ACUTE TREATMENT SERVICES (ATS) FOR SUBSTANCE USE DISORDERS (ASAM Medically Monitored Intensive Inpatient Services)

PURPOSE

Performance specifications are intended to enhance MassHealth Enrollee experience and outcomes by promoting transparency and consistency across Plans and providers. Performance specifications are expectations imposed on providers who contract for these specific and related services. Information contained in this document is based on publicly available documents, Plan expectations, your contract, and MassHealth guidance. This information should be and will look materially like any other MassHealth contracted Plan. Performance specifications, your provider manual, and other requirements can be found at providerexpress.com.

Providers contracted for this level of care or service must meet all BSAS contractual and regulatory requirements, comply with applicable regulations set forth in the Code of Massachusetts Regulations and must meet all requirements of these service-specific performance specifications. In addition, providers of all contracted services are held accountable to the General Performance Specifications. Where there are differences between the service-specific and General performance Specifications, the service-specific specifications take precedence.

The requirements outlined within these service-specific performance specifications take precedence over previous performance specifications. Additionally, providers must meet all Department of Public Health/Bureau of Substance Addiction Services (DPH/BSAS) contractual and regulatory requirements within 105 CMR 164.000 *Licensure of Substance Use Disorder Treatment Programs.*

OVERVIEW

Acute Treatment Services (ATS) for Substance Use Disorders (ASAM Medically Monitored Intensive Inpatient Services) consist of 24-hour, seven-day-per-week, medically monitored inpatient services that provide medically supervised withdrawal symptom management and/or induction onto maintenance treatment. Withdrawal management services are delivered by nursing and counseling staff, under the direction of a licensed medical provider (e.g., Physician, Nurse Practitioner, Physician Assistant), to monitor an individual's withdrawal from alcohol and other drugs and to alleviate symptoms.

Services include implementation of withdrawal management protocols; a multidimensional biopsychosocial assessment; treatment planning; individual and group counseling; psychoeducational groups; case management; medication monitoring, and discharge planning.

ATS are provided to Enrollees experiencing, or at significant risk of developing, an uncomplicated, acute withdrawal syndrome because of an alcohol and/or other substance use disorder. Enrollees receiving ATS (ASAM Medically Monitored Intensive Inpatient Services) do not require the medical and clinical intensity of a hospital-based, medically managed withdrawal management, nor can they be effectively treated in a less intensive outpatient level of care. Admission to ATS (ASAM Medically Monitored Intensive Inpatient Services) is appropriate for Enrollees who meet diagnostic and dimensional admission criteria specified in accordance with the American Society of Addiction Medicine Criteria®.

Acute Treatment Services providers must facilitate access to treatment for co-occurring psychiatric conditions either directly or through referral for Enrollees with co-occurring disorders. Pregnant women receive specialized services within Acute Treatment Services (ATS) for Pregnant Women to ensure substance use disorder treatment and obstetrical care are treated concurrently. ATS services are provided in licensed freestanding or hospital-based programs.

The performance specifications contained within pertain to the following services:

- Acute Treatment Services (ATS) for Substance Use Disorders: ASAM Medically Monitored Intensive Inpatient Services
- Acute Treatment Services (ATS) for Pregnant Women: ASAM Medically Monitored Intensive Inpatient Services

Exclusion criteria must be based on clinical presentation and not include automatic exclusions based on stable medical conditions, homelessness, medications prescribed including MOUD, compliance with medications, lack of prescription refills, or previous unsuccessful treatment attempts.

ATS programs will provide ASAM Medically Monitored Intensive Inpatient Services until:

1. Withdrawal signs and symptoms have been sufficiently resolved.
2. The Enrollee's symptoms can be safely managed at a less intensive level of care.
3. Induction onto FDA approved medication has been initiated, and the Enrollee is stabilized.

SERVICE COMPONENTS

1. At minimum, the provider complies with all requirements of the Department of Public Health (DPH) Bureau of Substance Addiction Services (BSAS) 105 CMR 164 *Licensure of Substance Use Disorder Treatment Programs*, including reporting requirements.
2. The provider accepts admissions 24 hours per day, 7 days per week, 365 days per year.
    a) A thorough physical examination, which conforms to principles established by the American Society of Addiction Medicine, is completed for all Enrollees as part of the admission process.
    b) A multidimensional biopsychosocial assessment is completed within 48 hours of patient's admission.
3. Therapeutic programming is provided seven days per week, including weekends and holidays, with sufficient professional staff to maintain an appropriate milieu and conduct the services

below based on individualized Enrollee needs. The scope of required service components provided in this level of care includes, but is not limited to, the following:

a) Medical monitoring of the Enrollee's progress and medication administration as needed.
b) Induction onto FDA-approved Medications for Addiction Treatment/Medication for Opioid Use Disorder (MAT)/MOUD) as clinically indicated and appropriate with referral for ongoing MAT at discharge.
c) Access to psychiatric crisis evaluation and clinical services based on the biopsychosocial assessment.
d) HIV, Hepatitis C, TB, tobacco use and other health related education programs:
    I. HIV and Viral Hepatitis risk assessments are integrated as a part of each Enrollee's medical/nursing assessment.
    II. HIV and Hepatitis C education/risk reduction education is provided for all Enrollees.
    III. Referral to HIV antibody counseling and testing sites and on-site HIV antibody counseling.
e) Education about the benefits and risks of medication approved for addiction treatment.
f) Opioid overdose risk and prevention.
g) Access to appropriate laboratory and toxicology tests.
h) Access to routine medications.
i) Counseling and case management which incorporates evidence-based practices, including individual, group, and family therapy.
j) Behavioral/health/medication education and planning.
k) Psycho-educational groups.
l) Access to peer support and/or other recovery-oriented services either directly or through referral.
m) Development and/or updating of crisis prevention plans, or safety plans as part of Crisis Planning Tools, and/or relapse prevention plans, as applicable.
n) Introduction to self-help groups and the continuum of SUD and mental health treatment.
o) Direct operational affiliations with other services especially Clinical Stabilization Services, Transitional Support Services, Residential Rehabilitation Services, Opioid Treatment Programs, Office-Based Opioid Treatment, Community Behavioral Health Centers (CBHCs), and psychiatric services.
p) Case management that directly connects (warm handoff) to appropriate providers.
q) Management of mild to moderate medical complexities with updates with primary care providers and specialists (with consent).
r) Support services and referrals for Enrollee's family and significant others.

4. The provider provides a comprehensive, formal, structured treatment program which incorporates the effects of substance use disorders, mental health disorders, and recovery, including the complications associated with dual recovery, and provides a minimum of four hours of service programming per day. At least two hours of psycho-educational group time per week is dedicated to the discussion of HIV/AIDS, Hepatitis C, and other health issues.
5. The provider ensures that all Enrollees have access to prescribers specializing in addiction medicine and are educated on their options for MAT/MOUD.
6. The provider has the capacity to treat Enrollees with alcohol and/or other substance use disorders who are assessed to be at a mild to moderate risk of medical complications during withdrawal.

7. The program admits and has the capacity to treat Enrollees currently maintained on MAT/MOUD for the treatment of opioid use disorder. Such capacity may take the form of documented, active Affiliation Agreements with providers licensed to provide such treatments.
    a) The provider is responsible for updating its available capacity, once each day at a minimum, seven days per week, 365 days per year on the Massachusetts Behavioral Health Access website (www.MABHAccess.com)
    b) The provider is also responsible for keeping all administrative and contact information up to date on the website.
    c) The provider is also responsible for training staff on the use of the website to locate other services for Enrollees, particularly in planning aftercare services.
8. Substance-specific withdrawal management protocols are individualized, documented, and available on-site. At minimum, these include withdrawal management protocols for alcohol, stimulants, opioids, and sedative hypnotics (including benzodiazepines) with capacity to use all FDA-approved medications.
9. With Enrollee consent and the establishment of the clinical need for such communication, the provider makes documented attempts to contact the following: the parent/guardian/caregiver, family member, and/or significant others, primary care physician (PCP), other prescribers, other team members involved in Enrollee's care, within 48 hours of admission, unless clinically or legally contraindicated.
10. The provider (with appropriate consent from the Enrollee) provides the above with all relevant information related to maintaining contact with the program and the Enrollee, including names and phone numbers of key nursing staff, primary treatment staff, social worker/case manager/discharge planner, etc. If contact is not made, the Enrollee's health record documents the rationale.
11. The provider is responsible for ensuring that each Enrollee has access to medications prescribed for physical and behavioral health conditions, and documents so in the Enrollee's health record.
12. Prior to medication dispensing, the provider engages in a medication reconciliation process to avoid inadvertent inconsistencies in medication prescribing that may occur in transition of an Enrollee from one care setting to another. The provider does this by reviewing the Enrollee's complete medication regimen at the time of admission (e.g., transfer and/or discharge from another setting or prescriber) and comparing it with the regimen being considered in the ATS. The provider engages in the process of comparing the Enrollee's newly issued medication orders by the ATS prescriber to all medications that he/she has been taking to avoid medication errors. This involves:
    a) Developing a list of current medications, i.e., those the Enrollee was prescribed prior to admission to the ATS.
    b) Reviewing Massachusetts Prescription Awareness Tool.
    c) Developing a list of medications to be prescribed in the ATS.
    d) Comparing the medications on the two lists.
    e) Making clinical decisions based on the comparison and, when indicated, in coordination with the Enrollee's primary care provider (PCP).
    f) Communicating the new list to the Enrollee and, with consent, to appropriate caregivers, DMH, BH-CPs, the Enrollee's PCP, and other treatment providers. All activities are documented in the Enrollee's health record.

13. All urgent consultation services resulting from the intake evaluation and physical exam, or as subsequently identified during the admission, are provided within a timely manner for these services. Non-urgent consultation services related to the assessment and treatment of the Enrollee while in the ATS program are provided in a timely manner, commensurate with the level of need. Routine medical care (not required for the diagnosis related to the presenting problem) may be deferred, when appropriate, if the length of stay in the ATS program is brief. All these services are documented in the Enrollee's health record.
14. The milieu does not physically segregate individuals with co-occurring disorders.
15. A handbook specific to the program is given to the Enrollee and parent/guardian/caregiver at the time of admission. The handbook includes but is not limited to Enrollee rights and responsibilities, services available, treatment schedule, grievance procedures, discharge criteria, and information about family support and peer and recovery-oriented services.
16. Co-occurring psychiatric services, medication evaluation and management, and related laboratory services are offered. Such services are available virtually, or on-site within 8 hours, or referred to an off-site provider within 24 hours, as appropriate to the severity and urgency of the Enrollee's mental health condition.
17. The ATS will ensure that for pregnant Enrollees, coordination with OB/GYN, pediatrics, and any other appropriate medical, social services providers, and state agencies will be provided.
18. The ATS will facilitate access to recovery support navigator services and/or peer recovery coach services either directly or through referral.
19. The provider trains all staff at the site on the use of ASAM Criteria ®.
20. The provider complies with the Department of Public Health's (DPH) implementation of the Culturally and Linguistically Appropriate Services (CLAS) Standards.

STAFFING REQUIREMENTS

1. If program feels they cannot meet these specifications, Bureau of Substance Abuse Services (BSAS) has a waiver process for certain requirements. The waiver process is described in the Department of Public Health (DPH) Bureau of Substance Addiction Services (BSAS) 105 CMR 164. The provider is responsible for informing the payer of any waivered requirements if the waiver is approved. Providers are additionally responsible for communicating hardships that are not regulatory in nature to payers.
2. The provider complies with the staffing requirements of the applicable licensing body and the staffing requirements outlined in 105 CMR 164 *Licensure of Substance Use Disorder Treatment Programs* and the staffing requirements in the applicable Plan provider manual.
3. Medically Monitored Intensive Inpatients Services (ATS) staffing must include nurses, physicians for psychiatric and pharmacological consultation, and clinical assistant/nurses' aide staff, all with established skills, training, and/or expertise in the treatment of individuals with substance use disorders; including:
    a) A Medical Director is responsible for all medical services performed by the program, either by performing them directly or by delegating specific responsibilities to qualified healthcare professionals such as a nurse practitioner and physician assistant functioning under the Medical Director's direct supervision. They will ensure 24-hour clinical coverage, 7 days per week onsite or remotely, for consultation, to examine, and assess Enrollees within 24 hours of admission. The Medical Director should have demonstrated

clinical experience treating substance use disorders and specifically opioid use disorders.

b) Nursing coverage must be flexed according to case mix, acute/complex clinical acuity, and the needs of patients in the program, on-site 24/7. There must be a minimum of one nurse per 16 patients, per shift. One of the nurses on each shift must be a Registered Nurse.

c) A Nurse Manager, who provides direct and continuous supervision of nursing staff and is responsible for ensuring on-site 24/7 nursing coverage. Nursing staff support medication compliance and monitoring of symptoms.

d) A full-time Program Director who carries full responsibility for the administration and operations of the program.

e) A Clinical Director, who meets the criteria in 105 CMR 164 for Senior Clinician and/or Clinical Supervisor. A Clinical Director is the designated authority responsible for ensuring adequate and quality behavioral treatment is being provided.

f) One recovery specialist per 16 patients, per shift. The recovery specialist provides recovery-oriented supports in the form of psychoeducation, peer supports, introduction to self-help groups, etc.

g) Under 130 CMR 418.410(C)(1)(g), ATS programs must designate sufficient counseling staff to cover 12 hours a day, seven days a week. This requirement applies to ATS programs serving Enrollees under 18. All other ATS programs must provide sufficient staff coverage on all shifts to ensure that patient needs are met, as described in 105 CMR 164.000.

h) Under 130 CMR 418.410.(C)(1)(h), ATS programs must designate one case manager to cover 12 hours each day, seven days a week. ATS programs may fulfill this minimum staffing requirement by designating two or more case managers. Between the two designated case managers, the ATS program must ensure that at least one case manager is staffing the program 12 hours each day, seven days a week.

i) There is a psychiatrist or psychiatric nurse practitioner on staff or available through a qualified service organization agreement for psychiatric evaluation and consultation, as needed to address the needs of patients with co-occurring disorders.

j) There is an obstetrician/gynecologist on staff or available through a Qualified Service Organization Agreement (QSOA) to accommodate pregnant patients.

4. All ATS sites must have at least one staff member assuming each of the following roles:

a) There is an **HIV/AIDS Coordinator**: responsible for overseeing confidential HIV risk assessment and access to counseling and testing; staff and resident HIV/AIDS and hepatitis education; and Department requirements for admission, service planning and discharge of HIV positive residents.

b) There is a **Tobacco Education Coordinator**: responsible for assisting staff in implementing BSAS guidelines for integrating on of tobacco assessment, education, and treatment into program services.

c) There is an **Access Coordinator**: responsible for development and implementation of the evaluation, plan, and annual review of the site's performance in ensuring equitable access to services as required by 105 CMR 164

d) There is a **CLAS Coordinator** (Culturally and Linguistically Appropriate Services) who ensures that the service meets the language and cultural needs of the patients.

e) At minimum, there is one staff person trained in CPR and Naloxone administration on duty each shift.

5. The provider ensures that Enrollees have access to supportive milieu and nursing staff 24 hours per day, 365 days per year. Enrollees also have access to counseling and case management staff 12 hours a day.
6. The provider ensures that all staff receive supervision consistent with site's credentialing criteria.
7. The provider ensures that team members have all trainings required by regulation, including training in evidence-based practices, and are provided with opportunities to engage in continuing education to refine their skills and knowledge in emerging treatment protocols.

SERVICE, COMMUNITY AND OTHER LINKAGES

1. The provider complies with all provisions of the 105 CMR 164.000 *Licensure of Substance Use Disorder Treatment Programs* related to community connections collateral linkages.
2. With Enrollee consent, if an Enrollee is referred to another treatment setting, the provider collaborates in the transfer, referral, and/or discharge planning process to ensure continuity of care.
3. The staff members are familiar with the levels of care/services necessary to meet the needs of the Enrollees being served, and are able and willing to accept referrals from, and refer to, these levels of care/services when clinically indicated. The provider must maintain written Affiliation Agreements with local providers of these levels of care that refer a high volume of Enrollees to its program and/or to which the program refers a high volume of Enrollees. Such agreements include the referral process, as well as transition, aftercare, and discharge processes.
4. With Enrollee consent, the provider collaborates with the Enrollee's primary care provider and other community providers.
5. When necessary, the provider provides or arranges transportation for services required external to the program during the admission and, upon discharge, for placement into a step-down 24-hour level of care, if applicable. The provider also makes reasonable efforts to assist Enrollees upon discharge to the community and/or non-24-hour levels of care with identifying transportation options when needed, including public transportation, Prescription for Transportation (PT-1) forms, etc.

PROCESS SPECIFICATIONS

Assessment, Treatment Planning and Documentation

1. The provider complies with all provisions specified in 105 CMR 164.000 *Licensure of Substance Use Disorder Treatment Programs* related to assessment and recovery planning.
2. The provider has a policy regarding the speed at which they will inform the referral source/individual seeking admission (ideally within the hour after receipt of referral). The provider accepts admissions 24 hours per day, 7 days per week, 365 days per year. Every admission declination must be documented and include reason for declination and referrals provided.

3. A comprehensive nursing assessment is conducted at the time of admission, which includes obtaining a Clinical Institute Withdrawal Assessment (CIWA) score and/or a Clinical Opiate Withdrawal Scale (COWS). Results are documented in the Enrollee's health record.
4. A registered nurse evaluates each Enrollee within three hours of admission to assess the medical needs of the Enrollee. If an RN is unavailable, this function may be designated to a licensed practical nurse (LPN) acting under an RN's or the physician's Enrollee-specific supervision. All activities are documented in the Enrollee's health record.
5. The provider ensures that a physical examination which conforms to the principles established by the ASAM is completed for all Enrollees within 24 hours of admission. If the examination is conducted by a qualified health professional who is not a physician, the results and any recommendations arising from the examination are reviewed by the nursing supervisor prior to implementation.
6. The provider ensures that a treatment plan is completed, as delineated in the General Performance specifications, and in conjunction with the Enrollee. The provider makes best efforts to also involve current community-based providers including PCP and behavioral health providers, family member, parents/guardians/caregivers, and/or significant others in the treatment planning process.
7. The provider assigns a multi-disciplinary treatment team to each Enrollee within 24 hours of admission. A multi-disciplinary treatment team meets to review the assessment and develop an initial treatment/recovery plan and initial discharge plan within 48 hours of admission. On weekends and holidays, the treatment/recovery plan may be developed by an abbreviated treatment team, with a review by the full treatment team on the next business day.
8. The provider must document any missed sessions and attempts to make follow-up contact, the reason(s) given for absence, and if necessary, the staff's rationale for continuation or discontinuation of ATS.
9. The treatment/recovery and discharge plans are reviewed by the multi-disciplinary treatment team with each Enrollee at least every 48 hours (a maximum of 72 hours between reviews on weekends), and are updated accordingly, based on each Enrollee's individualized progress. All assessments, treatment and discharge plans, reviews, and updates are documented in the Enrollee's health record.
10. The assigned case manager under the supervision of the Clinical Director meets with the Enrollee daily for the purposes of assessment, counseling, treatment, case management, and discharge planning. All activity is documented in the Enrollee's health record.
11. With Enrollee consent and the establishment of the clinical need for such communication, coordination with family member/partners/legal guardians, etc., and other treatment providers, including primary care providers and behavioral health providers, is conducted by appropriate staff relative to treatment and care coordination issues. All such contact is documented in the Enrollee's health record.
12. For anyone who could become pregnant, a pregnancy test is administered prior to the administration of any medications.
13. For anyone who is pregnant, the provider coordinates care with her PCP and OB/GYN and consults with those physicians as needed.
14. The provider arranges appropriate drug screens/tests, urine analysis, toxicology samples and laboratory work as clinically indicated, and documents these activities in the Enrollee's health record.

15. The provider ensures the continuous assessment of the Enrollee's mental status throughout the Enrollee's treatment episode and documents such in the Enrollee's health record.

Discharge Planning and Documentation

1. The provider complies with all provisions of 105 CMR 164.000 *Licensure of Substance Use Disorder Treatment Programs* related to discharge planning.
2. The provider conducts discharges 7 days per week, 365 days per year.
3. At the time of discharge, and as clinically indicated, the provider ensures that the Enrollee has a current crisis prevention plan, and/or safety plan, and/or relapse prevention plan in place and that they have a copy of it. The provider works with the Enrollee to update the existing plan, or, if one was not available, develops one with the Enrollee prior to discharge. With Enrollee consent and as applicable, the provider may contact the Member's local Adult or Youth Mobile Crisis Intervention (AMCI/YMCI) to request assistance with developing or updating the plan. With Member consent, the provider sends a copy to the AMCI Director/YMCI at the Member's local AMCI/YMCI.
4. The provider engages the Enrollee in developing and implementing an aftercare plan when the Enrollee meets the discharge criteria established in their treatment/recovery plan. The provider provides the Enrollee with a copy of the plan upon their discharge and documents these activities and the plan in the Enrollee's health record.
5. Prior to discharge, the provider assists Enrollees in obtaining post-discharge appointments, as follows: within 7 calendar days of discharge for outpatient therapy services (which may be an intake appointment for therapy services), if necessary; and within 14 calendar days of discharge for medication monitoring, if necessary. In the event of a discharge against medical advice (AMA), providers must ensure patients are given resources to reconnect with services.
6. This function may not be designated to aftercare providers or to the Enrollee to be completed before or after the Enrollee's discharge. These discharge planning activities, including the specific aftercare appointment date/time/location(s), are documented in the Enrollee's health record.

QUALITY MANAGEMENT

1. The provider will develop and maintain a quality management plan that is consistent with their contractual responsibilities to Optum, and which utilizes appropriate procedures to monitor, measure, and improve the activities and services it provides.
    a) Specifically, the provider will work to improve these outcomes within their patient population receiving SUD treatment:
        I. Increase in MAT/MOUD induction and continuation
        II. Decrease in readmissions to ED and inpatient services
        III. Increase in referrals and transitions to lower levels of care
        IV. Increase in program's capacities to admit and treat individuals with behavioral health and co-occurring physical health conditions.
    b) Providers will be required to report Enterprise Service Management (ESM) data to BSAS at admission and discharge per DPH/BSAS Licensing Regulation.
    c) The provider will collect data to measure the quality of their services.

2. The provider must have a continuous QI process to evaluate the care provided and review adherence to policies and procedures within the sites. Data may be collected via satisfaction surveys, electronic medical records, and other forms.
3. Clinical outcomes data must be made available to Optum upon request and must be consistent with the performance specifications of this service.
4. Providers must report any adverse incidents and other reportable events that occur to the relevant authorities.