REHABILITATION & COMMUNITY PROVIDERS ASSOCIATION

Opioid Crisis:
Fair Rate Setting Process Needed

Pennsylvania is experiencing an opioid crisis of unprecedented proportions. The Commonwealth must have a strong and expanding network of drug and alcohol treatment programs and providers to address the serious problems that are leading to the disability and death of its citizens.

A critical factor in ensuring an adequate number of capable treatment providers in the long term is to provide for fair rates that not only sustain providers, but also encourage their growth and improvement in treatment outcomes. The drug and alcohol programs have been chronically underfunded for many years. The Pennsylvania Department of Human Services (DHS) and the Department of Drug and Alcohol Programs (DDAP) oversee the implementation and operation of HealthChoices and the Single County Authority (SCA) system. It falls on these agencies to ensure that HealthChoices Behavioral Health Managed Care Organizations (BH-MCOs) and SCAs establish a fair, consistent, and meaningful process for determining reimbursement rates for drug and alcohol treatment services.

Treatment providers have worked to operate efficiently and within the constraints of budgeting limitations. However, the consequences of these financial limitations, including lack of rate increases, have caused severe financial strain on the provider system. The lack of a rate setting process which assures that the reasonable cost of services are covered has led to inadequate rates, resulting in programs closing, no longer working in the publicly funded system, or refusing to increase the size of their commitment to offering services to public clients.

For example, the rates paid for residential detox and rehabilitation services provided to uninsured patients funded by the block grant funds to SCAs are established based on a process specified by DDAP referred to as the *XYZ Package*. This system, in theory, establishes the cost of care. Unfortunately, the *XYZ Package* rate determinations are largely ignored, resulting in rates that are set in an arbitrary and unilateral manner by the SCAs. This results in rates which are significantly below the actual cost of delivering residential services. With the rates so far below the costs of providing care, there is little incentive for organizations to establish additional capacity to serve publicly funded patients. The consequences have been providers rationing access to addiction treatment services to publicly funded patients, or even the total economic failure of essential programs. Additionally, in many cases the HealthChoices BH-MCOs have refused to grant rate increases, resulting in rates which are now even lower than the SCA rates.

In contrast, while there is an actuarial-based system to increase county/commonwealth-specific payments to BH-MCOs, it has become apparent that rate increases are infrequently passed on to providers. It has also been reported that in some areas reinvestment funds have been plentiful for the development of new programs and services, at the expense of provider rate increases for existing services. Many providers have experienced a complete refusal by some BH-MCOs to consider rate increases, and have gone multiple (five or more) years without any. Unfortunately, the improvement in access and ability to support people needing treatment services on a long-term basis is handicapped by this inequitable and often absent system of

determining BH-MCO reimbursement rates for services provided to patients with addictive disease.

One RCPA member reported: “There are not enough treatment beds in the state,” and many other members receive complaints about inadequate access to other levels of care. In the six months from January 2016 to June 2016, this provider’s call center turned away over 4,000 people due to a lack of beds. This number will total over 8,000 for the year. During that same period, they were able to accept about 5,000 people in treatment, with the result that for nearly every two people who called, they only had the capacity to treat one. This provider tried to place callers with other providers, but they were generally full as well.

RCPA members believe that the Commonwealth has a responsibility to provide quality, accessible services that assure long-term engagement in treatment for this chronic disease, for citizens being served in publicly funded drug and alcohol programs. In order to accomplish this the Commonwealth must ensure that routine, periodic, and fair determination of rates is provided by BH-MCOs and responsible counties. This is especially true for detoxification, inpatient rehabilitation, partial hospitalization, and intensive outpatient programming.

RCPA requests the development and implementation of an actuarially sound annual rate setting process between all BH-MCOs/counties which takes into account:

1. Direct service costs, defined as the costs associated with the delivery of direct service, which include, but are not limited to, direct client care, clinical supervision and program/service development, room and board, maintenance, staff training and credentialing, patient certification and reauthorization, the development and maintenance of individual client records including the cost of electronic health records, medication control and dispensation, diagnostic testing, clinical data management, capital costs related to direct clinical service delivery, patient support services, and other related clinical activity required to implement the service protocol.
2. Administrative costs, defined as the costs associated with general managerial functions or activities which are supportive to, but not an intrinsic part of, the provision of direct service. Administrative functions and activities include, but are not limited to, executive supervision, personnel management, accounting, purchasing and billing, community board activities, data (administrative, financial) management and reporting, education and training, certification and credentialing costs, capital and related supportive costs, financing and debt service costs, and clerical services which are supportive to these administrative functions and activities.
3. Regulatory and accreditation demands and costs such as documentation, staffing standards, and credentialing standards that affect the skill and pay levels required.
4. Local labor cost variables.
5. Reasonable rates of increase in these costs, particularly any unusual cost increases caused by significant treatment advancements such as Medication Assisted Treatment.
6. Capacity limitations and inefficiencies imposed by quality and regulatory demands.

DHS and DDAP must act now to ensure that all rates for services, whether set by the department or intermediaries, are subject to a routine, fair, and sound rate setting process. The Commonwealth has noted that this is a crisis situation; therefore, it must respond as such.