National Evaluation of Treatment Outcomes for Cocaine Dependence," *Archives of General Psychiatry*, Vol. 56, June 1999, pp. 507-514.

NIDA publications reflect the DATOS findings. *Principles of Drug Addiction Treatment* cites the significance of the three-month threshold for most patients.[5] It calls attention to the importance of providing the appropriate service mix, not only counseling and psychotherapy but also medical, social, and legal services, to meet the individual patient's needs. NIDA also noted that managed care review has resulted in shortened lengths of stay in inpatient rehabilitation programs.

Pennsylvania Studies[6]

Act 152 Outcomes Study

The Department of Public Welfare contracted with Villanova University to evaluate the implementation of Act 1988-152. Act 152 was enacted to provide more Medicaid-eligible clients with drug and alcohol services and to help ensure that those being served were receiving better and more appropriate care than may have formerly occurred. The 1995 report contained observations from both a qualitative and quantitative perspective. From the qualitative perspective, the delivery system was found to be fragmented, with the report noting ambiguity in defining nonhospital residential treatment and a lack of standards based on treatment outcomes research. The quantitative section of the study sought to associate treatment

[5]*Principles of Drug Addiction Treatment: A Research-Based Guide*, National Institute on Drug Abuse, National Institutes of Health, Publication No. 00-4180, July 2000.

[6]See Appendix I for information on Criminal Justice Outcomes Studies.

modalities with specific behavioral outcomes such as criminal activity, economic status, medical care, and substance abuse after treatment.[7]

The study found that long-term nonhospital residential rehabilitation was most commonly associated with positive outcomes, including less criminal activity, higher wages and employment, less inpatient mental health care, and less use of detoxification services. Short-term nonhospital rehabilitation (8 to 31 days) was also associated with positive outcomes, although less so than long-term nonhospital rehabilitation.

Hospital rehabilitation and outpatient services were associated with both positive and negative outcomes. Hospital detoxification was the treatment service most commonly associated with negative outcomes. The report attributed the negative outcomes to a possible lack of follow-up treatment. Nonhospital detoxification and intensive outpatient services did not have a statistically significant association with any outcomes, positive or negative.

SCA clients showed a greater tendency to use combinations of hospital, nonhospital, and outpatient services. The report attributed their frequent mixing of fee-for-service and Act 152 treatment modalities to the limited responsibility of the SCAs, which could authorize only nonhospital services. Their average length of stay for nonhospital rehabilitation exceeded 80 days, indicating a tendency to stay once they entered it. Reductions in criminal activity were most strongly associated with SCA clients who had received nonhospital rehabilitation, regardless of its duration.

Comparative PA Medicaid Outcomes Study

Medicaid recipients in Philadelphia experienced a two-step change in the payment structure through which substance abuse treatment was provided during the 1990s. Approximately 80 percent of the eligible patients were receiving fee-for-service care in community clinics as of 1992. Three years later, Medicaid clients were going to the same community clinics, but most of them were having their care managed by for-profit HMOs in which they had enrolled voluntarily. The second change occurred when the Philadelphia Department of Health formed a not-for-profit managed care company, Community Behavioral Health (CBH). It was managing substance abuse care for most of the Medicaid recipients by the end of 1997.

The Treatment Research Institute, in conjunction with the University of Pennsylvania, sought to determine whether these changes in reimbursement arrangements were associated with (1) the type and number of services received and (2) the outcomes from outpatient substance abuse treatment. The study looked at

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[7]Martin Asher, Nurit Friedman, Christine Lysionek, and Christopher Peters, *Evaluation of the Implementation of Pennsylvania's Act 152 (1988): The Quantitative Findings*, Villanova University, January 1995.

547 participants who had been admitted to one of four outpatient providers since 1991. The providers had treated patients under each of the three payment systems, and the participating patients had been treated during periods when one or another of the three systems was the predominant form of Medicaid coverage.[8]

While the study found some differences in the type and number of services received, there were no clear differences in patient outcomes between the three payment systems. Patients received the most drug and alcohol services through the fee-for-service system. For-profit HMO members received the fewest. Outcome differences were only marginally associated with the payment systems. Patients on average showed statistically significant and clinically meaningful improvement in reducing substance use and other measures after seven months, regardless of the payment system.

The finding of differences in services, but not in outcomes, contradicted earlier studies indicating a relationship between the quantity and range of services and improved patient outcomes. The researchers note, however, that the study examined services and outcomes in the limited context of outpatient treatment and monitored only the number and type (not quality) of services provided.

Assessing the Effectiveness of Treatment Services Is Difficult Due in Part to Multiple Data Systems

Drug and alcohol treatment data in Pennsylvania is collected through many payers. In addition to commercial insurance plans, public payers include the Department of Health through the county SCA system; Medicaid through the Department of Public Welfare; the Department of Corrections; and the Pennsylvania Commission on Crime and Delinquency.[9] However, because the payer data collection systems are not integrated, it is impossible to associate the type and duration of service with client outcomes. Moreover, with the exception of PCCD-funded drug and alcohol treatment service (see Appendix C), little data is collected on outcome measures. Some states, most notably Tennessee, have taken steps to collect and use treatment data to promote outcomes-based policy decisions.

Without such information and public reporting, it is difficult to assess overall drug and alcohol system accountability. To at least partially address this concern, in the 2001-2002 legislative session in Pennsylvania, several bills were introduced

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[8]The patients had four-to-six-week treatment plans calling for two-hour sessions twice weekly for two weeks and tapering to one session by the last week. The providers used the Addiction Severity Index (ASI) at intake. Telephone interviewers collected follow-up information from the patients 2, 4, 8, 12 weeks, and 7 months after intake to determine what kinds of services they were receiving in the ASI problem areas. The interviewers used the ASI for the seven-month follow-up.

[9]The Children's Health Insurance Program (CHIP) also collects certain data and is planning to report additional information about drug and alcohol services.

to mandate aggregate reporting by managed care firms and other insurers. (See Appendix J.)

Department of Public Welfare

DPW collects HealthChoices data on all behavior health services, including drug and alcohol services, through its Performance Outcome Management System (POMS).[10] Substance abuse data is collected for the following categories of services:

- Inpatient detoxification
- Inpatient rehabilitation
- Nonhospital services (nonhospital detoxification, rehabilitation and halfway-house)
- Outpatient, including methadone maintenance and intensive outpatient
- Other drug and alcohol services, including partial hospitalization

The usefulness of the data is limited, however, because many services are bundled together. For example, the system does not differentiate between nonhospital rehabilitation and halfway house programs or between regular outpatient and intensive outpatient services.[11] Moreover, the POMS system only collects encounter (service) data, not outcome data for drug and alcohol clients. DPW reports that POMS does not collect outcome data due to drug and alcohol confidentiality restrictions.

Department of Health

DOH collects SCA drug and alcohol data through its Client Information System (CIS), which collects episode data only, not prevention or case management data. This system collects data in somewhat greater detail than does the POMS system. The various types of service in CIS system are:

- Inpatient hospital
- Inpatient nonhospital
- Partial hospitalization
- Outpatient
- Shelter

There are four sub-categories within each of these: detoxification, drug-free (rehabilitation), other chemo, and experimental.[12] In the CIS, shelter equates to HealthChoices halfway house and partial hospitalization is its own category. Intensive outpatient is included within the outpatient category and is not separately designated.

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[10]POMS collects data on all behavioral health services in addition to drug and alcohol.
[11]We did, however, receive data from one HealthChoices payer on a service-specific basis, which suggests that the payers may collect disaggregated data but are not required to report it to the Department in this manner.
[12]"Other Chemo" is a term that the Bureau of Licensure used. The term is an outdated one. "Experimental" is defined as an innovative treatment opportunity not generally used for the treatment of substance abuse clients. Both categories of care for all services have very few clients.

The CIS is currently in process of being rewritten from a DOS-based system to a web-based system. The goal is to centralize the data to enable easier extraction of reports and make the system's applications available to providers, with the ultimate goal of being able to use the data to improve treatment practices. The modifications to the system, however, are not expected to include outcome measures.

Department of Insurance – The Children's Health Insurance Program

CHIP contractors submit quarterly reports containing aggregate data such as the number of services provided, the total cost of providing specific services, and the unduplicated number of children who received services. Providers treated 2,825 children for substance abuse from September 1999 through February 2002. They provided partial hospitalization services for 1,013 and outpatient services for 1,812. Reports from CHIP contractors indicated substance abuse patients had not filed any formal Act 68 complaints or grievances from September 1999 through August 2002.

The CHIP collected unaudited HEDIS[13] data in FY 1999-00 and began collecting audited data in FY 2000-01. Although the HEDIS data does not separate out substance-abuse-only clients, the data on mental health service utilization (which includes substance abuse services) showed CHIP clients up to age 12 had used such services approaching twice the national median rate, with longer average lengths of stay, than children covered by commercial health insurance. CHIP clients aged 13 to 17 had used mental heath services at a rate more than 25 percent higher than compared to children in commercial plans.

The PA Insurance Department is developing a centralized data system to monitor the quality of CHIP health care services. It received assistance from the National Committee for Quality Assurance in determining the readiness of CHIP contractors to collect and submit accurate and timely data. The selection of data sources for quality care indicators and a pilot test will precede the implementation of the system in 2003.

Data Integration Efforts

To improve the usefulness of the data they collect, the Departments of Health and Public Welfare have joined together to submit a competitive application to the federal Substance Abuse and Mental Health Services Administration (SAMHSA) for technical assistance to integrate the two data sets. The goal of the project is to create a data system with improved quality control measures to increase data

[13]HEDIS (Health Plan Employer Data and Information Set) is a set of standardized performance measures to provide comparative information on plans for consumers and employers. Such measures include, for example, childhood immunization status, adolescent immunization status, prenatal care in the first trimester, low-birth weight babies, and checkups after delivery.

accuracy, completeness, and validity. The system would also incorporate measurable outcomes to better manage the service delivery system and to satisfy SAMHSA and to respond to Congress's outcome measurement mandates. As of mid-December 2002, the Departments had not yet received a response from SAMHSA.

The Department of Health is also working on an initiative to better coordinate treatment services between the different payers in its delivery system. Because 31 percent of all SCA clients come from the criminal justice system, DOH is working closely with the Department of Corrections on this project. One of the goals is to determine exactly what each department does and when it is done. For example, client assessments are done several times as a client moves throughout the system. Eliminating some of these assessments could allow more time and dollars for treatment.

Third Party Data Integrator

Concerns over protecting patient confidentiality makes it especially difficult to assess the results of the services public agencies are subsidizing. To account for a patient's care throughout the continuum of treatment modalities, all payers would need to use the same patient identification code. DOH made its identification codes available for HealthChoices but encountered resistance to substituting them for existing codes in other DPW programs. The departments could not agree on a unique identifier because two questions were never answered: (1) Would the data being transferred between systems cover all program clients? (2) If it did, would the DPW system have the capacity to receive it?

We talked with the Pennsylvania Health Care Cost Containment Council (HC4) about the possibility of serving as a third party data integrator for drug and alcohol client admission and treatment data. HC4 currently carries out such a function for hospital inpatient admissions, including for hospital based drug and alcohol detoxification and rehabilitation treatment. The Council's Executive Director indicated that HC4 was an appropriate entity to collect and report on client data across payer streams and said that it would be interested in exploring such a venture. Other entities that might play such an integrator and analytic role regarding drug and alcohol data include private vendors, universities, and the Institute of Research, Education and Training in Addiction (IRETA) based in Pittsburgh. IRETA's Executive Director expressed interest in further discussing IRETA's role in such an activity.

Other Data Collection Efforts[14]

The most widely-adopted set of performance measures is the Health Plan Employer Data and Information Set (HEDIS). The National Committee for Quality Assurance, a managed care accreditation entity, supports the HEDIS, which sets performance standards for effectiveness, access, cost, and other categories to facilitate comparison by purchasers and consumers. The HEDIS includes four performance measures for substance abuse services:

1. Access: The number of such providers serving plan participants.
2. Utilization: The number of inpatient discharges by age and gender per 1,000 members per year, total days of inpatient care, and average length of stay.
3. Availability: The number and the percentage of members receiving all such services and inpatient, day/night, and ambulatory services by age and gender.
4. Recidivism: The number and the percentage of members, by age and gender, reentering the hospital for chemical dependency treatment within 90 and 365 days of inpatient discharge.

Although the fourth measure is an outcome indicator, it may be more indicative of availability and access if the plan limits treatment benefits.

Tennessee Outcomes for Alcohol and Drug Services

The Tennessee Department of Health has had a data system contract with the University of Memphis since 1988 to monitor and evaluate facilities and programs funded through its Substance Abuse Prevention and Treatment (SAPT) federal block grant. Tennessee's 54 participating facilities offer four primary treatment modalities: residential rehabilitation, halfway house, intensive outpatient, and outpatient treatment. In 2000, the Bureau of Alcohol and Drug Abuse Services forwarded data on 10,586 admissions to the Tennessee Outcomes for Alcohol and Drug Services (TOADS) project. The University of Memphis processes the data for all clients who give their consent to participate in a follow-up study.[15]

Telephone interviewers collected performance indicators to measure treatment effectiveness using a questionnaire based on the Treatment Outcomes and

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[14]The Foundation for Accountability has recommended quality measures which would reflect a managed care plan's capacity not only to treat substance abuse and dependence but also to educate and intervene. Such proposals imply a need to observe and measure the continuity of inpatient and outpatient care. Health plans typically do not monitor their members after treatment to determine whether they are using drugs or alcohol again and how their social and economic circumstances have changed. The need for meaningful performance measures linking outcomes with treatment modalities is important.

[15]Satish Kedia, *Substance Abuse Treatment Effectiveness in Tennessee: 2000-2001 Statewide Treatment Outcome Evaluation*, Occasional Paper 20, Department of Anthropology, University of Memphis, March 2002. Although approximately 80 percent of 6,590 unduplicated clients gave their consent, the TOADS had to eliminate 55 percent whom the interviewers could not reach to complete their follow-up reports. Another 19 percent gave correct telephone numbers but did not return the interviewers' calls. Hence, 26 percent (1,350) of the consenting patients completed follow-up interviews six months after their admission dates.

Performance Pilot Studies Enhancement (TOPPS II).[16] TOPPS II collects a set of common core items for comparing a patient's status at intake and six months later. A majority of the respondents (71 percent) received treatment in residential programs, 18 percent enrolled in outpatient programs, and 11 percent entered halfway houses. Almost half (48 percent) had received treatment at least once before. Table 9 shows the completion rates and abstinence rates during the six months following treatment for the three modalities.

Table 9

Completion and Abstinence Rates by Treatment Modality

Treatment Modality	Completed Treatment	6-Month Abstinence
Residential Rehabilitation	79%	63%
Halfway House	58	68
Outpatient	65	62

Source: Satish Kedia, *Substance Abuse Treatment Effectiveness in Tennessee: 2000-01 Statewide Treatment Outcome Evaluation*, Occasional Paper 20, Department of Anthropology, University of Memphis, March 2002.

Although the completion rates are not necessarily predictive of abstinence rates, the TOADS project team did not make a determination as to the effectiveness of each modality because outcomes may depend on a continuum of care, particularly aftercare programs. Table 10 shows the abstinence rates for participants and nonparticipants in aftercare programs.

Table 10

Abstinence Rates by Aftercare Participants

Program	Participants	Nonparticipants
Treatment Facility Aftercare	72%	60%
Alcoholics/Narcotics Anonymous	66	58

Source: Satish Kedia, *Substance Abuse Treatment Effectiveness in Tennessee: 2000-01 Statewide Treatment Outcome Evaluation*, Occasional Paper 20, Department of Anthropology, University of Memphis, March 2002.

Although participants in facility aftercare programs had the highest reported abstinence rates, respondents showed a preference (65 percent to 27 percent) for Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) over aftercare provided by the facility where they received treatment. The AA/NA programs received a "very" or "somewhat" helpful rating from 94 percent of the participants, compared to 76 percent for facility-based aftercare. The treatment programs themselves were rated as very or somewhat helpful by 91 percent of all clients participating in the surveys.

[16]This instrument is now also being used by 19 other states to develop more extensive information for evaluating the performance of treatment providers.

The outcomes indicated statistically significant improvement in several economic and social measures. Table 11 shows three examples.

Table 11

Changes in Economic and Social Outcome Indicators

Outcome Indicator	Admission Status	6-Month Follow-Up
Unemployed	68%	33%
Living with Family[a]	10	24
Arrest Record	52[b]	13

[a]Living with at least one immediate family member.

[b]Arrested at least once during the two years prior to admission. The primary reason for arrest during the two years prior to admission was driving under the influence (DUI), as reported by 62 percent of the clients who had been arrested. Recidivism tended to be a problem for clients with DUI records. Their six-month abstinence rate was 54 percent, compared to 68 percent for clients who had not been arrested for DUI.

Source: Satish Kedia, *Substance Abuse Treatment Effectiveness in Tennessee: 2000-2001 Statewide Treatment Outcome Evaluation*, Occasional Paper 20, Department of Anthropology, University of Memphis, March 2002.

A large majority (81 percent) of the respondents reported improved physical health six months after entering treatment. In addition, 60 percent reported they had not experienced any psychological or emotional problems in the 30 days before their follow-up interview. Clients with such problems were most likely to have experienced serious depression (83 percent) or anxiety or tension (61 percent).

The TOADS project identified policy implications and recommendations based on its findings. They included:

- The overall abstinence rate of 63 percent and the clients' perceptions of program helpfulness supported previous conclusions about the effectiveness of treatment in general.
- Clients' perceptions of AA/NA programs as helpful called for further support and encouragement of participation.
- The low rate of participation in treatment aftercare called for more funding and support to improve participation.
- The reduction in clients' unemployment called for the enhancement of training in job skills during treatment.

Drug Evaluation Network System

The Drug Evaluation Network System (DENS) is a national, electronic tracking system for collecting clinical and administrative information on patients entering substance abuse treatment programs. The Treatment Research Institute at the University of Pennsylvania and the National Center on Addiction and Substance Abuse at Columbia University are collaborating on the project, sponsored by the White House Office of National Drug Control Policy and Center for Substance Abuse Treatment.

The seven DENS pilot sites collect information on the nature, number, and severity of patients' problems at intake; their length of stay; and the type of discharge. The project designers envision the system as providing the framework for a national monitoring system and the basis for outcome studies. The DENS software enables assessment counselors to produce narrative admission summaries after entering the patients' Addiction Severity Index data, which the counselors can enhance by selecting additional questions from a set of 40 in a central server. The integrated narrative summary with the interviewer's comments meets the requirements of the Joint Commission for the Accreditation of Healthcare Organizations.

The central server stores the data transferred from the pilot sites. Participating treatment programs have access to their own data and comparative aggregate data from the other programs. They also receive quarterly reports comparing their data to the complete DENS database.

Oregon

Oregon uses its drug and alcohol databases to evaluate substance abuse treatment programs. Providers receiving public funding report client admission and discharge data. The data seeks to answer questions regarding service utilization under managed care. Basic study questions include:

- Access: Is access to substance abuse treatment reduced under managed care?
- Placement: What was the impact of mandated use of ASAM placement criteria?
- Service Utilization: Was the rate of outpatient and methadone service use reduced under managed care?
- Duration: Were fewer clients retained in treatment under managed care?
- Outcomes: Were the outcomes of treatment reduced under managed care?

Washington

Washington uses drug and alcohol data to address various policy issues surrounding certain populations, including pregnant women, indigent persons, Supplemental Security Income (SSI) recipients, mentally ill/chemically dependent persons, involuntarily committed clients, and AFCD/TANF clients.

The public entity that collects and analyzes the data is the Division of Alcohol and Substance Abuse within the Department of Health and Social Services. The Division administers a program similar to Pennsylvania's SCA system. Washington's system can link into Medicaid by using data sharing agreements. Data is also collected from several different departments so that outcomes of drug and alcohol treatment can be determined:

- Employment Services: Together with three other offices, the Division receives a quarterly report on employment. Social security numbers are used to gather the

data, but Employment Services does not know from which office each request has come, so that confidentiality is preserved.

- State Patrol: The Division receives a data dump, updated every year, that includes all arrest records. Drug and alcohol clients are sifted out internally.
- Mental Health: Similar data dumps indicate to the division the impact of mental health problems and overnight psychiatric stays. Clients are again determined internally.
- Medical Health: Data received from Medicaid records for both fee-for-service and managed care programs are used to determine the relationship between D&A treatment and physical health.
- Birth Records: In Washington, birth weight is a required element of birth certificates. The Division uses these records to determine the relationship of D&A treatment to birth weight.

The following is an example of how Washington uses its outcomes data to improve drug and alcohol services. Data received through birth records showed that substances abusing pregnant women are more likely to have a low birth weight baby and that chemical dependency treatment during pregnancy is associated with higher birth weights. The policy implications impacts from this data included continued expansion of programs for pregnant women and a pilot project to assess the cost-benefit of several delivery models for women who deliver a drug-exposed infant.

G. New Approaches Are Emerging to Overcome Some of the Difficulties in the Traditional Managed Care Model

One academic expert suggested to us that managed care, as it exists today, was intended as a temporary measure, not a permanent solution to the problems in the health care system. Perhaps not surprisingly, therefore, we found that new models of managed care for behavioral health services are evolving to address some of the problems created by the traditional for-profit BHCOs. These models typically involve more stakeholders in decision-making capacities and may include providers assuming some degree of risk. Stakeholders, sometimes referred to as the five "Ps," include payers, providers, policymakers, patients, and purchasers.

Three somewhat nontraditional models operate in Pennsylvania and are discussed below. In one model, treatment providers are able to provide the services they believe appropriate without prior approval in exchange for assuming a degree of risk. The other two models take advantage of a HealthChoices provision which allows savings to be reinvested in services. In the past six years, HealthChoices counties have reinvested approximately $81 million into a variety of initiatives. Several examples include transitional housing, a variety of mobile services, case management services for children and adolescents, family support services, respite care, psychiatric rehabilitation, and various outreach programs.

Community Behavioral Healthcare Network of Pennsylvania

Community Behavioral Healthcare Network of Pennsylvania (CBHNP) was incorporated in May 1995 as a Pennsylvania not-for-profit corporation. It was created through an investment of 104 charter member agencies that provide behavioral health services within the Commonwealth. These organizations are all members of the Pennsylvania Community Providers Association (PCPA). PCPA maintains rights to membership on the governing Board of Directors. Other members of the Board of Directors include the CBHNP CEO and agency directors elected by the membership at large.

CBHNP was created to contract with insurers, HMOs, and other purchasers to provide quality managed drug and alcohol and mental health services. CBHNP is unique in Pennsylvania for its management model that relies on collaborations among member agencies to provide infrastructure, management expertise, and service capacity, thus reducing start-up costs and duplication of resources in new program areas. Member agencies also agree to provide up-to-date treatment service information that CBHNP can use to monitor provider practices.

CBHNP serves as the behavioral healthcare subcontractor for the Pennsylvania HealthChoices Medicaid Managed Care Program in the Capital Area, including Cumberland, Dauphin, Lancaster, Lebanon, and Perry counties. The company also provides behavioral healthcare management services for the Regional Referral Center (RRC) in Scranton through its close affiliate, the Community Behavioral HealthCare Network of Northeast PA (CBHN-NEPA). CBHN-NEPA was established as an extension of CBHNP to satisfy requirements for a local corporate entity in the Scranton/Wilkes-Barre area.

The RRC was established to manage behavioral health services for enrollees of First Priority Health (FPH), the HMO subsidiary of Blue Cross Northeast. CBHN-NEPA took over operations of the RRC from Magellan Behavioral Health in January 1997. The number of covered lives is 500,000, which includes 20,000 Medicare Plus members.

CBHN-NEPA has become a shared-risk partner with FPH in a model that uses a prospective payment methodology to align incentives among FPH, CBHN-NEPA, and its provider members. The model allows a significant degree of responsibility for treatment decisions to reside with the traditional caregivers and increases administrative efficiency by eliminating the need for prospective and concurrent review for services.[1] A more typical MCO model is in place for non-risk providers.

Institute of Research, Education and Training in Addiction

The CBHNP model has several characteristics similar to the "self-managed care" model developed by the Institute of Research, Education and Training in Addiction (IRETA), a Pittsburgh-based and federally funded drug and alcohol policy group. Under the IRETA model, a care manager is employed by the insurer or the network to monitor the services provided. Through improved performance and outcomes data, care managers and providers would be better able to assess patient needs and provide a cost effective treatment plan. IRETA believes that science, data technology, and medical models have evolved to the point where this may increasingly become a viable approach.

As shown in Exhibit 8, such a model would:

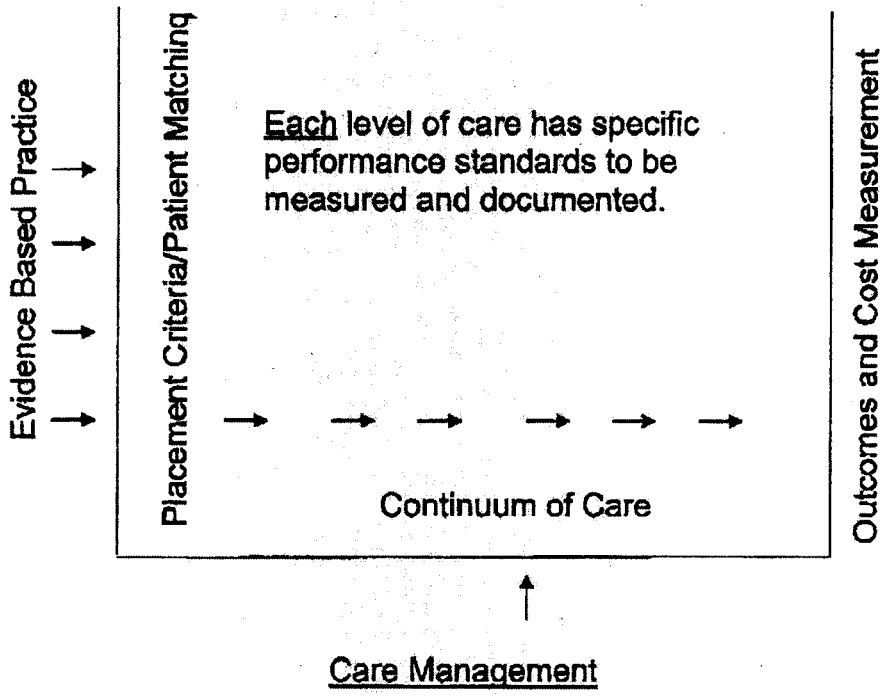
- incorporate appropriate scientific results/evidence for all levels of substance abuse treatment that exist within a service continuum;
- include a system by which specific substance abuse treatment programs may monitor specified treatment processes and outcomes in real time (i.e., data are available and reported to the clinicians as they provide treatment); and
- be a comprehensive partnership with selected substance abuse treatment providers, payers, researchers, and large employers.

The model establishes an advisory group through local stakeholders. The network identifies best practice/science, standards, and real-time process measures

[1]Risk participating providers are reimbursed prospectively based on recent activity.

Exhibit 8

Toward a Self-Managed Care Model



Each case is assigned a Care Manager who assures the compliance to treatment continuum, monitors LOS, performance adherence and outcome.

At first, the Care Manager would be in the insurer's employ but, over time and confidence, be transitioned to the provider's employ.

The Care Manager would implement the appropriate Continuum of Care for each client.

Without a Managed Care company, finances would be freed for treatment.

Licensing and peer review would hold the integrity of the system as well as ultimate cost and outcome.

Source: IRETA

and outcome measures. This could include using a combination of the medical model currently used by behavioral health care organizations and a social rehabilitation model. IRETA believes such a model could be successfully used by a BHCO that assumes all risks or for one that uses a risk-sharing arrangement with its

service providers. (See Finding II.F for a discussion of some of the emerging information system technologies that could support such a model.)[2]

Community Care Behavioral Health Organization

Community Care Behavioral Health Organization (CCBHO) was incorporated in October 1996 as a nonprofit behavioral health management company, primarily for public sector clients. With its partnership with UPMC Health System and Community Behavioral Health Network of Pennsylvania, it provides mental health and drug and alcohol services to both commercial clients and HealthChoices members in Allegheny County. Roughly half of CCBHO's members are commercial and half are HealthChoices.

CCBHO assumes full risk and handles all the functions of a BHCO, including utilization review; network development and management; provider relations; claims payment; member services; quality improvement; compliance and credentialing; and financial and other administration.

The HealthChoices program allows any savings accrued after the annual audit to be reinvested to develop cost-effective services for mental health and drug and alcohol treatment.[3] CCBHO reported that this provision allowed it to reinvest $6.5 million to add services that were not available through fee-for-service, including psychosocial rehabilitation, respite, continuous treatment teams, homeless outreach, and outreach to African American children.

Community Behavioral Health

Community Behavioral Health (CBH) is a nonprofit 501c(3) corporation that has been in operation since February 1997 under contract to Philadelphia to provide mental health and drug and alcohol services to HealthChoices clients. When HealthChoices was implemented, counties were given the choice of contracting directly with a BHCO, having the state contract for them, or developing their own BHCO. Philadelphia opted to launch its own BHCO, the only county to do so, and CBH is the result. The city decided that it could achieve a more coordinated continuum of care by directing its Medicaid dollars into services rather than contracting with an outside BHCO.

Philadelphia serves approximately 375,000 medical assistance recipients; many have significant mental health problems in combination with substance addictions. Because of these co-occurring disorders, Philadelphia viewed managing its

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[2]Other software packages are also emerging such as through the Betty Ford Institution.

[3]Other counties in the HealthChoices program, in both the southwest and southeast, also have reinvested savings to provide additional services.

behavioral health services as an opportunity to better coordinate services, including not only mental health, but other social services.

Philadelphia reported that it, too, has realized savings and has been able to reinvest money in additional services. CBH has established a 90-day Risk and Contingency Fund to handle unforeseen occurrences, such as a change in welfare law or funding. Savings dollars are also being directed toward homeless services; there are an estimated 25,000 homeless over the course of a year in Philadelphia and many of them have substance abuse problems. Additional proposals under review include hiring more substance abuse case workers, vocational training, and increasing mobile outreach services.

III. Background Information on Commonwealth Laws and Regulations Pertaining to Drug and Alcohol Treatment Services

Several State Acts Govern Drug and Alcohol Treatment Services and Providers

Pennsylvania Drug and Alcohol Abuse Control Act

The Pennsylvania Drug and Alcohol Abuse Control Act, Act 1972-63, as amended, 71 P.S. §1690.101 et seq., requires the Department of Health (DOH) to develop and coordinate a comprehensive health, education, and rehabilitation program for the prevention and treatment of drug and alcohol abuse and dependence. The act provides for a system of emergency medical treatment, and it provides for treatment and rehabilitation alternatives to the criminal process for drug and alcohol dependence. Specifically, the Department is responsible for the development of a state plan for the control, prevention, intervention, treatment, rehabilitation, research, education, and training aspects of drug and alcohol abuse and dependence problems.

Other provisions of the act require confidentiality of patient records and permit minors who suffer from the use of controlled substances to consent to medical care or counseling related to diagnosis or treatment without the consent of their parents or legal guardians. The act declares that drug and alcohol abuse and dependence is to be considered a major health and economic problem for purposes of all state welfare programs.

Single County Authorities. Single County Authorities (SCAs) are established in regulation at 4 Pa. Code Ch. 254 under the authority of the Pennsylvania Drug and Alcohol Abuse Control Act. SCAs are to plan and evaluate community drug and alcohol prevention, intervention, and treatment services. The SCA typically does not provide treatment services, but arranges for these services by grant or contract. There are three types of SCAs:

- Planning Council – Local authorities establish a Drug and Alcohol Planning Council that functions independently from the county MH/MR agency and has the responsibility for planning and developing a comprehensive drug and alcohol service delivery system.
- Executive Commission (Public): A separate county department established by the commissioners with the responsibility of delivering drug and alcohol prevention, intervention, and treatment services.

- Executive Commission (Private): A nonprofit community organization chosen by the commissioners to deliver drug and alcohol prevention, intervention, and treatment services through a contract between the non-profit and the commissioners.

SCAs (planning council and public agency option) have the authority to review and evaluate drug and alcohol services; prepare the annual Comprehensive Drug and Alcohol Treatment and Prevention Plan; review and amend this plan; recommend approval of county drug and alcohol related projects; and monitor the compliance and performance of service providers with policies, regulations, contractual obligations, goals, and objectives. SCAs that are private agencies have all of the above responsibilities and also approve contracts for purchase of services and funds to implement drug and alcohol projects.[1]

Each SCA must also have a drug and alcohol administrator on staff. This person must have three years experience in public health, psychology, sociology, education, corrections, theology, or social work, including one year involving related social services community planning and organization and a bachelor's degree in social welfare, sociology, psychology, education, or a related field. In the SCA planning council option, this person serves on the MH/MR staff and administers the CDATPP, insures that Act 63 required drug and alcohol services are available; assists in the development of the CDATPP; reviews and evaluates facilities; maintains liaison with governmental and private community services, agencies and organizations, and state-operated facilities; and prepares and submits an annual report to local authorities.[2]

Health Maintenance Organization Act

The HMO Act of 1972, as amended, 40 P.S. §1551 et seq., provides for the establishment of HMOs in Pennsylvania. The act requires HMOs to have a certificate of authority to issue insurance in Pennsylvania and to file provider contracts with DOH and other contracts, such as for marketing, administration, or enrollment, with the Insurance Department. The act mandates HMOs to have a grievance resolution system approved by DOH. The act sets forth penalties that DOH and the Insurance Department may invoke if the HMO does not provide adequate care, if it does not meet contractual obligations to its subscribers, for misrepresentation in advertising, and if it generally does not comply with the act.

Department of Health regulations for HMOs require that they provide basic health and other services and have availability and access to emergency services, prescription drug services, continuity of services, and have quality assurance standards. DOH and Insurance regulations relating to the HMO Act set forth

[1]SCA boards consist of 11 to 15 members representing criminal justice, business and industry, education, medicine, psycho-social professional, student, elderly, client, and community.
[2]See #1.

additional details as to requirements placed on HMOs. Both DOH and Insurance set forth application requirements for issuing the joint certificate of authority along with the review process to be undertaken by the departments. Both departments also set forth HMO reporting requirements. DOH requires detailed information in its annual report from HMOs, and DOH and Insurance regulations give detailed requirements for HMO contracts. DOH also has detailed regulations regarding availability and access to services, complaints and grievances, CREs, utilization review operational standards, and provider credentialing.

The Quality Healthcare Accountability and Protection Act (Act 68)

Act 1998-68 provides for quality health care accountability and protection and sets forth responsibilities of managed care plans. Under the act, managed care plans are to assure availability and access to adequate health care providers in a timely manner that enables enrollees to have access to quality of care and continuity of health care services. Managed care organizations must also adopt and maintain a definition of "medical necessity," ensure emergency services, and have procedures for providing services "outside the plan" and for "life-threatening, degenerative or disabling disease or conditions." Each managed care provider must also have a process and standards for handling complaints and grievances, among other responsibilities.

A plan must establish a credentialing process, including written criteria and procedures approved by DOH, to enroll its providers and create an adequate network. DOH is responsible for establishing credentialing standards to be used by the plans. Every two years the plan is to report on its process to the DOH. Managed care plans must pay all clean claims from providers within 45 days of receipt. Failure to do so results in a 10 percent penalty. HMOs must file an annual report to the Insurance Department.[3]

Regulating Coverage and Services[4]

Act 1986-64, as amended by Act 1989-106 (40 P.S. §908.1 et seq.)[5] specifically addresses the issue of the coverage of drug and alcohol treatment services under certain insurance policies or contracts. Act 106 applies to:

- All group health or sickness or accident insurance policies providing hospital or medical/surgical coverage.
- All group subscriber contracts or certificates issued by any entity (providing hospital or medical/ surgical coverage) subject to:

[3]Failure to do so can result in sanctions against the managed care plan under Act 68 and the Insurance Code including, for example, a civil penalty or suspension or revocation of a certificate of authority.
[4]The regulation of the complaint and grievance process is discussed in Finding II.E.
[5]All references to the requirement of this statute are referred to as Act 106 in this discussion.

- this act;
- Chapter 61 (relating to hospital plan corps);
- Chapter 63 (relating to professional health services plan corporations);
- the HMO Act; or
- the Fraternal Benefit Society Code.

Act 106 specifically exempts from its coverage all Medicare or Medicaid supplemental contracts, limited coverage accident or sickness policies, and other similar policies as the Insurance Department determines.

Act 106 requires that the covered policies and contracts "shall . . . include within the coverage those benefits for alcohol or other drug abuse and dependency as provided in sections [908-3 (relating to inpatient detoxification), 908-4 (relating to nonhospital residential services), and 908-5 (relating to outpatient services)]." *(emphasis added)* Sections 908-3, 908-4, and 908-5 of Act 106 each has three general areas of requirements that are mandated: (1) each section sets forth requirements for the qualifications of the facility providing the drug and alcohol treatment services; (2) each section also has requirements for the types of services that are to be covered; and (3) each section places certain usage limits on the services covered. Sections 908-4 and 908-5 additionally include a requirement that an insured be certified and referred by a physician or licensed psychologist to be covered.

Section 908-3 of Act 106 pertains to mandated coverage for inpatient detoxification. Section 908-3 requires that the covered inpatient detoxification services must be provided in a facility that: (1) is a hospital or inpatient nonhospital; (2) has a written affiliation agreement with a hospital for emergency, medical, and psychiatric support services or psychological support services; (3) meets minimum standards for client-to-staff ratios and staff qualifications as established by DOH; and (4) is licensed as an alcoholism and/or drug addiction treatment program. Section 908-3 requires that certain specific detoxification-related services must be provided. Act 106 goes on to state that treatment "may" be subject to a lifetime limit of four admissions of seven days each (or the equivalent).

Section 908-4 of Act 106 addresses nonhospital residential drug and alcohol treatment services. This section of Act 106 requires that residential services must be provided in a facility that is a DOH drug and alcohol licensed facility. Before one can receive benefits as required by the act, a licensed physician or licensed psychologist must: (1) certify the insured as a person suffering from alcohol or other drug abuse or dependency and (2) refer the insured for appropriate treatment. Again, certain specific residential-related services must be provided. Act 106 states that the treatment under this section "shall be covered for a minimum of 30 days per year" and "may" be subject to a lifetime limit of 90 days.

Section 908-5 of Act 106 deals with outpatient alcohol or other drug services. Act 106 requires that outpatient services must be provided in a DOH drug and

alcohol licensed facility. As with the residential services (the language used here is identical with the language discussed under §908-4), before one can receive benefits as required by the act, a licensed physician or licensed psychologist must: (1) certify the insured as a person suffering from alcohol or other drug abuse or dependency and (2) refer the insured for appropriate treatment. Act 106 states that the treatment under this section "shall be covered . . . for a minimum of 30 outpatient, full-session visits per year" or in the alternative coverage may be for "equivalent partial visits per year." There "may" be a lifetime limit of 120 full-session visits or the equivalent partial visits.

Additional coverage may be obtained under Section 908-5(d). This section mandates 30 sessions of outpatient coverage that may be exchanged 2 to 1 for 15 additional nonhospital residential days of service. Department of Insurance regulations adopted pursuant to Act 1986-64 clarify that this is 30 additional days of outpatient services being required and that it may be exchanged for 15 residential days. No subsequent regulations have been adopted since the Act 1989-106 amendments to the statute.

Act 35

Act 1996-35 instructs the Department of Public Welfare (DPW) to assist "needy persons" who meet all department eligibility requirements. "Assistance" is money, services, and payment for medical coverage for needy persons who are residents of Pennsylvania, in need of assistance, and otherwise eligible. Persons eligible under Act 35 are: (1) those for whose assistance federal participation is available under AFDC; (2) those eligible for state supplemental assistance; and (3) those who are eligible for general assistance.

Act 35 states that an eligible person undergoing active treatment for substance abuse in a program licensed or approved by DOH (or administered by a federal agency) qualifies for general assistance (if the program precludes the person from employment under DOH standards). There is a lifetime cap on assistance in this instance of nine months.

Act 152

Act 1988-152 provides for a continuum of alcohol and drug detoxification and rehabilitation services to persons eligible for Medical Assistance and directs DPW to provide to such persons coverage for detoxification, treatment, and care in a nonhospital alcohol or alcohol detoxification facility. Act 152 was intended to address the problem of Medicaid's policy of not paying for inpatient treatment in nonhospital settings. Act 152 specifically requires that drug or alcohol dependent persons be admitted to a licensed facility and treated based on medical or psychotherapeutic need and shall not be discriminated against based on Medical Assistance eligibility.

Department of Health Regulations

DOH regulations, 28 Pa. Code §§701.1–713.43, adopted under the Pennsylvania Drug and Alcohol Abuse Control Act, set forth detailed requirements for drug and alcohol facilities and services, setting forth: (1) staffing requirements; (2) licensing standards for freestanding facilities; and (3) certification standards for activities in a healthcare facility.

Staffing Requirements. A provider must have a written compliance plan for meeting DOH staffing requirements. Requirements include qualifications for project director, facility director, clinical supervisor, counselor, and counselor assistant. Facilities must have a staff development program in compliance with DOH regulations and comply with DOH client/staff and client/counselor ratios.

Licensing Standards. Facilities must apply to DOH for an annual license based on standards set forth in DOH regulations based on whether the facility provides: (1) freestanding treatment – to include: (a) intake, evaluation and referral activities; (b) inpatient nonhospital activities; (c) partial hospitalization activities; (d) outpatient activities; and (e) inpatient nonhospital drug and alcohol activities in free-standing psychiatric hospitals; (2) treatment activities that are part of a health care facility – to include: (a) approval procedures; (b) intake, evaluation, and referral activities; (c) residential treatment and rehabilitation; (d) short-term detoxification activities; (e) transitional living facilities; (f) partial hospitalization activities; and (g) outpatient activities; and (3) prevention and intervention activities to include: (a) approval procedures; (b) general activities; and (c) education and information and alternative activities.

Other health regulations adopted under Act 68 set forth operational standards, availability and access requirements, and credentialing rules relating to the provision of treatment services.

Operational Standards. An HMO is required to maintain an adequate network of providers to provide basic health services as medically necessary and appropriate without unreasonable limitations as to frequency and cost. An HMO is to provide emergency, inpatient, outpatient, or preventive services as it determines to be medically necessary and appropriate and must provide other services as may be mandated by federal or state law. All HMOs are to undergo external quality assurance assessments within 18 months of enrollment, with a site visit by DOH, findings issued by the external quality review organization to the HMOs senior management, and a possible corrective action plan issued by DOH.

Availability and Access. An HMO is required to have an ongoing quality assurance program for review, analysis, and assessment of access, availability, and provision of health care services. Detailed standards for the program are set forth

in DOH regulations. An HMO must have a written policy stating the HMOs commitment to respecting an enrollee's rights in providing treatment. The definition of "medical necessity" must be consistent among the HMOs material and must be compliant with the HMO Act, the PPO Act, Act 68, and DOH regulations.

Provider Credentialing. HMOs must establish, maintain, and adhere to a provider credentialing system, including standards for: (1) initial credentialing; (2) recredentialing every three years; (3) inclusion of quality assurance data in recredentialing process; and (4) enrollee access to only properly credentialed providers. HMOs must also verify licensure, education, training, board certifications, DEA certifications, malpractice claims and insurance, work history, and hospital privileges

HMOs must pay a clean claim submitted by a provider within 45 days of receipt. If it does not, the HMO is subject to a 10 percent per annum penalty.

IV. Appendices

APPENDIX A

Scientifically Based Approaches to Drug Addiction Treatment*

Relapse Prevention

A cognitive-behavioral therapy developed for the treatment of problem drinking and adapted later for cocaine addicts. Cognitive-behavioral strategies are based on the theory that learning processes play a critical role in the development of maladaptive behavioral patterns. Individuals learn to identify and correct problematic behaviors. Relapse prevention encompasses several cognitive-behavioral strategies that facilitate abstinence as well as provide help for people who experience relapse.

Supportive-Expressive Psychotherapy

A time-limited, focused psychotherapy that has been adapted for heroin- and cocaine-addicted individuals. The therapy has two main components: (1) supportive techniques to help patients feel comfortable in discussing their personal experiences; and (2) expressive techniques to help patients identify and work through interpersonal relationship issues. Special attention is paid to the role of drugs in relation to problem feelings and behaviors, and how problems may be solved without recourse to drugs.

Individualized Drug Counseling

Focuses directly on reducing or stopping the addict's illicit drug use. It also addresses related areas of impaired functioning—such as employment status, illegal activity, family/social relations—as well as the content and structure of the patient's recovery program. Through its emphasis on short-term behavioral goals, individualized drug counseling helps the patient develop coping strategies and tools for abstaining from drug use and then maintaining abstinence.

Motivational Enhancement Therapy

A client-centered counseling approach for initiating behavior change by helping clients to resolve ambivalence about engaging in treatment and stopping drug use. This approach employs strategies to evoke rapid and internally motivated change in the client, rather than guiding the client stepwise through the recovery process. This therapy consists of an initial assessment battery session followed by two to four individual treatment sessions with a therapist.

Behavioral Therapy for Adolescents

Incorporates the principle that unwanted behavior can be changed by clear demonstration of the desired behavior and consistent reward of incremental steps toward achieving it. Therapeutic activities include fulfilling specific assignments, rehearsing desired behaviors, and recording and reviewing progress, with praise and privileges given for meeting assigned goals. Urine samples are collected regularly to monitor drug use. The therapy aims to equip the patient to gain three types of control: (1) stimulus control, (2) urge control, and (3) social control.

Multidimensional Family Therapy (MDFT) for Adolescents

An outpatient family-based drug abuse treatment for teenagers. MDFT views adolescent drug use in terms of a network of influences (that is, individual, family, peer, community) and suggests that reducing unwanted behavior and increasing desirable behavior occur in multiple ways in different settings. Treatment includes individual and family sessions held in the clinic, in the home, or with family members at the family court, school, or other community locations.

Appendix A (Continued)

Multisystemic Therapy (MST)

Addresses the factors associated with serious antisocial behavior in children and adolescents who abuse drugs. These factors include characteristics of the adolescent (for example, favorable attitudes toward drug use), the family (poor discipline, family conflict, parental drug abuse), peers (positive attitudes toward drug use), school (dropout, poor performance), and neighborhood (criminal subculture).

Combined Behavioral and Nicotine Replacement Therapy for Nicotine Addiction

Consists of two main components: (1) the transdermal nicotine patch or nicotine gum reduces symptoms of withdrawal, producing better initial abstinence; and (2) the behavioral component concurrently provides support and reinforcement of coping skills, yielding better long-term outcomes.

Community Reinforcement Approach (CRA) Plus Vouchers

An intensive 24-week outpatient therapy for treatment of cocaine addiction. The treatment goals are twofold: (1) to achieve cocaine abstinence long enough for patients to learn new life skills that will help sustain abstinence; and (2) to reduce alcohol consumption for patients whose drinking is associated with cocaine use.

Voucher-Based Reinforcement Therapy in Methadone Maintenance Treatment

Helps patients achieve and maintain abstinence from illegal drugs by providing them with a voucher each time they provide a drug-free urine sample. The voucher has monetary value and can be exchanged for goods and services consistent with the goals of treatment. Initially, the voucher values are low, but their value increases with the number of consecutive drug-free urine specimens the individual provides. Cocaine- or heroin-positive urine specimens reset the value of the vouchers to the initial low value.

Day Treatment With Abstinence Contingencies and Vouchers

Developed to treat homeless crack addicts. For the first two months, participants must spend 5.5 hours daily in the program, which provides lunch and transportation to and from shelters. After two months of day treatment and at least two weeks of abstinence, participants graduate to a four-month work component that pays wages that can be used to rent inexpensive drug-free housing. A voucher system also rewards drug-free related social and recreational activities.

The Matrix Model

Provides a framework for engaging stimulant abusers in treatment and helping them achieve abstinence. Patients learn about issues critical to addiction and relapse, receive direction and support from a trained therapist, become familiar with self-help programs, and are monitored for drug use by urine testing. The program includes education for family members affected by the addiction.

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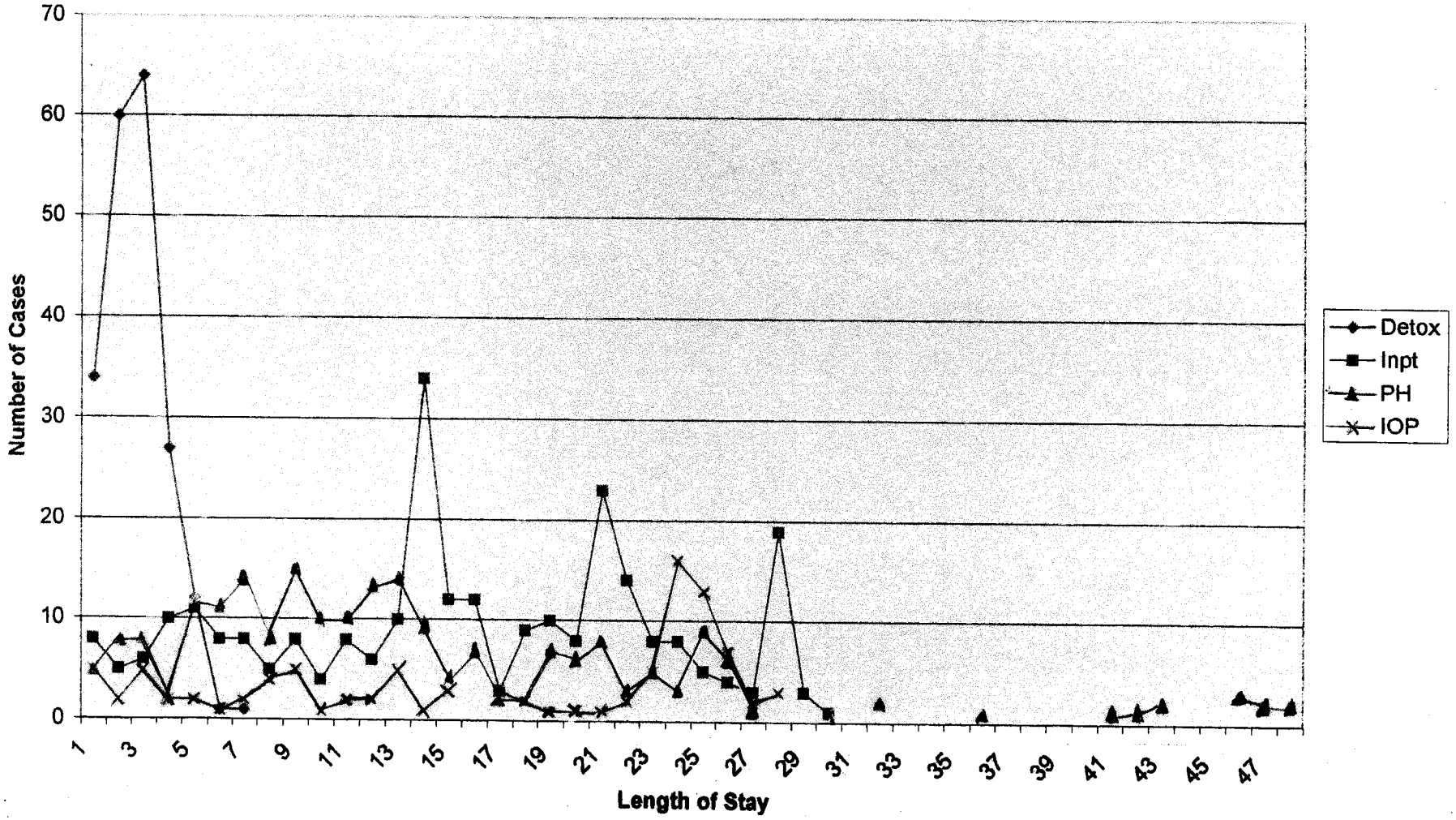
*This appendix is not a complete list of efficacious, scientifically based treatment approaches. Additional approaches are under development as part of the National Institute on Drug Abuse's (NIDA) continuing support of treatment research.

Source: *Principles of Drug Addiction Treatment – A Research-Based Guide,* National Institute on Drug Abuse, National Institutes of Health, NIH Publication No. 99-4180, October 1999.

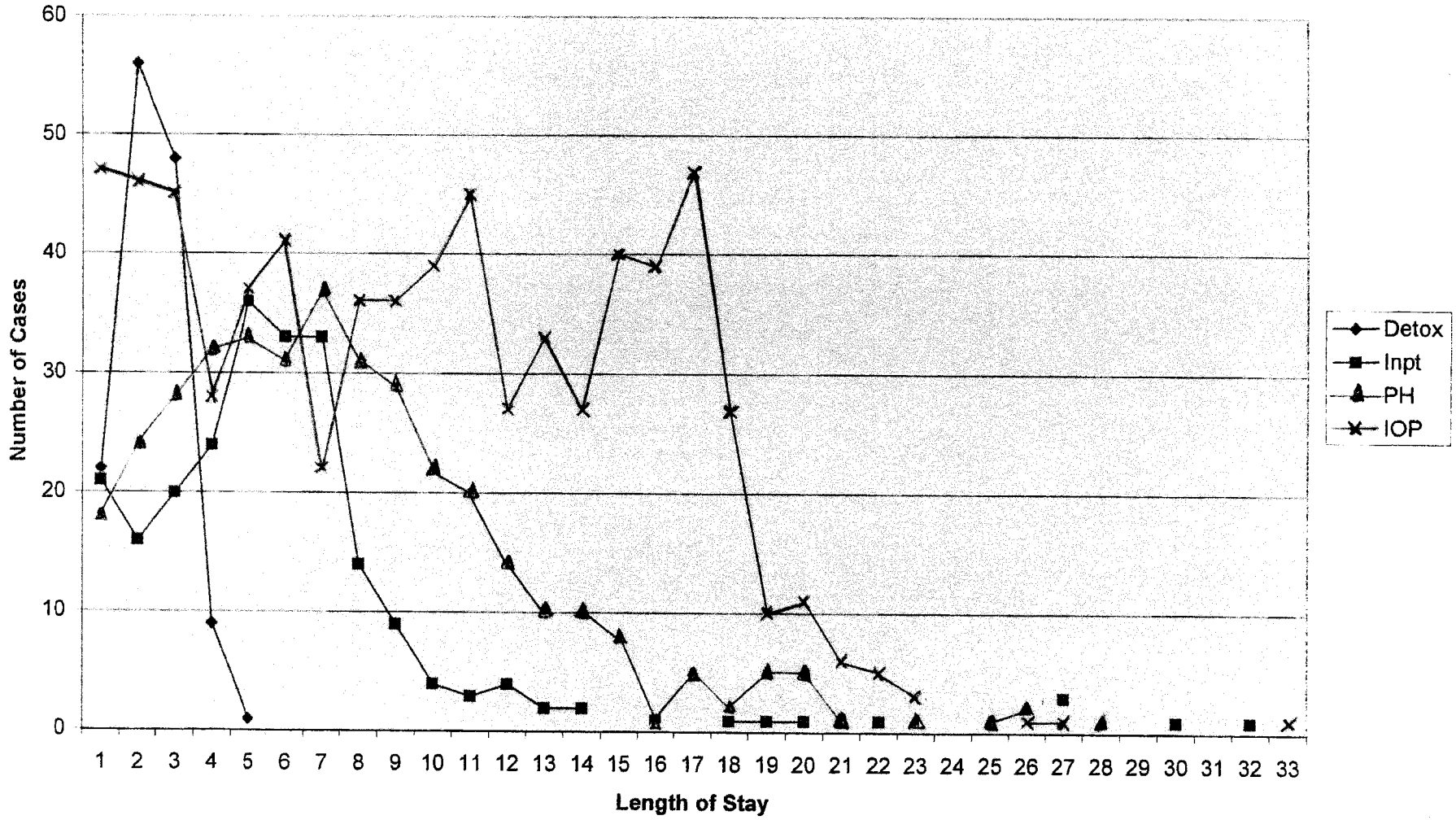
APPENDIX B

GATEWAY REHABILITATION CENTER
FREQUENCY DISTRIBUTION OF LENGTHS OF STAY
BLUE CROSS CASES ONLY - 1992



Appendix B (Continued)

GATEWAY REHABLITATION CENTER
FREQUENCY DISTRIBUTION OF LENGTHS OF STAY
BLUE CROSS CASES ONLY - 2001



Source: Gateway Rehabilitation Center, Aliquippa, PA.

APPENDIX C

Payer Data Collection Techniques and Constraints

Payer Data. We collected data from a variety of public and private payers. We could not verify or validate this data directly, but discussed and clarified with the source organizations the nature and specifics of the data elements. We received data from:

- *Department of Health*. SCA data is collected within the Client Information System (CIS), developed to satisfy federal reporting requirements. It collects data on three levels: facility, SCA, and state level. We have reported state level data on the number of clients served in each of several treatment modalities.
- *Department of Public Welfare*. Counties report their HealthChoices data to DPW, and we received consolidated county data through the Performance Outcome Management System (POMS). The system reports are by service, and, within each service, data is reported by age, number of recipients, number of units, expenditures, average cost per unit, and recipients served per 1,000 eligibles. For this data set, we have reported both penetration rates and average lengths of stay.
- *Pennsylvania Employees Benefit Trust Fund (PEBTF)*. The data we received from PEBTF is based on state employees' use of drug and alcohol treatment services. This data, however, is not broken out by service, but instead only gives a picture of how many people received service. We were unable to obtain length of stay data.
- *Private Insurers*. We arranged to obtain data from several commercial behavioral health organizations, however, we were unable to obtain penetration data from all of them.

Constraints in Data Collection and Analysis. Although we obtained data from a variety of sources, we did have some difficulties in compiling the data:

- Common Terms. In speaking to the various stakeholders in drug and alcohol treatment, we found that there is no consistent language or terminology for the various forms of drug and alcohol services. For example, some use the term "inpatient services" to identify services that take place within a hospital setting, but others considered inpatient to be any residential treatment. In Pennsylvania, partial hospitalization and intensive outpatient services are sometimes used interchangeably. We also found that there are specific time requirements for these two services.
- Data Bundling/Unbundling. Another difficulty was that, for some of the payers who reported to us, we were unable to unbundle services to get a true picture of penetration and length of stay. For example, the Department of Public Welfare was unable to separate the nonhospital detox, nonhospital rehabilitation, and halfway house services. They were also unable to separate partial hospitalization, intensive outpatient and outpatient services. The Department of Health was unable to separate intensive outpatient and outpatient services.
- Different terms. Some behavioral health care entities were unable to give us data based on the terms of services used by the Department of Health and did not necessarily provide services according to those definitions. This data was therefore placed in the most appropriate subtable.

Source: Developed by LB&FC staff.

APPENDIX D

ASAM Patient Placement Criteria

The *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised (ASAM PPC-2R)* is a clinical guide used in matching patients to appropriate levels of care. The criteria reflect a clinical consensus of adult and adolescent treatment specialists and input from related personnel. The purpose of the ASAM Patient Placement Criteria is to enhance the use of multidimensional assessments in making objective patient placement decisions for various levels of care. The PPC-2R describes treatment as a continuum marked by five basic levels of care:

Level 0.5:	Early Intervention
Level I:	Outpatient Treatment
Level II:	Intensive Outpatient/Partial Hospitalization Treatment
Level III:	Residential/Inpatient Treatment
Level IV:	Medically Managed Intensive Inpatient Treatment

Level 0.5: Early Intervention. Early intervention constitutes a service for specific individuals who, for a known reason, are at risk of developing substance-related problems or for those for whom there is not yet sufficient information to document a substance use disorder.

Level I: Outpatient Treatment. Level I encompasses organized services that may be delivered in a wide variety of settings. Addiction or mental health treatment personnel provide professionally directed evaluation, treatment, and recovery service. Such services are provided in regularly scheduled sessions and follow a defined set of policies and procedures or medical protocols.

Level I outpatient services are designed to treat the individual's level of clinical severity and to help the individual achieve permanent changes in his or her alcohol- and drug-using behavior and mental functioning. To accomplish this, services must address major lifestyle, attitudinal, and behavioral issues that have the potential to undermine the goals of treatment or inhibit the individual's ability to cope with major life tasks without the non-medical use of alcohol or other drugs.

Level II: Intensive Outpatient Treatment/Partial Hospitalization. Level II is an organized outpatient service that delivers treatment services during the day, before or after work or school, in the evening, or on weekends. For appropriately selected patients, such programs provide essential education and treatment components while allowing patients to apply their newly acquired skills within "real world" environments. Programs have the capacity to arrange for medical and psychiatric consultation, psychopharmacological consultation, medication management, and 24-hour crisis services.

Level II programs can provide comprehensive biopsychosocial assessments and individualized treatment plans, including formulation of problem statements, treatment goals, and measurable objectives—all developed in consultation with the patient. Such programs typically have active affiliations with other levels of care, and their staff can help patients access support services such as child care, vocational training, and transportation.

Level III: Residential/Inpatient Treatment. Level III encompasses organized services staffed by designated addiction treatment and mental health personnel who provide a planned regimen of care in a 24-hour live-in setting. Such services adhere to defined sets of policies and procedures. They are housed in, or affiliated with, permanent facilities where patients can reside safely. They are staffed 24 hours a day. Mutual and self-help group meetings generally are available on-site. Level III encompasses four types of programs:

- clinically managed low-intensity residential treatment;
- clinically managed medium-intensity residential treatment;
- clinically managed high-intensity residential treatment; and
- medically monitored inpatient treatment.

The defining characteristic of all Level III programs is that they serve individuals who need safe and stable living environments in order to develop their recovery skills. Such living environments may be housed in the same facility where treatment services are provided or they may be in a separate facility affiliated with the treatment provider.

Level IV: Medically Managed Intensive Inpatient Treatment. Level IV programs provide a planned regimen of 24-hour medically directed evaluation, care, and treatment of mental and substance-related disorders in an acute care inpatient setting. They are staffed by designated addiction-credentialed physicians, including psychiatrists, as well as other mental health- and addiction-credentialed clinicians. Such services are delivered under a defined set of policies and procedures and have permanent facilities that include inpatient beds.

Level IV programs provide care to patients whose mental and substance-related problems are so severe that they require primary biomedical, psychiatric, and nursing care. Treatment is provided 24 hours a day, and the full resources of a general acute care hospital or psychiatric hospital are available. The treatment is specific to mental and substance-related disorders; however, the skills of the interdisciplinary team and the availability of support services allow the conjoint treatment of any co-occurring biomedical conditions that need to be addressed.

Opioid Maintenance Therapy: OMT is a separate service that can be provided at any level of care. This service involves methadone maintenance and is delivered in an ambulatory setting.

Source: *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders, Second Edition-Revised, 2001,* American Society of Addiction Medicine, Inc.

APPENDIX E

Statement Regarding the Use of Pennsylvania Health Care Cost Containment Council Data

The Pennsylvania Health Care Cost Containment Council (PHC4) is an independent state agency responsible for addressing the problem of escalating health costs, ensuring the quality of health care, and increasing access to health care for all citizens regardless of ability to pay. PHC4 has provided data to the Legislative Budget and Finance Committee staff in an effort to further PHC4's mission of educating the public and containing health care costs in Pennsylvania.

PHC4, its agents and staff, have made no representation, guarantee, or warranty, express or implied, that the financial, patient, payer data and physician specific information provided to the LB&FC staff, are error-free, or that the use of the data will avoid differences of opinion or interpretation.

The analysis was not prepared by PHC4. The analysis was done by the LB&FC staff. PHC4, its agents and staff, bear no responsibility or liability for the results of the analysis, which are solely the opinion of the LB&FC staff.

09/27/02

APPENDIX F

Insurance Department Letter Interpreting Act 106

COMMONWEALTH OF PENNSYLVANIA
INSURANCE DEPARTMENT
Office of Chief Counsel
1341 Strawberry Square
Harrisburg, PA 17120

Governor's Office
of General Counsel

Phone (717) 787-2734
Fax (717) 772-1969

November 21, 2002

Linda Williams
Senior Deputy Attorney General
Health Care Unit
Strawberry Square
14th Floor
Harrisburg, PA 17120

RE: Act 106 of 1989

Dear Linda:

The proper interpretation of Act 106 of 1989, 40 P.S. § 908-1 et seq., related to mandated benefits for drug and alcohol treatment, has been an issue we have discussed for some time. I thought it was appropriate to set forth what I believe to be an appropriate interpretation of Act 106 in the overall context of regulation by the Pennsylvania Insurance Department.

The issue presented to your Office, as well as informally to the Office of Chief Counsel, has been whether the medical director of a managed care plan or health insurer, or of a "carve-out" managed mental health provider under contract to a managed care plan or health insurer, may determine (a) whether care should be provided; (b) the appropriate level of care; or (c) the appropriate length of stay.

I believe that the answer to that question is yes, provided that a knowledgeable treating physician does not make a recommendation that an otherwise denied treatment or service should be covered based upon compliance with appropriate clinical criteria. So, for example, absent a contrary recommendation from a treating physician, the determination of a "carve-out" contractor's medical director generally would control on the issue of medical necessity, provided it is based upon the failure to meet appropriate clinical criteria and such failure is uncontested by a knowledgeable treating physician. Should, however, a treating physician contest the medical director's decision to deny, reduce the level of, or to terminate care, the treating physician's certification that the clinical criteria have been complied with should control as long as all other legitimate coverage requirements (i.e. other than medical necessity) have been met by the patient/insured.

It is my opinion that Act 106 compels this conclusion. Section 908-4 of Act 106 (related to non-hospital residential treatment) and Section 908-5 (related to outpatient services) require only "a licensed physician or licensed psychologist" to certify the need for such care, a requirement which is met by certification by a treating physician. No higher standard can be imposed under

Section 908-3 (related to inpatient detoxification), which does not include the "a licensed physician" language. Thus, a health insurer or managed care plan cannot, under Act 106, require that their medical director or the medical director of a carve-out contractor be the only one empowered to made such a certification.

Any analysis of a specific situation would require careful examination of the relevant evidence of coverage and other contractual documents, as well as the clinical facts of the specific situation. In the context of an Act 68 of 1998, 40 P.S. § 991-2101 et seq., appeal or grievance, in the event of any ambiguity such documents will generally be construed in favor of the enrollee/insured/member. In this regard, special attention must be paid to whether pre-certification or concurrent review of care is authorized under the relevant documents. Moreover, where the insurer or plan relies upon a coverage exclusion, the burden of proving the applicability of such an exclusion would be on the insurer or plan.

There has been considerable attention paid to former Deputy Commissioner Brenner's memorandum of April 5, 1993, related to this topic. That memorandum was written before the allegedly aggressive use of pre-certification criteria by, inter alia, carve-out behavioral health contractors. Moreover, at that time, such decisions were frequently made by treating primary care physicians. The memorandum was also written well before Act 68 and its complaint and grievance procedures were enacted into law. Accordingly, no weight can be accorded to that memorandum, which it was never reduced to regulation. I might add that this Office has been unable to find any legal analysis or legislature history underlying the memorandum. Nevertheless, we do not read Act 106 as prohibiting pre-certification of drug and alcohol treatment or of exclusions from coverage for treatment that is not medically necessary. Indeed, Act 106 appears to justify the use of certifications by treating physicians for the reasons described earlier. I hope this opinion is helpful to you as the Office of the Attorney General reviews matters involving Act 106.

Very truly yours,

David F. Simon
Chief Counsel

cc: Ronald Gallagher
Geoffrey Dunaway
Jonathan Greer
Todd Shamash, Esq.✓

APPENDIX G

HealthChoices Appeal Process

Under HealthChoices, the BH-MCOs must comply with Act 68 guidelines, but they must also comply with additional rules including federal rules under the Medicaid State Plan approved by the Federal Government and special conditions set forth by OMHSAS. A major difference is the speed with which medical determinations can be reviewed if challenged (known as grievances). While standard HMO practice under Act 68 allows up to 30 days to have grievances reviewed and decisions made, HealthChoices BH-MCOs must complete their 1st level reviews within five calendar days. At the 2nd level, where standards for HMOs under the act required a decision within 45 days from filing of a 2nd level grievance, HealthChoices BH-MCOs must complete their 2nd level decisions within 30 days. Additionally, the 2nd level complaint and 2nd level grievance committees must have at least 1/3 membership of individuals enrolled in the HealthChoices BH-MCO who have had experience with receiving substance abuse services from the BH-MCO.

Further, 2nd level reviews are held at a location near where the member lives rather than making the member appear at the business offices of the BH-MCO. OMHSAS has a Division of Grievances and Appeals that works actively and proactively with the county programs and their contracted BH-MCOs to ensure that the complaint and grievance processes work in a timely manner and in a way that is easily accessible to the members. The number of cases that end up in the Department of Health or the Insurance Department external review is remarkably few. And, the Department of Health has not been forced to impose penalties on HealthChoices BH-MCOs.

APPENDIX H

Selected Bibliography on Drug and Alcohol Treatment Services and Managed Care

Inpatient Alcohol Treatment, Who Benefits? – Source: William R. Miller, Reid K. Hester; *American Psychologist,* July 1986, Vol. 41, No. 7, 794-805.

Although uncontrolled studies have yielded mixed findings, 26 controlled comparisons have consistently shown no overall advantage for residential over nonresidential treatment settings, for longer over shorter inpatient programs, or for more intensive over less intensive interventions in treating alcohol abuse. Data suggest that intensive treatment may be differentially beneficial for more severely deteriorated and less socially stable individuals. The outcome of alcoholism treatment is more likely to be influenced by the content of interventions than by the settings in which they are offered. Third-party reimbursement policy should discourage the use of intensive residential models for addressing alcohol abuse when more cost-effective alternatives are available and should reinforce the use of research-supported treatment methods regardless of setting. Such policy priorities run directly counter to the current practices and financial interests of many for-profit providers.

The Effect of Managed Care on the Treatment Outcome of Substance Use Disorders – Source: Ellen A. Renz, Ph.D.; Richard Chung, M.D.; T. Orvin Fillman, Dr. P; David Mee-Lee, M.D.; and Mike Sayama, Ph.D., *General Hospital Psychiatry* 17, 287-292, 1995.

This study examined the effect of managed care and other reimbursement mechanisms on the outcome of substance abuse treatment at a single treatment facility. Results showed that recidivism rates were not different for managed vs. nonmanaged care patients. Also, recidivist patients had significantly more diagnoses than nonrecidivist patients. Specifically, this study shows that managed care patients are not more apt to return to treatment because of truncated treatment episodes.

Management of Mental Health and Substance Abuse Services: State of the Art and Early Results – Source: David Mechanic, Mark Schlesinger, and Donna D. McAlpine, *The Milbank Quarterly,* Vol. 73, No. 1, 1995.

It appears that the application of managed care to the treatment of mental illness and substance abuse can produce a substantial reduction in costs. Prepaid group practices provide lower-cost care by reducing hospitalization and often by substituting less expensive and less intensive outpatient services for more costly approaches. This report discusses the organization of managed care for mental health services; general approaches to services; the impact of managed care on the use, cost, and quality of mental health services; utilization review; high cost case management; and cost offsets in medical care.

Mental Health and Substance Abuse Parity: A Case Study of Ohio's State Employee Program – Source: Roland Sturm, Ph.D., William Goldman, and Joyce McCulloch, *The Journal of Mental Health Policy and Economics,* 1, 129-134, 1998.

Documents the experience of the State of Ohio with adopting full parity for alcohol, drug abuse, and mental health (ADM) care for its state employee program under managed care. The study concludes that managed care can provide long-run cost containment for ADM care even when patient copayments are reduced and coverage limits are lifted.

Substance Abuse Service Utilization Under Managed Care: HMOs Versus Carve-Out Plans – Source: Bradley Stein, M.D., M.P.H., Elaine Reardon, Ph.D., and Roland Sturm, Ph.D., *The Journal of Behavioral Health Services & Research,* 450-455, November 1998.

Once, most of the insured received their medical coverage under a fee-for-service insurance plan. The majority is now covered under some type of managed care plan. Recent estimates are that more than 160 million people now have their behavioral health care managed by some type of managed behavioral healthcare organization. An increasingly common approach to managed care has been the development of behavioral health care carve-outs, so named because the management of health care and substance abuse benefits are separated from other health care benefits.

Appendix H (Continued)

Substance abuse claim data generated from the experience of one large employer was used to investigate the effects of switching its employees, initially receiving care in 23 different HMOs, to one behavioral health care carve-out. Inpatient and outpatient service utilization were found to decrease, but intermediate service utilization increased dramatically.

New Directions in Alcohol and Drug Treatment Under Managed Care – Source: Constance Weisner, DrPH, MSW; Dennis McCarty, Ph.D.; and Laura Schmidt, MSW, MPH, *The American Journal of Managed Care,* Vol. 5, Special Issue, June 25, 1999.

Managed care has had major effects on the organization of service delivery, the workforce, and the provision of services. Most of the changes have occurred without the benefit of clinical or policy research. Although managed care has the potential ability to address longstanding problems associated with alcohol and drug treatment, it also presents additional barriers to access and improving treatment outcome. The review suggests that organizational approaches, particularly the settings in which treatment is placed, will differ in their impact on ties between treatment agencies and the medical community, and ties with other health and social service agencies. There is a new emphasis on accountability of treatment through the mechanisms of outcomes monitoring and performance indicators.

A National Evaluation of Treatment Outcomes for Cocaine Dependence – Source: D. Dwayne Simpson, Ph.D., George W. Joe, Ed.D., Bennett W. Fletcher, Ph.D., Robert L. Hubbard, Ph.D., and M. Douglas Anglin, Ph.D., *Arch Gen Psychiatry,* Vol. 56, June 1999.

Studied 1,605 cocaine-dependent patients from 11 cities nationwide, focusing on post treatment outcomes of community treatments. Patients with the most severe problems were found more likely to enter long-term residential programs, and better outcomes were reported by those treated 90 days or longer.

The State of Behavioral Health in Managed Care – Source: David Mechanic, Ph.D.; *The American Journal of Managed Care, Vol. 5, Special Issue,* June 25, 1999.

The most dramatic change in health care in recent years has been the rapid growth of large, private behavioral healthcare organizations that have contracted with private employers, healthcare plans, and government agencies to manage mental health and substance abuse services on administrative and risk bases. As managed behavioral healthcare has gotten into the insurance sector, it has shown that, in private non-profit hospitals, the average length of stay decreased by about three days despite the fact that admitted patients were more seriously ill. For managed behavioral healthcare in the public sector, there is evidence that managed care reduces the cost of public sector care, but is less clear that it can reduce the cost to those patients who are most severely and persistently ill. Although there is no indication that managed behavior healthcare has reduced access to initial mental health services, complaints from professionals, patients, and consumer organizations indicate that managed care has inappropriately reduced the intensity of care.

Managed Care and Unmet Need for Mental Health and Substance Abuse Care in 1998 – Source: Roland Sturm, Ph.D., Cathy Donald Sherbourne, Ph.D., *Psychiatric Services,* February 2000, Vol. 51, No. 2.

No differences were found in self-reported unmet need by whether the individual was or was not enrolled in a managed care program. The rate of unmet need defined by no care was lower under managed care, but the rate defined by less or delayed care was higher. While managed care may have improved access to some treatment, significant problems remaining providing access to comprehensive care.

Six-Month Outcome and Satisfaction With Managed Alcohol Treatment Services – Source: Paul R. Marques, Ph.D., Evangeline R. Danseco, Ph.D., and Doreen G. Branch, M.S., Pacific Institute for Research and Evaluation, Landover, MD 20785, November 15, 2000- Board O.

Research information about clinical outcomes under managed alcohol treatment is the least well documented of the changes in managed behavioral healthcare. This study shows that about 50 percent of those treated were alcohol free and health status and behavioral issues were significantly improved. The study also shows that those with previous treatment were least likely to benefit from services.

Appendix H (Continued)

Alcoholism Treatment in Managed Private Sector Plans: How Are Carve-Out Arrangements Affecting Costs and Utilization? – Source: Roland Sturm, Ph.D., Bradley Stein, M.D., M.P.H., Weiying Zhang, and J.E. Stan, *Recent Developments in Alcoholism, Volume 15: Services Research in the Era of Managed Care,* Ch. 12, 2001.

Provides a profile of carve-out cost and utilization of alcohol-related services in recent years in 77 employer sponsored managed care plans. Also measures how various components of the total costs of alcohol abuse treatment services have changed over the past decade. The study concludes that alcohol treatment is rare among those with private insurance, but patients receiving this treatment have the highest per user behavioral health costs. In addition, the total alcohol-related costs and costs for intermediate alcohol-abuse treatment have remained constant. It was found that alcohol abuse treatment patients did not have a greater tendency to disenroll than other members. Finally, alcohol detoxification follow-up figures are substantially better than those seen in nonprivate plans.

Modeling Treatment Process and Outcomes – Source: D. Dwayne Simpson, Ph.D., *Addiction,* 96, 207-211, 2001.

The length of stay in drug abuse treatment is one of the most consistent predictors of follow-up outcomes. Significant improvements in outcomes usually begin to emerge after critical thresholds of retention are reached, averaging about three months residential and outpatient drug-free treatments, but ranging up to a year for methadone treatment.

The Impact of Managed Care on Addiction Treatment: A Problem in Need of Solution – Source: Marc Galanter, M.D., President, American Society of Addiction Medicine, May 6, 2002.

This report examines the impact of managed care on all areas of the health care system and, in particular, on addiction treatment. The report evaluates how managed care has caused a decline in the availability of care for many addicted patients. Although costs have gone down as a result of managed care, managed care has also caused providers problems in making treatment decisions for their patients. An unintended consequence of managed care has resulted in decreased value of substance abuse treatment benefits.

A National 5-Year Follow-up of Treatment Outcomes for Cocaine Dependence – Source: D. Dwayne Simpson, Ph.D., George W. Joe, Ed.D., and Kirk M. Broome, Ph.D., *Arch Gen Psychiatry,* Vol. 59, 538-544, June 2002.

Long-term outcomes of community treatment for cocaine dependence were examined in relation to problem severity at treatment entry and treatment exposure throughout the follow-up period. The large decreases in cocaine use one year after treatment discharge were sustained during the five-year follow-up.

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*This appendix supplements the discussion of drug and alcohol treatment literature found in Finding II.B and especially in Finding II.F of the report. Studies referenced in those findings are generally not included here.

Source: Selected from articles provided by behavioral health organizations, administrators, providers, and others as key studies in the drug and alcohol treatment field, especially in relation to managed care.

APPENDIX I

Criminal Justice System Outcomes Studies

Pennsylvania had 16,100 prison inmates enrolled in substance abuse treatment programs in 2001, a 36 percent increase over a five-year period. Former inmates receive aftercare services following their release to their home communities, and parole violators and other offenders enter community-based treatment programs as alternatives to imprisonment.

Residential Substance Abuse Treatment. RSAT provides 18 months of drug and alcohol services to prisoners who have been given relatively short sentences for parole violations. Their treatment begins in prison and continues after their release. A grant from the U.S. Department of Justice funded an outcomes study of the RSAT program by the Vera Institute of Justice in 2002.[1]

The study looked at RSAT 412 participants and a demographically-matched control group of 288 technical parole violators to determine whether the RSAT subjects would have lower rates of criminal recidivism than the control group. Two factors reduced the control sample size further, limiting the feasibility of a direct comparison. Background data on the control group was generally incomplete, and many never left prison because they were serving consecutive sentences. The RSAT participants were also subject to closer supervision, the report on the study noted.

The only outcome measure for RSAT recidivism was the rate of return to state prison, because the study team did not have complete information on arrests or the time spent in local jails. Although the RSAT group had a 55 percent failure rate, less than one percent returned to custody because of new offenses. Eleven percent failed to complete the initial six-month phase in prison. The rest of the failures resulted from violations such as escaping or walking away from a Community Corrections Center (CCC), breaking other facility rules, or testing positive for alcohol or drugs.

RSAT participants showed an increasing tendency to drop out as they moved from one program phase to the next. They have strong incentives to complete the first phase because failure results in their return to the general prison population where they will probably remain incarcerated for a longer time than they would have if they had stayed in the program. Hence, 89 percent of the study group qualified for release to a CCC.

The completion rates declined in each of the next two phases: six months residing in a CCC followed by six months receiving outpatient treatment under parole supervision. The CCC completion rate was 63 percent, and another 15 percent were still in the second phase at the time of the study. Hence, the CCC failure rate was at least twice the prison rate. The dropout rate doubled again in the parole phase, where 56 percent had completed six months or were still in the program.[2]

The report cited a sharp decrease in the amount of services and increasing variation in treatment philosophy and content at each phase as possible factors contributing to the declining retention rates. The study team also looked for regional differences between the two prison-based RSAT groups it had tracked. The completion rates for each of the three phases showed no significant differences between the participants from southeastern and western Pennsylvania.

RSAT participants were incarcerated for significantly shorter periods of time than prisoners in the control group. Although reduced terms imply cost savings, the "one strike only" policy of RSAT parole might offset the savings with the costs of returning violators to prison. In addition, concerns about public safety result in closer scrutiny of RSAT parolees. The almost negligible rate of return for new offenses indicates tighter security and its associated costs may not be necessary, the report suggests.

Appendix I (Continued)

Community-Based Treatment Program. A community-based provider reported an improvement in its patients' completion rate after making changes based on follow-up interviews with successful clients, about 90 percent of whom enter involuntarily through the criminal justice system. The mid-year completion rate for 2002 was approximately 70 percent, compared to a 52 percent historical rate.

The provider began its follow-up evaluations in 1999. It focused on the completion rate, because the National Institute on Drug Abuse (NIDA) had cited retention as the most powerful and consistent indicator of treatment outcomes. The provider interviews former clients two months and one year after treatment. It had collected pre-treatment data on 363 clients by mid 2002 and had information on living arrangements and criminal justice supervision for 311 after two months and 179 after one year. The follow-ups collected more comprehensive information, including substance abuse and employment patterns, from 124 and 50, respectively.

The research analysis concentrated on former clients who had completed the rehabilitation program because the provider wanted to know how they had benefited from the full range of its services. The database contained 106 two-month and 40 one-year follow-up interviews with such clients. The following table compares the outcomes for completers and non-completers.

Treatment Outcome Measures for a Community-Based Program

	After 2 Months		After 1 Year	
	Completed Treatment	Did Not Complete	Completed Treatment	Did Not Complete
Living in secure, drug-free housing[a]	63%	12%	47%	10%
Receiving aftercare treatment	91	12	81	8
Employed	87	6	74	5
Incarcerated or fugitives[b]	17	71	24	60

[a]Including residential center, halfway house, or private home.

[b]Including technical parole violators.

Source: Treatment Trends, Inc.

The provider attributed the outcome rates for clients who had completed the program to their perseverance in meeting the rigorous expectations of their treatment plans. Entry through the criminal justice system was a factor, according to the provider, who cited NIDA reports on how the impending consequences of severe sanctions could produce retention rates and outcomes similar to what voluntary clients achieved.

[1]Rachel Porter, *Breaking the Cycle: Outcomes from Pennsylvania's Alternative to Prison for Technical Parole Violators*, Vera Institute of Justice, New York, NY, August 2002.

[2]The study team did not have parole data differentiating between participants who had completed the program and those who were still involved.

Source: Developed by LB&FC staff from PCCD and other information.

APPENDIX J

Selected Legislative Initiatives Relating to Drug and Alcohol Treatment Services

(2001-02 Legislative Session)

HB 2804 amends the Insurance Code to require that any purchaser of a health policy that provides drug and alcohol services (1) who has established a worksite-based employee assistance program dealing with drug and alcohol issues and (2) that employs certified employee's assistance professionals are entitled to coverage from the health policy for any drug and alcohol treatment ordered by the certified employee assistance professionals so long as those services are covered by the health package.

HB 2805 creates the Alcohol and Drug Abuse and Dependency Treatment Reporting Act. It requires that all carriers and health plans doing business in the state must annually report on the provision of drug and alcohol treatment services, including total subscribers; number of subscribers receiving drug and alcohol treatment; a breakdown of the treatment provided by type, level of care, and length of stay within each type of treatment; and names and addresses of subcontracting MCOs administering treatment and drug and alcohol dependency treatment facilities used. The reports are to be given to the Office of Attorney General's (OAG) Health Care Unit, the Bureau of Drug and Alcohol Programs (BDAP) in the Department of Health, the Insurance Department, the Senate's Public Health and Welfare Committee, and the House's Health and Human Services Committee. Also, BDAP is to review the annual reports for compliance and determination that required parties are providing treatment services required under state law. BDAP is to report its conclusions to the House and Senate committees and to the Health Care Unit at OAG.

HB 2806 creates the Alcohol and Drug Abuse and Dependency Treatment Standards Act. It requires all carriers and health plans doing business in the state to submit an annual drug and alcohol treatment plan that is to include the estimate of prevalence of chemical dependency in the subscriber pool; estimate of need and lengths of stay for each type of drug and alcohol treatment; follow-up plan for continuing care; outreach plan to increase identification and treatment of subscribers with drug and alcohol problems, methods of access to assessment, and treatment displaying timeliness and appropriateness for handling drug and alcohol affected persons; proposed addiction treatment program network with a full continuum of care, geographic availability, cultural sensitivity, and planning for special needs populations; a method to provide performance measures for these categories; and an annual assessment of success in meeting each plan goal. The submitted plans must be reviewed and approved within 90 days by both the Department of Insurance and BDAP in the Department of Health. Copies of these reviews must be given to HCU at OAG and to the appropriate House and Senate committees.

HB 2807 creates the Expense Ratio Disclosure Act. It requires "carriers" that own or contract with an MBHCO to distribute to its members (at the time of enrollment) specific drug and alcohol treatment services covered and specific exclusions; reimbursement methodology used for drug and alcohol treatment services; and procedure required for obtaining out-of-network BH services. Each such carrier must annually report to the Insurance Department, DOH, the Pennsylvania Commission on Crime and Delinquency, the appropriate Senate and House committees, and provide the drug and alcohol treatment expense ratio for this care. This ratio is defined as "the ratio of the total direct care expenses incurred for treatment service in relation to the total overall direct payments for behavioral health care services." A "carrier" is defined to include a health insurer, NP health service plan, HMO, PPO, 3d party administrator, and any other entity providing health benefit plans.

HB 2808 amends the Insurance Code to provide that, as long as services are covered, no subscriber of a health plan may be denied drug and alcohol treatment or coverage due to the identification of a drug and alcohol problem as a result of contact with the legal or criminal justice system, or where treatment is required by court order.

APPENDIX K

Joint Response of the Departments of Health, Insurance, and Public Welfare to This Report

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
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The Secretary

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FEB 26 2003

Mr. Philip R. Durgin
Executive Director
Legislative Budget and Finance Committee
400 Finance Building
Harrisburg, Pennsylvania 17105-8737

Dear Mr. Durgin:

On behalf of the Departments of Health (DOH), Insurance (INS) and Public Welfare (DPW), I want to thank you for the opportunity to review the Legislative Budget and Finance Committee (LBFC) draft report entitled "Drug and Alcohol Services in a Managed Care Environment." The Departments appreciate the work and professionalism of the LBFC and its staff in completing this study.

The Departments strongly recognize the need for quality drug and alcohol services in the Commonwealth. As the report indicates, the Commonwealth plays a vital role in both the direct delivery of drug and alcohol services and assuring that private commercial insurance plans provide necessary and appropriate care. Each Department is committed to continue to examine ways to improve upon the current delivery of these services and believes recommendations contained in the draft LBFC report will be useful to achieve this goal.

The following represent the comments of the Departments of Health, Insurance and Public Welfare:

General Comments:

The report should make a clear distinction between Medicaid Managed Care and Commercial Plans. The LBFC report indicates that many findings are relevant to both the Medicaid and commercial managed care plans, however, DPW recommends that a clearer distinction be made between the public Medical Assistance (MA) HealthChoices managed care plan administered by the Department's Office of Mental Health and Substance Abuse Services (OMHSAS) and the private sector commercial plans.

While the report makes some distinctions intermittently, DPW suggests that a clear distinction be made in an Executive Summary as well as highlighted throughout the document. It should be clearly indicated that in HealthChoices managed care delivery system drug and alcohol service utilization is higher; there are increased drug and alcohol services beyond what is available in MA fee for service delivery system; the

HealthChoices plan requires the use of standardized medical necessity criteria, and that there are reinvestment opportunities to address gaps in service. County governments serve as the primary contractor for the HealthChoices Behavioral Health Program, helping to ensure coordination with other county administered health and human service programs.

Recommendation #1: The Commonwealth's organizational structure for regulating and administering substance abuse treatment programs should be streamlined and strengthened.

The Departments of Health and Public Welfare concur that streamlining program licensing requirements, fiscal requirements, program requirements, reporting requirements, and payment mechanisms between the two Departments will have a positive impact on service delivery and coordination of care. This recommendation is consistent with Executive Order 2003-1 which Governor Rendell signed on January 21, 2003. This Executive Order establishes the Office of Health Care Reform and establishes a mechanism to improve the delivery and coordination of health care services in the Commonwealth. As such, the Department believes that the Executive Order will be the focal point for the Departments of Health and Public Welfare to work together in examining how the current regulation and administration of drug and alcohol programs can be better coordinated and structured.

Recommendation #2: The Department of Insurance should promulgate regulations to reinforce Act 106's provisions.

It has been suggested by numerous groups and LBFC that the Insurance Department should give consideration to establishing, by regulation, a separate process (i.e. separate from the Act 68 process) for resolving Act 106 complaints and grievances. It should be pointed out that the complaint and grievance procedures of Act 68 are mandated by statute. As such, the Department of Insurance believes any change to or separate process apart from such procedures must similarly be accomplished by legislative amendment. Therefore, INS believes it is inappropriate and impermissible to establish such a process by regulation. Furthermore, as noted in the report the INS has not seen any significant complaint activity related to drug and alcohol treatment coverage.

Recommendation #3: If the Department of Health's upcoming letter does not resolve the confidentiality dilemma, it should revise regulations to allow greater disclosure flexibility.

The Department of Health agrees that the 1997 letter interpreting the regulations needs further clarification. Rather than unilaterally revising the referenced letter, DOH will build upon an existing confidentiality workgroup, comprised of interested stakeholders, to evaluate confidentiality policy issues and develop specific recommendations to the department. These recommendations will then be evaluated to determine whether existing regulations and statute support the policy or if changes should be pursued.

Recommendation #4: If primary responsibility for mental health and substance abuse remains in separate departments, additional efforts should be made to better coordinate the two programs.

The Departments of Health and Public Welfare concur with this recommendation. As previously indicated, the recently signed Executive Order 2003-01 will be the vehicle for DPW and DOH to ensure that a thorough and complete analysis of this issue and what steps are necessary to improve the delivery of these services. As noted in the LBFC study, DPW and DOH have already been closely involved in discussing and problem-solving many issues of mutual concern. There is ongoing collaboration between the departments on such issues as licensing, HealthChoices, MISA, disaster preparedness and criminal justice. Both departments work together on developing integrated projects for individuals with co-occurring mental and substance use disorders, needs assessment, BDAP's Clinical Standards Committee, and legislative issues involving Act 126.

Recommendation #5: The Department of Public Welfare should reduce the 30-day "gap" period for HealthChoices enrollment.

The report makes numerous references to the 30 day "gap" period between when a person is determined eligible for MA and when they are enrolled in a HealthChoices plan. The report further states that the "gap" period creates a cost shift from MA to the SCAs and causes clients to be shuffled between programs.

While recognizing that the "gap issue" exists, DPW is concerned that the use of the term "gap" will be construed as implying a "gap" in services available to MA recipients, as opposed to a "gap" how these services are delivered and the funding for the services. DPW is aware of impact on the delivery of services created by the 30 day enrollment process. The 30 day "gap" period was designed to ensure that individuals have sufficient time to meet with an enrollment specialist and choose a HealthChoices Physical Health MCO and primary care practitioner. Prior to being enrolled in HealthChoices, funding of drug and alcohol services contained in the Medicaid State Plan (e.g. inpatient detox and rehab, outpatient clinic, etc.) is provided through the MA Fee for Service program. Act 152 services (e.g. non-hospital rehab and detox) are not included in the Medicaid State Plan, and payment for services provided to MA recipients prior to their enrollment in HealthChoices is provided through specific allocations from OMHSAS to the SCAs. Once a person is enrolled in HealthChoices, funding responsibility for Act 152 is shifted from the SCAs to HealthChoices.

This issue is focused on consumers who become MA eligible by virtue of their placement in an Act 152 program, and in many cases, may lose their MA eligibility upon discharge from the Act 152 program.

Given the observations of the LBFC study, DPW will review the administrative feasibility of reducing or eliminating the "gap," but wants it noted that such action (e.g. cost shift)

will result in a reduction of the Act 152 allocation to the SCAs and transfer of funding to the HealthChoices capitated program.

Recommendation #6: The Department of Health, together with the Department of Public Welfare, should initiate a task force to guide the development of an outcomes database.

The Departments of Health and Public Welfare concur with this recommendation. The development of an outcomes database, assuring appropriate confidentiality, should continue to be investigated and developed as part of the efforts of the Health Care Reform Office and Departments efforts to look at improvements to the regulation and delivery of drug and alcohol services. Both departments, in a collaborative effort to gain a comprehensive understanding of substance abuse issues throughout the Commonwealth, began working together over the last two years to review available data and to overcome obstacles in combining data systems between our agencies. We fully support the consolidation of data collection and storage systems and have applied to the Substance Abuse and Mental Health Services Administration (SAMHSA) for technical assistance to assist us in data integration.

Recommendation #7: The General Assembly should consider requiring private insurers to report encounter and outcomes data for substance abuse services.

If the General Assembly is supportive of this recommendation, the Departments will provide any assistance necessary with the development of the legislation.

Recommendation #8: The Insurance Department should take additional steps to reduced managed care payment delays.

The Insurance Department has committed substantial resources to the overall enforcement of Act 68, including compliance with Act 68's prompt payment provisions. Specifically, INS has conducted market conduct exams on all health maintenance organizations operating in the Commonwealth. HMOs currently operating in the Commonwealth have been examined twice. To date, these exams have resulted in the assessment of penalties of over 2.5 million dollars against non-compliers and have produced in excess of 1.6 million dollars of restitution for health care providers. A major focus of these reviews has been examination of claims payment data for prompt payment violations. Furthermore, as mentioned previously to the LBFC, INS had completed a data call examining market wide compliance with Act 68's prompt payment provisions. INS also handles complaints from providers that could involve a single prompt payment claim or as many as several hundred. In the process of handling each complaint, INS may make an enforcement referral and subsequent prosecution may result. Taken as a whole, these exams and reviews demonstrate the substantial pro-active steps taken by INS to enforce Act 68's prompt payment provisions.

Again, on behalf of the three Departments, we appreciate the opportunity to respond to this draft report.

Sincerely,

Estelle B. Richman

Estelle B. Richman
Acting Secretary