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ACCESS TO SUBSTANCE USE DISORDER TREATMENT IN MASSACHUSETTS

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EXECUTIVE SUMMARY

This report, required by Section 30 of Chapter 258 of the Acts of 2014, "An Act to increase opportunities for long-term substance abuse recovery," describes the continuum of care for substance use disorder (SUD) treatment in Massachusetts, evaluates coverage for those services across payers, including commercial health insurance,[1] MassHealth and the Department of Public Health's Bureau of Substance Abuse Services (BSAS). The report further examines the accessibility of SUD services based on provider availability and provides a description of specific potential barriers to treatment access.

BACKGROUND

Approximately 10% of the Massachusetts population suffers from SUD.[2] According to the Substance Abuse and Mental Health Services Administration (SAMHSA), "substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home."[3] The National Institute of Drug Abuse (NIDA) defines addiction as "a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences."[4] Due to the chronic nature of SUD, many individuals relapse and require continued treatment and services. Ensuring proper access to SUD treatment has gained increasing urgency, as fatalities in Massachusetts related to opioid overdose are projected to have increased by 46% from 2012 to 2013.[5]

1 This report reflects the commercial health insurance market that is fully-insured. However, it is important to understand that the majority (58%) of employer-sponsored health insurance is self-insured. See http://chiamass.gov/enrollment-in-health-insurance/. Self-insured plans are often administered by commercial health insurers and often utilize the same benefit package and approach to coverage as the fully-insured market. However, self-insured plans are not required to meet state mandated benefit requirements.

2 According to the National Survey on Drug Use and Health (NSDUH), approximately 10% of Massachusetts residents age 13 and older meet the criteria for abuse or dependence of alcohol and/or illicit drugs. Approximately 3.6% meet criteria for both an SUD and a mental health condition. SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2009-2012. Dependence or Abuse Past Year Ages 12+.

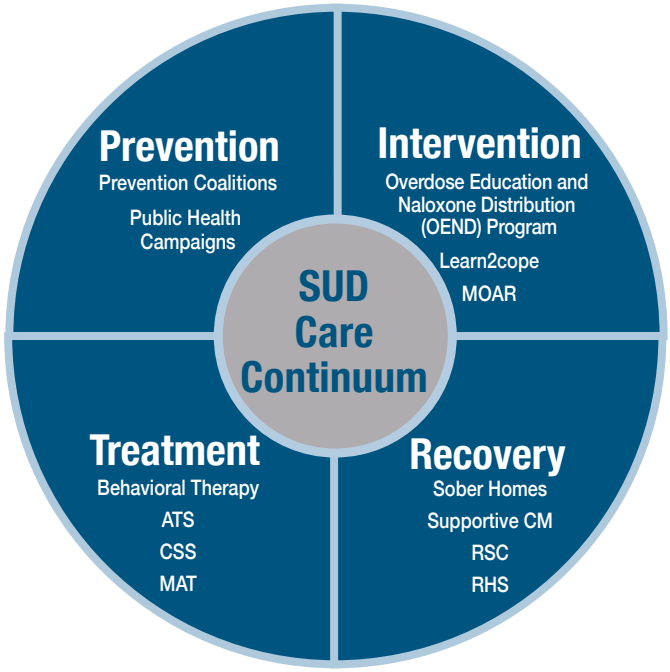
3 SAMHSA, (2014) *Mental and Substance Use Disorders*; accessible at: http://www.samhsa.gov/disorders.

4 National Institute on Drug Abuse (NIDA) website Media Guide, (2014). The Science of Drug Abuse and Addiction: The Basics. Accessible at: http://www.drugabuse.gov/publications/media-guide/science-drug-abuse-addiction-basics.

5 Governor Baker Announces Initial Steps to Combat Opioid Addiction Coverage, Press Release from Governor Baker, February 19, 2015.

A DESCRIPTION OF THE CONTINUUM OF CARE FOR SUBSTANCE USE DISORDER TREATMENT

For the purpose of this report, the SUD care continuum is described in four categories – prevention, intervention, treatment and recovery. There is no one correct way for patients with SUD to move through the continuum, given the risk of relapse with this chronic condition. Individuals should be able to move across and within the different SUD services based on their varying needs.



Prevention

Prevention strategies are the first part of the continuum of care and are primarily funded by BSAS. Initiatives focused on prevention are aimed at educating the general public, particularly adolescents and young adults, on techniques to reduce the risk of developing SUD.[6] These prevention strategies help individuals to develop the knowledge, skills and attitudes to make good choices, identify and understand risky use of substances, and avoid or stop harmful behaviors before the behavior becomes problematic.

Intervention

Intervention strategies are the second part of the continuum of care and, as with prevention, are primarily funded by BSAS. These initiatives focus on early identification of SUD and the beginning of treatment, as well as strategies to help reduce fatal overdoses, such as the Overdose Education and Naloxone Distribution (OEND) program. Other BSAS intervention efforts include providing funding to groups that support and advocate for individuals and families dealing with addictive disorders, such as the Massachusetts Organization for Addiction Recovery (MOAR) and Learn2Cope. In addition, BSAS is currently funding five Family Intervention Pilots focused on engaging adolescents, youth and their families on the need for treatment.

6 See description of prevention on the SAMHSA website, accessible at: http://www.samhsa.gov/prevention.

Treatment

The third part of the SUD care continuum is treatment. Treatment for SUDs is paid for primarily by commercial insurers, MassHealth and/or BSAS, depending on the particular services. Depending on the substance an individual is using, there are different treatment needs. For opioids, alcohol and benzodiazepines, treatment often starts with detoxification followed by clinical support services (CSS) and/or transitional support services (TSS). Effective treatment for SUDs includes behavioral therapy as well as use of medications when appropriate. For those with opioid addiction, studies show that it is most effective to combine behavioral therapy with medication assisted treatment (MAT).[7, 8] Medications that have been shown effective in treating opioid addiction include methadone, buprenorphine, and naltrexone. In addition, acamprosate and disulfiram have been shown effective in treating alcohol addiction.[9]

Recovery

The fourth part of the SUD continuum of care, recovery support services, which are primarily paid for by BSAS, are essential to assisting individuals and families affected by SUD to attain and maintain recovery. Many individuals find support at Recovery Support Centers (RSCs) through peers that have been through similar experiences. These drop-in centers offer a drug-free environment and a variety of activities including classes, leisure activities and support group meetings. BSAS also supports Recovery High Schools (RHSs) which provide a structured school environment for high-school aged youth in recovery to support these teens to maintain their recovery and complete their education. Though not covered by commercial health insurers, MassHealth or BSAS because they do not provide medical services, sober homes are another recovery support. Sober homes provide a group home environment for men or women trying to maintain their sobriety.

KEY FINDINGS

Evaluation of Access to the Care Continuum and Specific Barriers to Care

Services across the SUD continuum are available in Massachusetts, but the existence of a range of services does not mean that people with SUD are always able to access the care they need at the time they need it. Barriers to access include service capacity and design, benefit coverage, and inadequate information about the SUD care continuum.

Service Capacity

While not all patients in treatment follow the same service path, patients in acute treatment services (ATS) often seek clinical stabilization services (CSS); and those in CSS may seek to move to transitional support services (TSS). Bed capacity limitations in one area of the SUD system may impact access in other settings along the continuum. Key barriers in service capacity include:

1. Individuals report difficulty locating acute treatment services (ATS) for detoxification, and when discharged from ATS, difficulty locating available slots in stabilization services, residential services or community-based support services.[10]

7 U.S. Preventive Services Task Force, Final Recommendation Statement: Alcohol Screening and Behavioral Counseling Interventions in Primary Care; accessible at: http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/alcohol-misuse-screening-and-behavioral-counseling-interventions-in-primary-care.

8 Institute for Clinical and Economic Review. Management of Patients with Opioid Dependence: A Review of Clinical, Delivery System, and Policy Options; Final Report 2014. The New England Comparative Effectiveness Public Advisory Council. Released June 20, 2014; accessible at: http://cepac.icer-review.org/wp-content/uploads/2014/04/CEPAC-Opioid-Dependence-Final-Report-For-Posting-July-211.pdf.

9 National Institute on Drug Abuse (NIDA). (2012). Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition) accessible at: http://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/pharmacotherapies.

10 Consumer Advocate Focus Group, December 2014.

2. Individuals and families report long wait times and difficulty accessing CSS and TSS services.[11] Not all patients move from ATS to CSS or TSS, but patient flow between services is impacted by both bed availability and lengths of stay. Currently there are nearly three times the numbers of ATS beds (868) as CSS (297) or TSS beds (331).[12] Because the average length of stay in ATS (one week) is shorter than in CSS (two weeks) or TSS (four weeks), the number of patients leaving ATS each week is much greater than the number of new CSS or TSS beds vacated each week. Access to long-term residential programs is hampered by similar bed capacity and patient flow issues.
3. Due to the relatively high SUD treatment utilization rate of young adults (see Figure 3.3),[13] providers assert the need to tailor long-term residential programs to meet the needs of this population.[14] Services such as family support groups, recovery coaching, recovery specialists, aftercare, and life skills training were identified by providers as being of high-value to this population.[15] Similar program adjustments may be beneficial for populations with challenges in addition to SUD such as homelessness, unemployment, HIV, hepatitis C, criminal justice involvement or disengagement from their families.[16]
4. Sufficient outpatient SUD treatment capacity is crucial to a responsive, efficient SUD system of care and may reduce reliance on inpatient services. However, outpatient capacity is currently difficult to assess. There are no standards or reliable methods for assessing the adequacy of outpatient service capacity. There is a lack of data available to evaluate the capacity of licensed programs and the number of FTE providers offering services at each level of the SUD care continuum.
5. Access to buprenorphine is impacted by the limited number of providers that have received the required waiver from the Federal Drug Administration (FDA) to administer buprenorphine, and only a subset of these providers actively treat patients with SUD.[17] Additionally, waivered providers are not allowed to treat more than 100 patients.[18]

Service Design

Program services are sometimes limited in ways that hamper the ability to treat clients in the most effective manner. For example, there are 38 well-established methadone programs across the Commonwealth that provide methadone maintenance therapy combined with behavioral counseling. However, other Medication Assisted Treatment services such as the provision of buprenorphine and naltrexone are not available through these programs, limiting clients' treatment options at these programs to just methadone.

Benefit Coverage

Cost sharing requirements and non-quantitative treatment limits (NQTL), such as medical necessity standards, utilization review and fail-first policies present potential barriers to accessing SUD treatment. While managed care techniques are intended to reduce inappropriate care (thus reducing overall cost while maintaining quality), they may in some cases also restrict appropriate care.

1. Cost sharing requirements.

   Copayments vary significantly among commercial plans and products.[19] Copayments – particularly for patients receiving daily services, such as methadone treatment – may present a barrier to accessing care.

11 *Ibid*.

12 Special BSAS Report: Licensed Programs as of November 11, 2014.

13 2012 Commercial health plan utilization data, All-Payer Claims Database.

14 Residential Provider Focus Group, December 2014.

15 *Ibid*.

16 *Ibid*.

17 Massachusetts Department of Public Health, 2014, Findings of the Opioid Task Force and Department of Public Health Recommendations on Priorities for Investments in Prevention, Intervention, Treatment and Recovery.

18 http://buprenorphine.samhsa.gov/waiver_qualifications.html.

19 Health Insurance Carrier Surveys, December 2014.

2. Non-Quantitative Treatment Limits (NQTLs).

   Under federal parity laws, any NQTL policy must be applied in a non-discriminatory manner, and not more frequently or stringently for SUD treatment than for medical or surgical treatment. A 2013 national study examining benefits after MHPAEA was enacted but before final regulations were issued found multiple examples of NQTLs that were applied more strictly for behavioral health services than for medical/surgical services.[20] This national study may inform discussions of parity compliance in Massachusetts, but it is important to note that the study's findings are not directly applicable to the current Massachusetts healthcare market, as it was based on a nationally representative sample of large employer benefits in 2010. Parity compliance in Massachusetts is monitored by the Division of Insurance and the Attorney General's Office, who require detailed filings from carriers regarding their policies and procedures related to mental health parity compliance. NQTLs of particular concern to providers and consumers include medical necessity criteria, utilization reviews, and fail-first policies.[21]

   a. Medical Necessity Criteria. Carriers are required to develop medical necessity criteria according to processes required under section 16 of M.G.L. c. 176O. The American Society of Addiction Medicine (ASAM) has developed a widely recognized and utilized set of criteria to determine medical necessity. Both plans and providers report being guided by the ASAM assessment guidelines in constructing their own medical necessity criteria. However, these medical necessity criteria differ across carriers and from the criteria applied by providers for treatment. Provider focus group participants indicated that the differences in medical necessity criteria can lead to an administrative burden on providers as well as potential variation between a plan and a provider's medical necessity determinations.[22] Generalization as to whether carrier or provider criteria are more appropriate cannot be made, since decisions about appropriate care must be based on an individual's particular needs and circumstances.[23]

   b. Utilization Reviews.[24] Although the prior authorization process for patients seeking acute treatment services and clinical stabilization services will be eliminated in Massachusetts as of October 2015 for the fully-insured market, health insurance carriers may conduct concurrent utilization reviews related to these admissions.[25, 26] Utilization reviews have been demonstrated to reduce utilization, though no determinations around the appropriateness of this reduction can be made.[27]

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20 Between passage of MHPAEA in 2008 and the release of final regulations during November 2013, some carriers showed improvement in parity compliance but not perfect compliance. *Consistency of Large Employer and Group Health Plan Benefits With Requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act Of 2008*, November 2013 accesible at: http://www.dol.gov/ebsa/pdf/hhswellstonedomenicimhpaealargeemployerandghpbconsistency.pdf.

21 Consumer Advocate Focus Group, December 2014; ATS Focus Group, December 2014.

22 ATS Focus Group, December 2014.

23 Compass Health Analytics, Inc. (2014). Actuarial Assessment of Chapter 258 of the Acts of 2014: "An Act to increase opportunities for long-term substance abuse recovery". Acute Treatment and Clinical Stabilization Services and Substance Abuse Treatment Preauthorization, Center for Health Information and Analysis.

24 According to M.G.L. c. 176O, section 12, "(a) [u]tilization review conducted by a carrier or utilization review organization shall be conducted pursuant to a written plan, under the supervision of a physician and staffed by appropriately trained and qualified personnel, and shall include a documented process to (i) review and evaluate its effectiveness, (ii) ensure the consistent application of utilization review criteria, and (iii) ensure the timeliness of utilization review determinations.

A carrier or utilization review organization shall adopt utilization review criteria and conduct all utilization review activities pursuant to said criteria. The criteria shall be, to the maximum extent feasible, scientifically derived and evidence-based, and developed with the input of participating physicians, consistent with the development of medical necessity criteria pursuant to the provisions of section 16. Utilization review criteria shall be applied consistently by a carrier or a utilization review organization and made easily accessible and up-to-date on a carrier or utilization review organization's website to subscribers, health care providers and the general public; provided, however, that a carrier shall not be required to disclose licensed, proprietary criteria purchased by a carrier or utilization review organization on its website, but must disclose such criteria to a provider or subscriber upon request. If a carrier or utilization review organization intends either to implement a new preauthorization requirement or restriction or amend an existing requirement or restriction, the carrier or utilization review organization shall ensure that the new or amended requirement or restriction shall not be implemented unless the carrier's or utilization review organization's website has been updated to reflect the new or amended requirement or restriction."

25 For additional information on utilization review, see Appendix Two.

26 Sections 9, 21, 23, 25, and 27 of Chapter 258 of the Acts of 2014, "An Act to increase opportunities for long-term substance abuse recovery."

27 Compass Health Analytics, Inc. (2014). Actuarial Assessment of Chapter 258 of the Acts of 2014: "An Act to increase opportunities for long-term substance abuse recovery". Acute Treatment and Clinical Stabilization Services and Substance Abuse Treatment Preauthorization, Center for Health Information and Analysis.

c. Fail-first policies restrict coverage for higher levels of care unless a patient has attempted and "failed" at a lower level of care. These policies, while intended to encourage the use of appropriate levels of care, in some cases may also frustrate provider and patient attempts to access specific treatments.

Inadequate Information about the Care Continuum

Individuals seeking treatment and their families may not fully understand or receive information on the full range of appropriate treatment options and their availability within the Commonwealth.[28] Providers may also not understand the continuum of treatment options, or how to help patients access the appropriate services.[29] The lack of shared understanding of the continuum of care – and associated best practices – may exacerbate misunderstandings between patients, providers, and insurers about available options and best practices.

Cultural Competency within the Care Continuum

A recent Massachusetts study found the current behavioral health workforce to be insufficient to meet the needs of Massachusetts' diverse population, including a lack of capacity to offer services in a patient's native language.[30] Even when an interpreter is used, studies show that patients who do not speak the same language as their providers have worse outcomes and higher dropout rates. There is some evidence that provider racial/ethnic concordance with patients can improve retention in care.[31]

28 Massachusetts Department of Public Health, 2014, Findings of the Opioid Task Force and Department of Public Health Recommendations on Priorities for Investments in Prevention, Intervention, Treatment and Recovery.

29 *Ibid*.

30 O*p. cit*. Alegria, et. al.

31 *Ibid*.

I. SUBSTANCE USE DISORDERS AND COVERAGE IN MASSACHUSETTS

1.1 SUBSTANCE USE DISORDERS (SUD)

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), "substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home."[32] The National Institute of Drug Abuse (NIDA) defines addiction as "a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences."[33] NIDA further explains that brain imaging studies of people with addiction show physical changes in areas critical to judgment, decision making, learning and memory, and behavior control.[34] These changes may modify how the brain works, potentially contributing to the compulsive and destructive behaviors common to addiction. Changes in the brain may also complicate efforts to recover, even among people demonstrating readiness. Vulnerability to addiction varies among people, with genetic factors accounting for as much as 40 to 60%, while other contributing factors include age and presence of other medical and mental health conditions, as well as trauma history, developmental stage, social support, and environmental and cultural factors.[35]

Addiction can contribute to other medical issues, increasing the risk of lung or cardiovascular disease, stroke, cancer, and mental health disorders.[36] Given these co-occurring medical issues, individuals with SUD often have high overall medical expenses. According to a study of Medicaid costs in six states, Medicaid beneficiaries with SUD have an overall higher disease burden than patients with other behavioral health disorders, requiring more medical care and higher medical expenditures.[37] Alcohol and other substance related disorders are two of the top 10 causes of hospital readmissions among adult Medicaid patients ages 18-64.[38]

SUDs are both preventable and treatable. Similar to other chronic diseases, addiction can be managed successfully. Behavioral therapy combined with medication assisted treatment has proven to be successful in helping people to recover from the effect of substance use on their brain and behavior, and to regain control of their lives. However, the chronic nature of addiction means that relapse is a risk.[39] Addiction relapse rates are similar to those for chronic medical illnesses such as diabetes, hypertension, and asthma, which also have both physiological and behavioral components (see Figure 1.1).[40] As with other chronic conditions, substance use relapse may indicate a need for renewed intervention or modification of treatment and continuous support to better meet the individual's needs.

32 SAMHSA, (2014) *Mental and Substance Use Disorders*, accessible at http://www.samhsa.gov/disorders.

33 National Institute on Drug Abuse (NIDA) website Media Guide, (2014). The Science of Drug Abuse and Addiction: The Basics; accessible at http://www.drugabuse.gov/publications/media-guide/science-drug-abuse-addiction-basics.

34 Fowler JS, Volkow ND, Kassed CA, Chang L. (2007). Imaging the addicted human brain. *Science and Practice Perspectives* 3(2):4-16.

35 National Institute on Drug Abuse (NIDA). (2014). Drugs, Brains, and Behavior: The Science of Addiction; accessible at http://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/addiction-health.

36 *Ibid*.

37 Clark, R. E., Samnaliev, M. & McGovern, M. P. (2009). Impact of substance disorders on medical expenditures for Medicaid beneficiaries with behavioral health disorders. *Psychiatr Serv*. Jan ;60(1):35-42.

38 See Table 3; Conditions With The Largest Number of Hospital Readmissions by Payer, 2011, Statistical Brief 172, Healthcare Cost and Utilization Project (H-CUP), Agency for Healthcare Research and Quality (AHRQ), April 2014. Alcohol was 5th and other substance related disorders were 10th in the top 10 list.

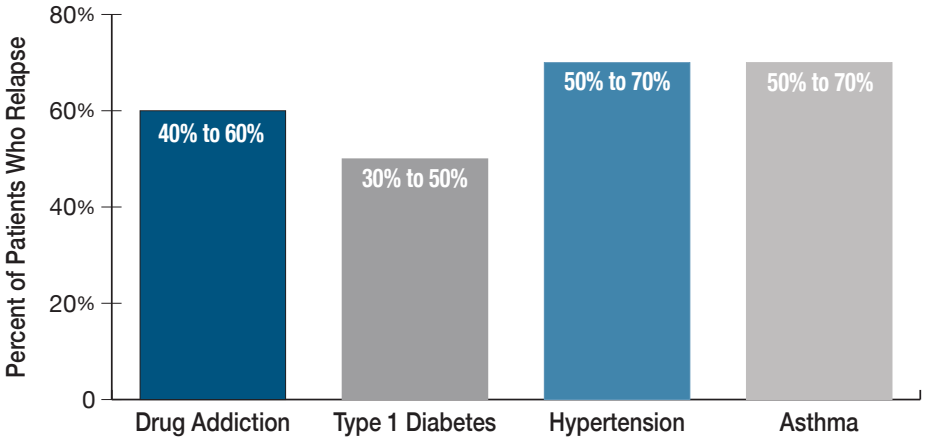
39 National Institute on Drug Abuse (NIDA). (2014). Drugs, Brains, and Behavior: The Science of Addiction; accessible at; http://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/addiction-health.

40 McClellan, AT, Lewis, DC, O'Brien, CP, and Kleber, HT, (2000). Drug Dependence, A Chronic Medical Illness: Implications for Treatment, Insurance, and Outcomes Evaluation, JAMA, 284(13): 1689-1695.

Nationally, only 11% of individuals with SUD receive treatment. Of those who do not receive treatment, 2% reported that they were unable to access services, while the vast majority (95%) report not feeling a need for treatment.[41] While overall treatment rates nationally remain low, there was a dramatic increase (346%) in opioid treatment admissions between 2001 and 2011.[42]

SUD affects all demographics. National rates of SUD are highest among 18 to 25 year-olds, who had a combined alcohol and drug dependence rate of 23.1% in 2012 and 2013, 2.7 times higher than the rate among adults ages 26 and older.[43] In addition, there is evidence of disparities in access to treatment. Racial and ethnic minorities who need treatment are less likely to access services when controlling for socioeconomic status and criminal justice history.[44]

Figure 1.1 Comparison of relapse rates between drug addiction and other chronic illnesses



Source: JAMA, 284:1689-1695, 2000

1.2 SUBSTANCE USE DISORDERS IN MASSACHUSETTS

In Massachusetts, 10% of the population meets the diagnostic criteria for SUD[45] with dependence or abuse rates for alcohol and drugs higher than the national average for all age categories, except 12-17 year olds.[46] Most people who meet the criteria for SUD do not receive treatment. The potential effects of untreated SUD can be serious. Between 2000 and 2012, fatal opioid overdoses in Massachusetts increased by 90%,[47] and are projected to have increased an additional 46% between 2012 and 2013.[48]

41 Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health 2011 and 2012, Tables 5.51A and 5.53A, SAMHSA.

42 SAMHSA's Treatment Episode Data Set (TEDS) 2001-2001; National Admissions to Substance Abuse Treatment Services.

43 Substance Abuse and Mental Health Services Administration. (2013). Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings (HHS Publication No. SMA 13-4795, NSDUH Series H-46).

44 Cook BL, Alegria M. Racial-ethnic disparities in substance abuse treatment: the role of criminal history and socioeconomic status. Psychiatric services. Nov 2011;62(11):1273-1281.

45 According to the National Survey on Drug Use and Health (NSDUH), approximately 10% of Massachusetts residents age 13 and older meet the criteria for abuse or dependence of alcohol and/or illicit drugs. Approximately 3.6% meet criteria for both an SUD and a mental health condition. SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2009-2012. Dependence or Abuse Past Year Ages 12+.

46 SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2012-2013 combined.

47 BSAS, Opioid Overdose Response Strategies in Massachusetts, 2014.

48 Governor Baker Announces Initial Steps to Combat Opioid Addiction Coverage, Press Release from Governor Baker, February 19, 2015.

1.3 COVERAGE OF SUBSTANCE USE DISORDER TREATMENT SERVICES IN MASSACHUSETTS

Coverage for SUD has increased over the last several years in Massachusetts, through a combination of expanded access and coverage in both commercial and publicly-funded or subsidized health care coverage. Coverage expansions under Massachusetts' 2006 health reform and the Affordable Care Act (ACA) provide greater access to health coverage to young adults and to lower and middle income, childless adults and parents who previously did not qualify for MassHealth. In addition to expanded coverage, commercial health insurance carriers have increased the amount and types of SUD treatment services covered, to meet both behavioral health parity laws, and the ACA's essential health benefits requirements.[49] Under the federal Mental Health Parity and Addiction Equity Act, health plans that provide coverage for mental health and substance use disorder treatment must refrain from applying financial requirements, quantitative treatment limits, and non-quantitative treatment limits to mental health or SUD treatment in a way that is more restrictive or more stringent than those applied to medical or surgical treatments.[50] Similarly, Massachusetts laws and the ACA require insurers to cover medically necessary SUD treatment services on a non-discriminatory basis.[51]

In Massachusetts, beginning in October 2015, health insurance carriers[52] will be:

- Prohibited from requiring prior authorization for certain SUD services, including ATS or CSS,[53] administered by a provider that is certified or licensed by DPH. ATS and CSS facilities will be required to notify the patient's health insurer and provide an initial treatment plan to the insurer within 48 hours of accepting the patient. Health insurers may begin to conduct utilization review on day 7 of a stay.[54] Appendix Two includes detailed information on the current prior authorization and continued stay (CS) reviews by commercial health insurers and MassHealth managed care plans as of December 2014.
- Required to pay for covered services provided by Licensed Alcohol and Drug Counselors I (LADC-I).[55]

Blue Cross Blue Shield Massachusetts currently reimburses broadly for methadone treatment services provided by Opioid Treatment Programs; several other carriers cover methadone treatment for certain populations in certain circumstances. As of July 1, 2015, all commercial health insurers will also reimburse for methadone maintenance services, although decisions have not yet been announced regarding accompanying copayments and medical necessity criteria.[56] MassHealth requires coverage of methadone maintenance services.

There are also several service capacity expansions in progress, including the addition of:

- 32 ATS and 32 CSS beds recently added in Quincy with 32 ATS and 32 CSS beds to be added in Greenfield
- Four office-based Opioid Treatment Programs utilizing buprenorphine and injectable naltrexone in federally qualified health centers (FQHCs)
- Six community-based youth-focused SUD treatment programs
- Extended hours of operations at existing Recovery Support Centers and addition of three Centers
- Ten Learn2Cope chapters, a family support organization.

In addition to this expanded capacity, BSAS is working to implement in 2015 a Central Navigation System and pilot six regional assessment centers. Together, these activities will assist consumers and their families to access the full continuum of SUD treatment services in Massachusetts. (See Section 2.3 for a discussion of SUD coverage on a service-by-service basis.)

49 45 CFR Parts 147,155 and 156. Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation: Department of Health and Human Services, Final Rule. February 25, 2013.

50 MHPAEA: Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, Pub. L. No. 110-343, §§ 511-512 (2008).

51 See MGL c. 32A §22, c.175 §47B, c.176A §8A, and c.176B §4A.

52 These requirements do not apply however to self-insured plans that make up a majority of the marketplace.

53 Both ATS and CSS are described in further detail in Section 3.3.

54 See sections 9, 19, 21, 23, 25, and 27 of Chapter 258 of the Acts of 2014. For additional information on utilization review, see Appendix Two.

55 See sections 10, 20, 22, 24, and 26 of Chapter 258 of the Acts of 2014.

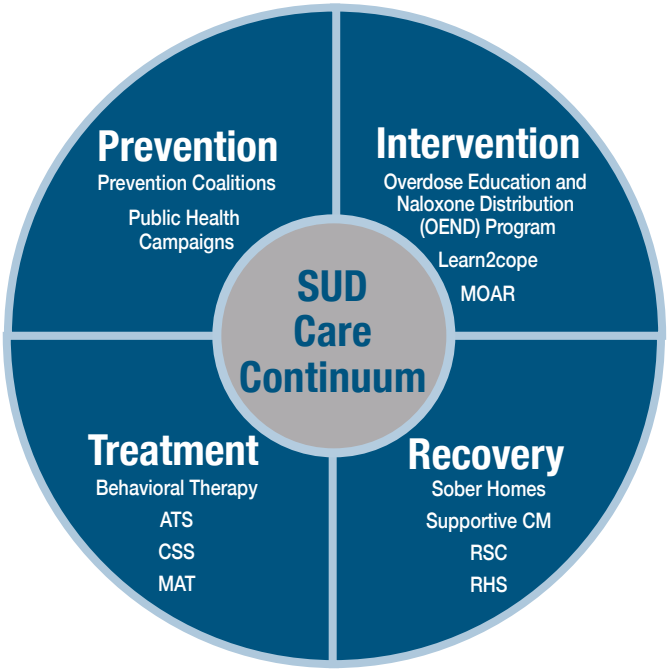
56 MAHP Member Health Plans Aggressively Move to Address Opioid Crisis, Press Release, February 6, 2015; accessible at; http://www.mahp.com/unify-files/MAHPMethadoneCoverageRelease.pdf.

II. SUD TREATMENT SERVICES: CONTINUUM OF CARE

2.1 OVERVIEW OF SUD TREATMENT SERVICES CONTINUUM

A comprehensive approach to address SUD includes activities that can be grouped into four major categories: prevention, intervention, treatment and recovery. Each aspect of the continuum plays an important role in the prevention and treatment of SUDs for all Massachusetts residents. This section will explore these different categories, describe available services and detail who pays for which services.

Figure 2.1 SUD Care Continuum



Patients do not move through the SUD continuum in only one way; due to the SUD's chronicity and the related risk of relapse, individuals often move across and within the different SUD treatment services, depending upon their particular needs. Many individuals will complete detoxification on several occasions over the course of treatment, and will also utilize other services on the continuum at different points in their recovery process.

2.1.1 PREVENTION

Prevention strategies are the first part of the care continuum and are primarily funded by BSAS. Initiatives focused on prevention are aimed at educating the general public, particularly adolescents and young adults to reduce the risk of developing SUD.[57] These prevention strategies help individuals to develop the knowledge, skills and attitudes to make good choices, identify and understand risky use of substances, and avoid or stop harmful behaviors before the behavior becomes problematic. Prevention strategies often supported by BSAS funding take root in local communities and are tailored to their unique characteristics. Environmental prevention strategies aim at restricting youth access to alcohol and other drugs.

57 See description of prevention on the SAMHSA website, accessible at: http://www.samhsa.gov/prevention.

2.1.2 INTERVENTION

Intervention strategies are the second part of the continuum of care and, as with prevention, most are primarily funded by BSAS. These initiatives focus on early identification of SUD and beginning of treatment, as well as strategies that help reduce fatal overdoses, such as the Overdose Education and Naloxone Distribution (OEND) program. The widespread availability and increased use of naloxone, a medication that when administered in a timely manner can reverse an opioid overdose, is an important tool for preventing fatalities of opioid addicted individuals.

Another tool aimed at intervention is the Massachusetts Department of Public Health's Prescription Monitoring Program (PMP), a secure website that provides a patient history of all prescriptions for controlled substances over the most recent 12 months.[58] Prescribers are required to utilize the PMP prior to the first time they provide an opioid prescription for an individual.

Other BSAS intervention efforts include providing funding to groups that support and advocate for individuals and families dealing with addictive disorders, such as Massachusetts Organization for Addiction Recovery (MOAR) and Learn2Cope. Currently BSAS is also funding five Family Intervention Pilots focused on engaging adolescents, youth and their families on the need for treatment.

Substance Abuse and Mental Health Services Administration (SAMHSA) has promoted Screening, Brief Intervention, and Referral to Treatment (SBIRT). SBIRT is a public health approach to the delivery of early intervention and treatment services for people with substance use disorders and those at risk of developing these disorders in a variety of medical and community-based settings.[59] SBIRT has shown to be particularly effective in identifying unhealthy alcohol use and is endorsed by the U.S. Preventive Services Task Force.[60]

2.1.3 TREATMENT

Treatment for SUD is paid for by commercial and public payers, including MassHealth and Medicare, as well as BSAS, depending on the particular services. Depending on the particular substance an individual is using, there are different treatment needs. For opioids, alcohol and benzodiazepines, treatment often starts with detoxification followed by clinical stabilization services and/or transitional support services (TSS). (See Section 2.3 for an in-depth description of SUD treatment options.)

For those with opioid addiction, studies show that it is most effective to combine behavioral therapy with medication assisted treatment.[61] Behavioral therapies are used to engage people in SUD treatment, to encourage them to modify harmful behaviors, and to reduce or eliminate their use of substances. These therapies help individuals to develop life skills to withstand stress and respond to environmental cues that trigger intense craving for their preferred substance. By participating in psycho-education, individuals can better understand the addiction process. These approaches and therapies are often used in different combinations to provide people the appropriate set of treatment services and a variety of tools to address their unique needs.

Medications that have been shown effective in treating opioid addiction include methadone, buprenorphine, and naltrexone. In addition, acamprosate, and disulfiram have been shown effective in treating alcohol addiction.[62] Medications can often be offered in an outpatient setting and are helpful at a number of stages of treatment and recovery for both opioid and alcohol addiction, including in treating withdrawal, helping individuals to stay in treatment, maintaining recovery and reducing risk of relapse.

58 For more information on the PMP see Massachusetts Online Prescription Monitoring Program Frequently Asked Questions; accessible at: http://www.mass.gov/eohhs/docs/dph/quality/drugcontrol/pmp-faq-public.pdf.

59 http://www.samhsa.gov/sbirt.

60 U.S. Preventive Services Task Force, Final Recommendation Statement: Alcohol Screening and Behavioral Counseling Interventions in Primary Care; accessible at: http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/alcohol-misuse-screening-and-behavioral-counseling-interventions-in-primary-care.

61 National Institute on Drug Abuse (NIDA). (2014). The Science of Drug Abuse and Addiction: Treatment and Recovery. accessible at: http://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery.

62 National Institute on Drug Abuse (NIDA). (2012). Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition) accessible at: http://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/pharmacotherapies.

2.1.4 RECOVERY

Recovery support services, primarily paid for by BSAS, are essential to assisting individuals and families affected by SUD to attain and maintain recovery. Organizations like MOAR and Learn2Cope help individuals and their families in the recovery process and work to reduce stigma associated with SUD. Many individuals find support through peers that have been through similar experiences at Recovery Support Centers (RSCs), drop-in centers which offer a drug-free environment and a variety of activities including classes, leisure activities and support group meetings. BSAS also supports Recovery High Schools (RHSs) which provide a structured school environment for high-school aged youth in recovery to support these teens to maintain their recovery and complete their education. Supportive case management services are also provided to individuals and families for recovery support and to help prevent homelessness.[63]

Though not funded by health insurers, MassHealth or BSAS, sober homes are another recovery support. Sober homes provide a group home environment for men or women trying to maintain their sobriety. Some individuals in recovery also participate with groups such as Alcoholics Anonymous or Narcotics Anonymous.

2.2 INITIATING TREATMENT

The success of SUD treatment depends on recognition by the individual of the need for treatment. Because of the high rate of relapse, many individuals will initiate treatment on multiple occasions.

Figure 2.2 Patient Experience of Initiating Care

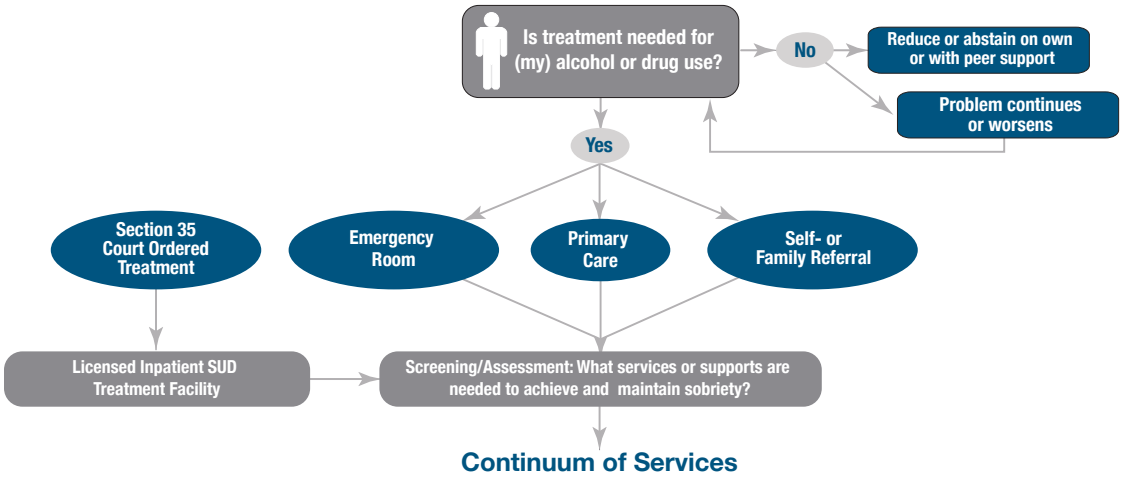


Figure 2.2 illustrates some of the ways[64] in which individuals may enter the SUD treatment system and begin to access treatment from a variety of provider types. The figure also reflects that some individuals are able to change their alcohol or drug use patterns on their own without professional assistance, or through participation in mutual self-help groups, such as Alcoholics Anonymous, Narcotics Anonymous, or other similar groups.[65, 66]

63 Recognizing the particular vulnerability of individuals that are homeless, BSAS has a long-established the Housing and Homelessness Unit that is focused on providing supportive case management services to individuals and families in permanent and transitional housing settings, including to homeless individuals in low threshold settings.

64 Many individuals also enter the SUD treatment system following an interaction with the criminal justice system and others enter through Section 35. Nationally, the criminal justice system is one of the largest referral sources for treatment for both adolescents and adults. See SAMHSA, Office of Applied Studies. Treatment Episodes Data Set (TEDS): 2002-2012. National Admissions to Substance Abuse Treatment Services. BHSIS Series S-71, HHS Publication NO. (SMA) 14-4850. Rockville, MD, 2014.

65 Humphreys, K., Moos, RH, Finnery, JW, (1995), Two pathways out of drinking problems without professional treatment, *Addictive Behaviors*, 20(4): 427–441.

66 Both Alcoholics Anonymous and Narcotics Anonymous are abstinence-based organizations and are not supportive of MAT.

Many individuals access SUD treatment during a crisis, such as acute intoxication or overdose, an accident or acute exacerbation of another health condition that is caused by substance use. In many crisis situations, individuals enter treatment following an emergency department visit.[67] In other circumstances, individuals begin treatment following an arrest for criminal behavior related to intoxication or addiction. The Massachusetts Executive Office of the Trial Court, in conjunction with BSAS and the Department of Mental Health, has developed a network of "drug courts" where individuals with SUDs who are arrested in a district with a drug court can participate in treatment to avoid jail time for offenses that likely would not have occurred but for the SUD.[68] Many individuals facing probation have requirements within their probation orders to maintain SUD treatment. Likewise, there are often similar requirements for those leaving incarceration and placed on parole. In addition, involuntary civil commitment petitions, often known as "Section 35s," provide a method to seek court-ordered detoxification and stabilization services for an individual whose substance use makes him or her an imminent threat to himself/herself or others.[69]

There are specific ATS and CSS beds reserved for individuals who are committed to treatment through Section 35. In less urgent cases, people may seek referrals to SUD treatment from their primary care provider or be identified with unhealthy substance use as part of an annual visit through routine screening. When initial screening indicates signs of SUD, physicians typically conduct a brief intervention and then refer patients to treatment.[70] Many individuals self-refer to acute treatment services (inpatient detoxification) and outpatient services, including medication assisted treatment services.[71] While some individuals seek detoxification or a longer term residential setting, the most frequently utilized SUD services are outpatient services.[72]

In order to determine the appropriate level of care, individuals seeking care need to receive a comprehensive assessment. The most widely recognized patient placement criteria for treatment of SUDs are the six dimensions developed by the American Society of Addiction Medicine (ASAM).[73] Health plans utilize these standards to determine their own medical necessity criteria, which vary across carriers. Providers report that this variation in medical necessity determinations between plans is confusing and results in an administrative burden.[74] At its best, a utilization review process results in a collaboration between skilled clinicians working for the health plan and providers, with the goal of making the best use of resources to meet the member's needs. However, there can be disagreement about the medical necessity of the requested services.[75] (See Section 5.0 for a discussion of medical necessity criteria and other managed care utilization tools.)

67 The Drug Abuse Warning Network (DAWN) estimated 5 million ED visits in 2011 due to alcohol or drug use. 40% of individuals who came to the ED for detoxification were referred for ongoing or follow-up care. K. Somal and T.George, *Referral Strategies for Patients with Co-Occurring Substance Use and Psychiatric Disorders*, Psychiatric Times, December 23, 2013; accessible at: http://www.psychiatrictimes.com/addiction/referral-strategies-patients-co-occurring-substance-use-and-psychiatric-disorders/page/0/1.

68 There are18 adult drug courts and one juvenile drug court in Massachusetts. For more details, including where the courts are located, see http://www.mass.gov/courts/programs/specialty-courts/. Individuals facing first or second degree driving under the influence (DUI) charges may be eligible to participate in SUD interventions in lieu of sentencing if they do not have other charges.

69 The statute allows for the spouse, blood relative or guardian to request commitment under Section 35. (Chapter 123, Section 35 of the Massachusetts General Laws.) M.G.L., Part 1, Title XVII, Chapter 123, Section 35, Commitment of alcoholics or substance abusers.

70 Some health insurance carriers will cover substance use screenings and/or brief interventions (SBIRT). When covered, these services are not subject to prior authorization. Members may be required to pay a co-payment towards the service however, and these co-payments can vary dramatically between plans. While MassHealth covers screenings and brief interventions for youth, it does not provide any additional payments for providers that utilize screening or brief interventions for adults.

71 Provider Survey, December 2014.

72 See Types of Treatment Programs for Substance Use Disorders; accessible at: http://www.massresources.org/substance-use-disorders-treatment.html.

73 Mee-Lee, D., The ASAM Criteria: Treatment *Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, American Society of Addiction Medicine*, Inc.

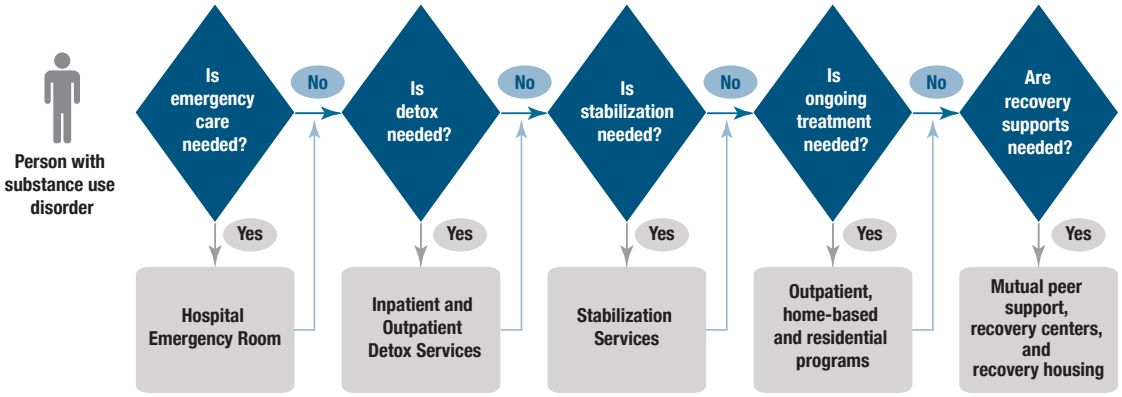
74 ATS Provider Focus Group, December 2014.

75 Patient with public or private health insurance may have appeal rights under applicable state or federal law. See, e.g., M.G.L. c. 176O, §§13-14; 45 C.F.R. 147.136; 130 CMR 610.000.

2.3 SUD TREATMENT SERVICES – A DEEPER DIVE

There is not one way to enter SUD treatment. There are a range of substance use treatment services that meet the needs of each individual depending on an individual's particular circumstances – whether it is an individual at risk for SUD, an individual who currently meets the criteria for SUD, or an individual in recovery. Figure 2.3 depicts the different levels of care based on an individual's level of need. Sufficient capacity at each level of care is necessary for a well-functioning SUD treatment continuum.

Figure 2.3 Access to SUD Treatment Services



It is important to note that while there are different stages within the SUD treatment continuum of care, individuals frequently move back and forth between levels of care and may initiate treatment at any point in the continuum, depending upon their needs. Due to the chronicity of addiction, which can generally be managed but not cured, many people experience relapse and will return to care.[76] This movement across and within the continuum of care requires the continuum to be well integrated to support effective transitions of individuals to and from services.

2.3.1 CRISIS INTERVENTION

If an individual experiences a medical crisis related to the use of substances, such as acute intoxication, overdose, or withdrawal, hospital emergency departments are one site to initially stabilize the patient.[77] When individuals receive care in the emergency department, they are assessed and treated to counter any overdose, maintain safety, and referred to the appropriate level of care for continued detoxification or ongoing treatment.

76 Drugs, Brains and Behavior: The Science of Addiction, National Institute on Drug Abuse, National Institute of Health; accessible at: http://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery.

77 BSAS indicates that 0.2% of their referrals for SUD treatment are from Emergency Departments. The majority of referrals are self-, family-, or non-medical professional referrals. (BSAS data, accessed 3/24/15).

2.3.2 DETOXIFICATION SERVICES

Acute Treatment Services (ATS)

Withdrawal from alcohol or opioids occurs over several days. Withdrawal symptoms can be painfully intense, and in the case of alcohol and benzodiazepines potentially life threatening. For this reason, detoxification often requires medically managed or monitored ATS to safely manage withdrawal. ATS are often referred to as detoxification programs. For those who require medical monitoring, services are typically provided in freestanding inpatient facilities.[78] Hospital-based ATS programs have the capacity to medically manage detoxification for people with significant co-occurring medical conditions, although some freestanding facilities offer programs for individuals with mental health diagnoses or who are also pregnant. Both free-standing and hospital-based ATS programs are licensed by BSAS;[79] the Department of Public Health Care Quality Division also licenses ATS programs that are hospital-based. Some free-standing ATS programs are limited to individuals who are court-ordered to treatment under Section 35. In addition to safely managing withdrawal, patients receiving ATS are also required to initiate psycho-education and motivational therapy as symptoms of withdrawal ebb. The average length of stay in ATS is approximately one week. Once detoxification is complete, behavioral therapy may continue as part of a step-down program or in the community.

Table 2.1 ATS Coverage and Capacity

Coverage	Capacity[80]	Cost Sharing[81]	Expected Additional Capacity[82]
Commercial MassHealth BSAS[83]	Hospital-based: 4 programs with 150 ATS Beds Freestanding: 20 programs with 710 ATS beds[84] (Can service approximately 3500 individuals per month) Section 35: 2 programs with 56 ATS beds[85]	Commercial plans have varying cost-sharing ranging from $69-$500 for 24 hour care, including ATS, depending on plan chosen (level of premium vs. level of deductible/cost-sharing which must first be met from member).	32 ATS beds to be added in Greenfield; several providers seeking licensure for new freestanding beds.

Combined ATS and CSS Services for Adolescents

Adolescents require different models of service than adults. For adolescents, the ATS and CSS level of care is combined to provide comprehensive detoxification and behavioral health stabilization in the same setting. There are two programs with a total of 48 beds. The average length of stay in this combined treatment is 2 weeks.

78 These facilities are referred to as free-standing as they are not attached to an acute hospital.

79 BSAS requires that funded ATS programs have the necessary certifications to provide methadone for detoxification from opioid disorders (See section 2.3.2.3).

80 Capacity for BSAS-licensed ATS as of 2/1/2015, BSAS. Special BSAS Report: Licensed Programs as of November 11, 2014. All capacity information included in the tables within this section is from the Special BSAS Report or updated by BSAS as of 2/1/2015.

81 Health Insurance Carrier Survey, December 2014.

82 BSAS update of licensure information as of January 2015.

83 BSAS only provides coverage for ATS services provided at freestanding facilities.

84 Note: 14 ATS beds have gone off-line since November 2014.

85 The two Section 35 programs house both CSS and TSS beds.

Medication Assisted Treatment (MAT) for Detoxification

For many individuals with SUD, use of MAT for detoxification is effective.[86] Particularly where there is limited capacity for ATS, expanding outpatient detoxification using MAT may provide increased flexibility to health plans and providers in seeking the best care path for a particular member.

There are three FDA approved medications for the treatment of opioid dependence - methadone, buprenorphine and naltrexone. Buprenorphine is often prescribed in combination with naloxone, and naltrexone is available in oral and injectable formulations.[87]

Methadone is only available in Opioid Treatment Programs (OTPs) that are SAMSHA certified and accredited in accordance with federal regulations. These federal regulations require that the administration of methadone used in treating addiction occur only at these OTPs, and to the extent that visiting such a clinic reinforces a stigma, patients might be reluctant to do so. OTPs are allowed to dispense methadone for up to 180 days for the purpose of detoxification. Outpatient OTPs are required to provide behavioral health counseling services in addition to dispensing medication, providing random drug screening tests and other ancillary services.

Buprenorphine can be provided in an inpatient detoxification facility or in office-based treatment settings by physicians who have received specialized training and a DEA "X" waiver which allow them to prescribe the medication.[88] OTPs are not able to administer buprenorphine or naltrexone, making the only treatment option offered by these programs methadone.

2.3.3 Stabilization Services

There are a number of community-based stabilization services, described below, that are typically accessed during a transition from another level of care, including as a step-down service following detoxification. Together these services help to stabilize individuals and give them the support to live successfully in the community. Patients who have completed detoxification are past the most severe symptoms of withdrawal from alcohol or opioids, but are likely to experience less intense symptoms that affect their cognition and emotions for some time. These symptoms affect individuals' ability to resist cravings, participate in treatment, and establish treatment goals. Those who are homeless also need transitional housing until they can enter a living environment that supports sobriety. People using drugs that cause dependence but do not require medical interventions to manage physical withdrawal, like marijuana and cocaine, may also need the intensive support of stabilization services to maintain recovery.

Clinical Stabilization Services (CSS) and Transitional Support Services (TSS)

Clinical stabilization services (CSS) offer a highly structured residential treatment setting for people who have recently stopped using substances and need high intensity stabilization services. It is appropriate either for individuals who have recently completed detoxification or for those with SUD who do not require detoxification medications, including individuals who are not currently using substances but are at risk for a relapse. Licensed by BSAS, CSS are provided around-the-clock for approximately two weeks, although BSAS standards allow individuals to stay for up to 30 days.[89] Some CSS capacity is limited to individuals ordered to treatment under Section 35.

86 Determination of the appropriate type of detoxification and setting is a complex decision that should focus on the patient's choice of services, availability of treatment and whether there are potential complications with SUD and co-occurring mental health or medical conditions that may require inpatient detoxification.

87 These medications are also used for maintenance for individuals in recovery. See section 2.3.4.

88 For additional information on MAT, see section 2.3.4.

89 Insurers typically do not pay for CSS for longer than two weeks. According to a BSAS analysis, individuals who stay in CSS longer have a better chance of making it to the next level of care and to continue in treatment. Transition Down Rates within 14 Days from CSS by Length of Stay, FY 2009, 2011, 2013.

Table 2.2 CSS Coverage and Capacity

Coverage	Capacity[90]	Cost-Sharing[91]	Expected Additional Capacity
Commercial MassHealth BSAS	General: 11 programs with 297 beds (Can serve approximately 600 individuals per month) Section 35: 2 programs with 142 beds	Commercial plans have varying cost sharing ranging from $69-$500 for 24 hour care, including CSS, depending on plan chosen (level of premium vs. level of deductible/cost-sharing which must first be met from member).	32 CSS beds to be added in Greenfield.

Some individuals also benefit from longer rehabilitation time within a clinically managed, supportive setting, known as transitional support services (TSS), which provides additional, low intensity support while waiting to transition to a residential treatment setting. Individuals may enter TSS directly from BSAS-funded ATS or CSS stays. TSS services are also licensed by BSAS and are typically provided for up to 30 days. MassHealth does not cover TSS services and only one commercial carrier covers TSS.[92]

Table 2.3 TSS Coverage and Capacity

Coverage	Capacity[93]	Expected Additional Capacity
BSAS[94]	9 programs with 339 TSS beds[95] (Can serve approximately 331 per month) Section 35: Two TSS programs with 80 beds[95]	Providers are seeking licensure for 4 new TSS beds

Day Treatment

Commercial health insurance carriers and MassHealth cover intensive outpatient services and partial hospitalization for SUD and treatment; BSAS does not license such services but does license a similar service known as Day Treatment.[96] Day treatment assists individuals in stabilizing in a community setting, by providing a minimum of 3 ½ hours of treatment five days per week.[97] These services may provide sufficient support and stability for people who have a place to live and a strong social support network, as they begin the recovery process. It is difficult to assess the capacity for this service as it is called different names by different payers, and some providers may operate this service through their hospital license as opposed to through a BSAS license. In addition, commercial health insurers may not make a distinction between whether programs serve only individuals with mental health needs or those with SUD.

90 Capacity for BSAS-licensed ATS as of 2/1/2015, BSAS. Special BSAS Report: Licensed Programs as of November 11, 2014. All capacity information included in the tables within this section is from the Special BSAS Report or updated by BSAS as of 2/1/2015.

91 Health Insurance Carrier Survey, December 2014.

92 For more information on MassHealth coverage and service details, see Appendices Three and Four.

93 All capacity information included in the tables within this section is from the Special BSAS Report or updated by BSAS as of 2/1/2015.

94 One commercial plan reported covering TSS on an ad-hoc basis, but it is not included as part of its benefit package. Carrier Survey, December 2014.

95 Capacity as of 2/1/2015; BSAS.

96 See 105 CMR 164.231 et. seq.

97 Some outpatient services are offered in the evening to allow participants to maintain employment or care for children.

2.3.4 Ongoing Treatment

Outpatient Treatment and Counseling

Once an individual's physical health and living situation has stabilized, outpatient SUD treatment and counseling by licensed professionals provide interventions and approaches to help individuals maintain recovery, manage situations that trigger a desire to use substances again, address any underlying psychosocial issues, and coordinate care. In some cases, individuals may be able to start treatment with outpatient counseling; in other cases, individuals may start with outpatient treatment even though inpatient services may be more appropriate, as they are only ready to commit to outpatient treatment. There are a number of evidenced-based outpatient treatment and counseling models,[98] including cognitive behavioral therapy, motivational interventions and the Adolescent Community Reinforcement Approach - Assertive Continuing Care that combines home and community-based counseling with case management.

Table 2.4 Outpatient Counseling Capacity

Coverage	Capacity[99]	Cost Sharing[100]
Commercial MassHealth BSAS	119 Programs plus unknown number of independently practicing outpatient behavioral health clinicians.	All of the commercial plans require some level of copay for outpatient counseling, at an average of $23 and ranging from $16 to $31 per visit. Some members are also subject to meeting a deductible prior to obtaining coverage through the plan.

There is no standard or reliable method for measuring outpatient capacity, limiting the ability to analyze system adequacy. Data are not available on the hours worked per week by licensed professionals. There are no national benchmarks on the appropriate level of outpatient services or on the optimal size of the workforce. There is also no standard measurement of wait times before appointment availability.

There is a widespread belief, however, that there are shortages in the workforce, even while there is not complete understanding of the size of the gap. The New England Comparative Effectiveness Public Advisory Council (CEPAC), a group that includes state Medicaid agencies, insurers and providers, assert that "there are not enough counselors to serve every patient with addiction" and, further, that those currently practicing are not "specifically trained in addiction."[101] Given the need for counseling services for those with SUD, mental health service capacity is also relevant. All Massachusetts counties are Designated Mental Health Care Health Professional Shortage Areas.[102]

98 For a better sense of the breadth and depth of the various outpatient treatment services for those with SUD explore SAMHSA's database of evidence-based programs, accessible at http://www.nrepp.samhsa.gov/ViewAll.aspx.

99 All capacity information included in the tables within this section is from the Special BSAS Report or updated by BSAS as of 2/1/2015.

100 Health Insurance Carrier Survey, December 2014.

101 Institute for Clinical and Economic Review. Management of Patients with Opioid Dependence: A Review of Clinical, Delivery System, and Policy Options; Final Report 2014. The New England Comparative Effectiveness Public Advisory Council. Released June 20, 2014; accessible at: http://cepac.icer-review.org/wp-content/uploads/2014/04/CEPAC-Opioid-Dependence-Final-Report-For-Posting-July-211.pdf.

102 U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA). http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/mentalhealthhpsaoverview.html.

Post-Detoxification Medication Assisted Treatment (MAT)

MAT is an important part of the SUD treatment system. As noted above, MAT can be used for opioid detoxification (see Section 2.3.2), but is more commonly used to provide maintenance to individuals in recovery. While MAT is available for treatment of alcoholism, it has been used primarily in the treatment of opioid addiction. There are three FDA approved medications for the treatment of opioid dependence: methadone, buprenorphine and naltrexone. Buprenorphine is often prescribed in combination with naloxone, and naltrexone is available in oral and injectable formulations. Each of these drugs may be used for long-term maintenance therapy. The medication used will vary based on each individual's circumstances.

As with detoxification, outpatient OTPs are required to provide behavioral health counseling services in addition to dispensing medication, and provide random drug screening tests and other ancillary services as part of long-term maintenance therapy. (See Sections 2.3.2 and 5.2 for further discussion of methadone treatment.)

Buprenorphine can be provided in office-based treatment settings by physicians who have received specialized training and a DEA "X" waiver which allow them to prescribe the medication. The use of buprenorphine as a MAT is authorized by the federal Drug Abuse and Treatment Act 2000 (DATA 2000), which recommends but does not require that behavioral health services or random drug screening be provided. More recently in Massachusetts, Chapter 258 requires DPH to release best practice guidance related to routine toxicology screenings and requires practitioners to adhere to these best practices.[103] Physicians with waivers from the DEA can provide medication assisted treatment to up to 30 patients in the first year, and 100 patients thereafter, in a physician's office.

Naltrexone is used in the treatment of opioid addiction only post-detoxification. A person must be opioid free for 7-10 days prior to initiating naltrexone, which is an opioid blocker and used to support opioid abstinence post-detoxification. Oral naltrexone can be prescribed for daily use; injectable naltrexone may be administered monthly in a qualified prescriber's office. There are no requirements for behavioral health treatment or random drug screening with this medication.

Because methadone maintenance is so effective in suppressing opioid use, it allows people to reestablish stability in their lives and has been shown to reduce unemployment, improve psychiatric symptoms, and reduce family and social problems.[104] Some individuals remain on methadone maintenance indefinitely, since there is a high rate of relapse after detoxification from methadone, and the risk of overdose from resuming use of opioids is heightened based on reduced tolerance.[105] Buprenorphine and oral naltrexone are also taken daily but can be provided in a physician's office.[106] The use of buprenorphine as a maintenance drug continues to increase,[107] however, consumers report encountering long wait times to initiate buprenorphine treatment.[108] This is due to the limited availability of physicians certified to administer these MATs and the limited number of patients these physicians can treat (currently capped at 100 patients/physician). In general, residential providers report that access to medication assisted treatment is more difficult in rural areas.[109]

103 Section 13 of Chapter 258 of the Acts of 2014, "An Act to increase opportunities for long-term substance abuse recovery."

104 SAMHSA-CSAT. (2012). TIP 43: Medication Assisted Treatment for Opioid Addiction in Opioid Treatment Programs.

105 Office of National Drug Control Policy, 2012, *Medication Assisted Treatment for Opioid Addiction*, Executive Office of the President.

106 Unlike OTPs which are covered as a behavioral health benefit, plans cover prescriptions for buprenorphine and naltrexone as part of their medical or pharmacy benefits.

107 Center for Health Information and Analysis, (2014) Benefit Mandate Review: Medication Assisted Opioid Treatment Proposed in Chapter 258 of the Acts of 2014: An Act to Increase Opportunities for Long-Term Substance Abuse Recovery.

108 Consumer Advocate Focus Group, December 2014.

109 Residential Provider Focus Group, December 2014.

Table 2.5 MAT Coverage and Capacity

Coverage	Capacity[110]	Cost Sharing[111]
Commercial[112] MassHealth BSAS[113]	39 Opioid Treatment Programs (OTP) providing methadone maintenance[114] At least 677 physicians have received a waiver from DEA through SAMHSA that allows them to administer buprenorphine for the purpose of treating opioid addiction in non-specialty setting.[115] These physicians may treat up to 100 patients with buprenorphine per year. BSAS supports staffing for Office-Based Opioid Treatment using both buprenorphine and naltrexone at 16 community health centers Unknown number of providers who prescribe and administer injectable or oral naltrexone.	Commercial plans have varying cost sharing for MAT services; including potential daily copayments for methadone of $20-$30 per visit and pharmaceutical cost sharing for use of buprenorphine and naltrexone. Cost sharing may vary depending on plan chosen (level of premium vs. level of deductible/cost sharing which must first be met from member)

2.3.5 Long-term Residential Programs

Many individuals who struggle with SUD require assistance finding housing and employment. For individuals that may benefit from living in a structured, substance-free environment with clinical and peer support, Massachusetts offers several clinical models of licensed residential programs. Programs also target specific populations including same sex programs for men and women, hard of hearing men, Latino men, adolescents, transitional age youth, pregnant and parenting women and whole family programs. Lengths of stay in these residential programs are typically 3 months, but may be up to a year or longer. Residents in programs for single adults are expected to engage in education, vocational training, or work, and are assisted to do so. These programs are not typically covered by MassHealth or commercial insurance, as they provide many services that are not medical in nature.

110 All capacity information included in the tables within this section is from the Special BSAS Report or updated by BSAS as of 2/1/2015.

111 Health Insurance Carrier Survey, December 2014.

112 At the time of the Carrier Survey only 5 of 10 health plans covered methadone maintenance; since the survey, all plans have agreed to cover methadone. (See MAHP Press Release, February 6, 2015; accessible at: http://www.mahp.com/unify-files/MAHPMethadoneCoverageRelease.pdf.

113 BSAS does not pay for naltrexone; for buprenorphine BSAS provides staff support to community health centers to administer buprenorphine, but not for the medication itself.

114 BSAS data, as of 2/1/2015.

115 Physicians listed on the SAMHSA Buprenorphine Physician and Treatment Program Locator; accessible at: http://buprenorphine.samhsa.gov/bwns_locator/index.html on 1/8/2015. SAMHSA estimates that only 40% of physicians with waivers agree to be listed on their website.

Table 2.6 Long-term Residential Program Coverage and Capacity

Coverage	Capacity[116]
BSAS[117]	Adult Residential: 79 programs with 2281 beds Family Residential: 8 programs that serve approximately 110 families[118] Adolescent Residential (age 13-17): 6 programs with 105 beds Transitional Age Youth Residential: 2 programs with 30 beds (Can serve approximately 600 per month)

2.4 RECOVERY SUPPORTS

People who have attained and maintain sobriety may continue to need community and peer support. Alcohol and Drug Free housing (also known as "sober homes") are an important part of the recovery continuum. Because they provide housing, not medical treatment, they are not covered by health insurance. These homes exist in the community and are subject to a variety of local laws. Because sober homes are of variable quality, in 2015 the legislature required that BSAS develop a voluntary certification program for sober homes that meet the minimum standards of the national certification board. BSAS issued a request for proposals to assist with this work and is reviewing the responses received.

Many individuals in recovery utilize one of the seven BSAS-funded Recovery Support Centers (RSCs), which are peer-led organizations offering a focus for continued social and peer support for recovery. Two additional RSCs were recently awarded funding and will be operational soon. BSAS, in collaboration with various school systems, also funds four recovery high schools to provide an educational environment supportive of recovery, including psychosocial groups and peer support. A fifth recovery high school will be added in the near future. Individuals may also utilize mutual peer support groups such as Alcoholics Anonymous and Narcotics Anonymous.[119] All of these groups and activities help individuals to rebuild social networks that can sustain recovery, since many must leave behind friendships with individuals who continue to abuse substances.

MassHealth pays for Community Support Programs (CSPs) which provide community-based supports to help individuals transition to community services after acute residential treatment, with a focus on people who have had previous relapses. This service can be used for several months.

116 All capacity information included in the tables within this section is from the Special BSAS Report or updated by BSAS as of 2/1/2015.

117 Four health plans also reported covering intermediate residential treatment programs for certain members, although it is not part of their benefit packages. Because recovery homes commented in the Residential Provider Focus Group held in December 2014 that they do not receive any payments from health plans, it is likely that health insurers may pay on a limited basis for out of state residential treatment programs.

118 Capacity as of 2/1/2015; BSAS.

119 While these are the most well-known of the peer support organizations, they both are abstinence organizations and do not support use of MAT. There are a number of non-abstinence based organizations that are supportive of MAT. For examples of these organizations see: *If Not AA, Then What? Five 12-Step Group Alternatives*; accessible at: http://www.rehabs.com/pro-talk-articles/if-not-aa-then-what-alternatives-to-12-step-groups/.

III. SERVICE AVAILABILITY

The services described above form the SUD treatment continuum in Massachusetts. The Commonwealth appears to meet the service availability standards put forth by ASAM and SAMHSA. For example, the Massachusetts continuum offers services at each ASAM-defined level of care based on intensity of service.[120]

Similarly, SAMHSA's standard for a modern behavior health system envisions a comprehensive SUD continuum offering crisis and acute services as well as a broad range of treatment, rehabilitative, supportive, and continuing care services.[121] Massachusetts' varied options for rehabilitation and support encompass virtually all of those enumerated in SAMHSA's standards. In addition, BSAS has embarked on a number of initiatives and pilots to implement innovative evidence-based individual treatments and more flexible modes of providing outpatient treatment and support, including case management and home-based and housing support services, and its continuum includes innovative offerings that most states do not have, such as family residential treatment and recovery high schools.

However, despite the existence of a broad range of services within the care continuum, it is widely perceived by both providers and families that these services are not available to everyone and not easily accessible.[122] The ability to access services across the continuum in a timely manner is critical, particularly for individuals in treatment or at risk for relapse. The following analysis examines capacity from most to least intensive care. It is important to note that there is not one defined pathway through the care continuum, as care choices should be made based on each patient's particular need.

3.1 ANALYSIS OF ADEQUACY OF CAPACITY OF 24-HOUR SERVICES (INPATIENT, DETOXIFICATION, STABILIZATION AND RESIDENTIAL SERVICES)

3.1.1 CAPACITY MISALIGNMENT

While services across the SUD care continuum are available in Massachusetts, providers and patients repeatedly report difficulty accessing them. ATS, CSS, TSS and long-term residential services were reported by patients and providers as being particularly difficult to access.[123] With a total of 868 ATS beds for the non-Section 35 population, a survey of ATS providers in December 2014 shows a daily occupancy rate between 91-100%, which is significantly higher than the average acute hospital occupancy rate of 66%.[124, 125] According to consumer advocate focus group participants, the inability to access services leads families to either send people out of state for detoxification services or resort to seeking detoxification through Section 35 commitments in order to obtain access to these specified beds.[126] The recent abrupt closure of a large ATS facility due to the closing of the Long Island Bridge has temporarily reduced available beds until the facility can reopen at an alternative site.[127] While outpatient detoxification services are available, focus group participants reported that these services are not as effective if used alone.[128]

120 ASAM Level of Care; accessible at: http://www.asam.org/publications/the-asam-criteria/about/.

121 SAMHSA website. (2011). Description of a Good and Modern Addictions and Mental Health Service System accessible at: http://www.samhsa.gov/sites/default/files/good_and_modern_4_18_2011_508.pdf.

122 ATS Provider Survey, December 2014; Consumer Advocate Focus Group, December 2014.

123 *Ibid*.

124 ATS Provider Survey, December 2014.

125 2013 403 Cost Report, CHIA.

126 Consumer Advocate Focus Group, December 2014.

127 http://www.bostonglobe.com/metro/2014/10/27/island-frozen-time-investments-and-services-waste/Lu9RZouWZBcWK9qma9jEVJ/story.html.

128 Consumer Advocate Focus Group, December 2014.

Individuals and families report long wait times and difficulty accessing CSS and TSS services.[129] Not all patients move from ATS to CSS or TSS, but patient flow between services is impacted by both bed availability and lengths of stay. There are currently nearly three times the number of ATS beds (868) as CSS (297) or TSS beds (331). Because the average length of stay in ATS (one week) is shorter than in CSS (two weeks) or TSS (four weeks), the number of patients leaving ATS each week is much greater than the number of CSS or TSS beds vacated each week.

More than half of the ATS providers responding to the survey administered for this report recommended that most of their clients be discharged to another 24-hour setting.[130] However, since CSS has capacity to serve only 600 individuals each month, current capacity provides access to only an estimated 17% of ATS discharges.[131] In addition, some individuals outside of residential treatment who are at risk for relapse would also benefit from direct admission to CSS. Geographical proximity also complicates access to these services, as variation in bed availability per capita exists between regions.[132] Individuals that receive services through Section 35 are able to receive both ATS and CSS levels of care through two programs for Section 35 commitments. There are also two TSS programs and four residential programs that provide priority access for the Section 35 population, providing dedicated access to 80 TSS beds and 200 residential recovery beds for single adults, as well as case management services.

Table 3.1 Estimated Service Capacity of BSAS-licensed Adult 24-hour SUD Programs by Level of Care

	Total Beds	Assumed Average Length of Stay	Average discharges per month
ATS	868	1 week	3472
CSS	297	2 weeks	594
TSS	331	1 month	331
Residential Rehabilitation	2398	3 months	600

Source: Special BSAS Report: Licensed Programs as of November 11, 2014

ATS providers surveyed indicated that the lack of adequate capacity for CSS and TSS programs impacts the lengths of stay in ATS programs because patients may remain longer, thus potentially contributing to a ripple effect of delays for new patients entering detoxification. Respondents also indicated that two of the three most significant reasons for delayed discharge for clients who had completed detoxification were waiting for CSS or TSS programs.[133,134]

129 *Ibid*.

130 For more information on the provider survey, see section 5.0.

131 Of the 13 ATS providers that participated in the survey, 8 reported that less than half of the clients that were recommended for residential step-down services were able to obtain such services.

132 DPH and DMH licensing data, April 2014.

133 However, health insurers typically stop paying for detoxification services when they are no longer medically necessary, making it unlikely that ATS programs will continue to serve an individual who has been detoxed once they are no longer eligible for payment for such services.

134 Nine of 13 providers identified waiting for CSS availability; and eight of 13 providers identified waiting for TSS availability. ATS Provider Survey Response, December 2014.

There are a number of indicators that there is insufficient capacity of ATS, CSS and TSS to meet demand. However, some of the demand for these services may be due to a lack of understanding of either alternative ways to enter the SUD treatment system or the value of outpatient based treatments, such as MAT for opioid addiction.[135] Increasing access to and use of ambulatory treatments may reduce demand for inpatient and residential treatment. Potential strategies to reduce demand may include assisting individuals and their families to understand all evidence-based treatment options and how to access the SUD treatment continuum. Distinguishing between opioid, alcohol, and other drugs is an important component of public education.

When individuals have completed CSS and TSS programs, they then often face difficulty in obtaining a residential placement.[136] While there are more than twice as many residential beds as ATS beds, the average length of stay in residential programs is considerably longer — an estimated three to four months for programs serving single adults, and often longer for programs serving pregnant women or families.[137] At most, approximately 600 beds, or a quarter of residential capacity, become available each month. This is significantly fewer than the approximately 3,000 people completing a 24-hour detoxification program in a month, or the approximately 900 completing CSS and TSS programs. While not all individuals need or want a residential placement, two of the most common reasons for a delayed discharge from a CSS or TSS program are wait times for residential or TSS services.[138] According to 2014 BSAS data, individuals waited an average of 19 days between initial contact with a residential program and admission. This varied considerably across the state and between programs, with DPH's Western and MetroWest regions averaging a two week wait time, and close to a month wait time in the Southeast and Northeast regions.[139]

Again, as with CSS and TSS programs, there are certain populations that have more difficulty accessing long-term residential care. The demand for specialized residential programs is high among clients with challenges in addition to SUD, including homelessness, unemployment, HIV, hepatitis C, criminal justice involvement or disengagement from their families.[140] Surveyed residential providers reported wait times as long as 10 weeks for entrance to their programs. Individuals that are not able to be transitioned directly from CSS or TSS into residential programs will not continue to receive treatment unless it is on an outpatient basis.

In order to treat younger adults, residential providers report shifting their treatment model to increase family involvement and support the needs of young adults. To do this, residential providers may need to offer family support groups, recovery coaching, recovery specialists, aftercare, and life skills training. However, providers note that the higher intensity of such services is not covered by the current BSAS daily payment rate.[141]

There are two co-ed programs for adolescents which each combine detoxification and stabilization services. While there is typically bed availability for detoxification for adolescents,[142] significant travel is necessary for many families because there are only these two programs offered across the state.

135 Massachusetts Department of Public Health, 2014, Findings of the Opioid Task Force and Department of Public Health Recommendations on Priorities for Investments in Prevention, Intervention, Treatment and Recovery.

136 Residential provider focus group, December 2014.

137 BSAS, Transition Down Rates within 14 days from CSS by Length of Stay, FY2009, 2011, and 2013. This report shows 8174 people were served in residential provider in FY13 according to BSAS records. Dividing licensed residential beds into number served results in an estimated 3.4 month length of stay.

138 Six of seven CSS providers identified waiting for residential availability; and five of seven CSS providers identified waiting for TSS availability. CSS Provider Survey Response, December 2014.

139 BSAS, *Admission / Enrollment Profile: Service Type: Recovery Home* Report Period: Jul 1, 2013 - Jun 30, 2014. Data As Of: Aug 12, 2014. For more information on DPH regions see: http://www.mass.gov/eohhs/gov/departments/dph/programs/admin/comm-office/regional-health-offices/.

140 ATS Focus Group, December 2014.

141 Residential Provider Focus Group, December 2014.

142 Review of MBHP Bedfinder.

An individual's ability to access services is dependent on more than just the number of beds in the system. As part of their agreements with BSAS, certain residential programs give priority to BSAS designated priority populations,[143] resulting in longer waits for people who fall outside of the designated populations. Some residential programs may avoid accepting clients on methadone, even though BSAS requires them to take clients regardless of medication use.[144] In addition, as reported in the provider focus group, some programs do not accept people who are involved in the criminal justice system with pending court cases.[145]

3.2 MASSACHUSETTS LICENSED SUD AMBULATORY CAPACITY

It is critical to have a robust and well-distributed network of outpatient SUD services. Strong outpatient services provide individuals with support in the community to help maintain their recovery. Unfortunately, there is no standard or reliable method for measuring outpatient capacity, limiting the ability to effectively analyze system adequacy. While there is data for BSAS-licensed services, there are many additional places where individuals may receive outpatient treatment, including through licensed community mental health clinics and outpatient treatment providers that practice independently.

Data are not available on the hours worked per week for licensed professionals or how many FTE providers offer treatment. There are also no national benchmarks on the need for outpatient services or on the optimal size of the workforce. In addition, there is little systematic information available about SUD treatment providers' capacity to provide culturally competent care. A lack of ethnically-matched and linguistically-capable service providers may affect engagement in and the effectiveness of SUD treatment. A recent Massachusetts study found the current behavioral health workforce to be insufficient to meet the needs of Massachusetts' diverse population, including lack of capacity to offer services in a patient's native language.[146] Even when an interpreter is used, studies show that patients who do not speak the same language as their providers have worse outcomes and higher dropout rates. There is some evidence indicating that ethnically matching patients to SUD providers can improve retention in care.[147]

As shown in Table 3.2, commercial and MassHealth plans generally agree on appropriate standards for wait times for behavioral health services. The expectation for routine treatment requests is to provide an appointment within 10 business days while emergency care should be provided immediately or within 24 hours. The timeframes in which health plans respond to urgent requests range from 24 hours to three business days. According to responses from the provider survey, most ambulatory providers state they meet or come in under the time frames for seeing patients required by the health insurers.

143 Priority populations are based on SAMHSA requirements for use of Block Grant funding and BSAS response to arising needs. Current priority populations include: intravenous drug users, homeless individuals, pregnant women, and individuals with chronic medical conditions. Prioritization of individuals within these groups is true across all BSAS-funded levels of care, not just residential services.

144 ATS provider focus group, December 2014.

145 *Ibid*; Courts require periodic written reports from residential programs on court-involved residents, who are also required to periodically report to court in person. Courts do not generally provide transportation, so some providers organize or provide transportation despite the fact that they are not reimbursed for it.

146 *Op. cit*. Alegria, et. al.

147 *Ibid*.

Table 3.2 Standards for Wait Time to SUD Services By Plans, Providers, and by Urgency of Need

Urgency of Need	Commercial Health Plans	MassHealth Health Plans	Opioid Treatment Program Provider Respondents	Intensive Outpatient Provider Respondents	SUD Outpatient Provider Respondents
Routine	10 business days (8)	10 business days (2)	48 hours (88%) No longer than 72 hours (100%)	48 hours or less (95%)	1 week or less (95%)
Urgent	24 hours (2), 48 hours (2), or 3 business days (3)	48 hours (1) or 3 business days (1)			
Emergency	Immediate (5) or within 24 hours (2)	Within 24 hours (1)			

Sources: Health Insurance Carrier Surveys and Provider Surveys

While providers responding to the survey suggest that they are relatively compliant with the timeframe requirements as set by the health plans and MassHealth, individuals and families consistently report that they are not able to access care in a timely way. There is currently no systematic, cross-payer review or aggregation of relevant data to clarify these differences in reported experience.

According to their survey responses, 17 of 20 intensive outpatient providers (IOPs)[148] provide patients with a first appointment within 48 hours. The remaining three IOPs provide services within a week of request. In all cases, the survey responses indicate that services are provided well within the 10 day standard. However, both provider and consumer focus group participants reported significant perceived delays in accessing this level of service.[149]

For outpatient services, survey respondents indicate that two-thirds of outpatient providers offer patients a first appointment within 48 hours of request, but 11% report wait times exceeding a week. Almost all providers (94%) are able to offer patients a second appointment within one week of the first. However, providers indicate that low reimbursement rates limit providers' ability to offer additional outpatient SUD treatment capacity.[150] This may be an area for further study.

Health plans indicate that they periodically survey behavioral health providers in their network about their ability to meet response standards for emergent, urgent and routine services.[151] Three plans submitted reports for review. One commercial plan found that its behavioral health network providers met their service standards for 85% of requests. Two MassHealth plans reported that providers met standards for a high percentage of adult requests for service, but were much less likely to meet the standards for adolescent requests.

148 As noted above, BSAS does not license IOP services – it licenses Day Treatment; however 20 providers responding to the survey identified as providing IOP services.

149 ATS Focus Group, December 2014. Consumer Advocate Focus Group, December 2014.

150 ATS Focus Group, December 2014.

151 Health plans do not differentiate between mental health and SUD providers within their reports.

3.3 SUFFICIENCY OF PROVIDER NETWORKS

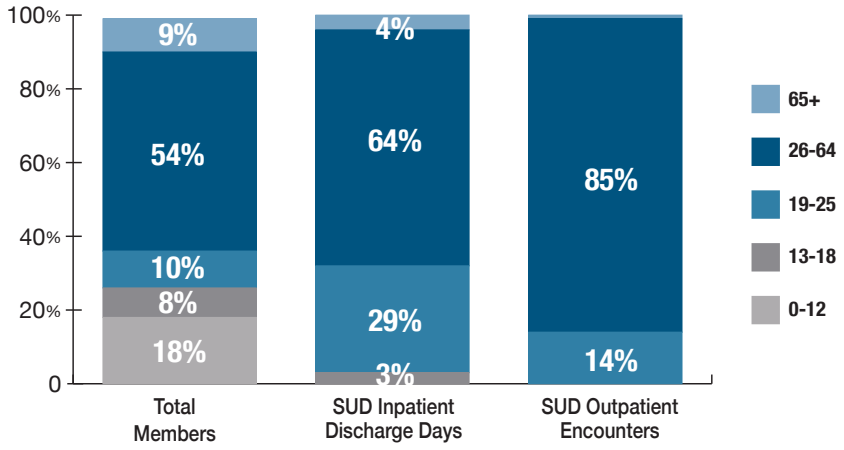
Commercial health plans are required by the Division of Insurance (DOI) to have comprehensive networks to provide covered services, including for SUD treatment. Likewise, MassHealth requires its managed care entities to meet network and access standards, including both distance and time standards. There is no requirement, however, that all SUD treatment providers be included within a provider network. As with any benefit, health plan members are typically limited to receiving services from SUD treatment providers within their health plan's network. Depending on the depth of the provider network, a member may not be able to access an otherwise available bed or service, leading to potential delays in treatment and/or having to receive services further from home.

Based on the survey responses, the plans vary in terms of the numbers of freestanding ATS programs within their network, as well as the number of CSS providers and OTPs. While the commercial plans' outpatient networks appear to include multiple providers of these services, outpatient providers rated finding a local provider who accepts the right insurance coverage to be a significant barrier to patients.[152]

3.4 SUD TREATMENT SERVICE UTILIZATION

In 2012, 1.2% of commercial members used SUD treatment services covered by the health plans and 4.9% of MassHealth members used SUD treatment services.[153] However, these figures do not capture members who accessed treatment outside of their plan, either by paying out of pocket or through BSAS. Figure 3.1 shows utilization by age group for commercial health plans for covered SUD services in 2012.[154]

Figure 3.1 Commercial Utilzation by Age



Service patterns differ for SUD services among adults of different ages. Younger adults between the ages of 19 and 25 represent only 10% of all members, but account for 29% of all SUD inpatient discharge days and 14% of all SUD outpatient encounters.[155] Adults ages 26 to 64 represent 54% of all members, while constituting 64% of all SUD inpatient discharge days and 85% of all SUD outpatient encounters provided.

152 ATS Focus Group, December 2014.

153 Penetration rates for commercial members included in the All Payer Claims Database, and for MassHealth members provided by MassHealth for the Health Planning Council.

154 Commercial Health Plan Utilization Data, 2012, Division of Insurance. Inpatient days include both hospital inpatient and intermediate residential days and outpatient encounters include both intermediate and outpatient visits.

155 As enrollment for 19-25 year olds has expanded through health care reform activities in Massachusetts and nationally, SUD discharges have also grown significantly – up 22% between 2006 and 2012. Division of Insurance.

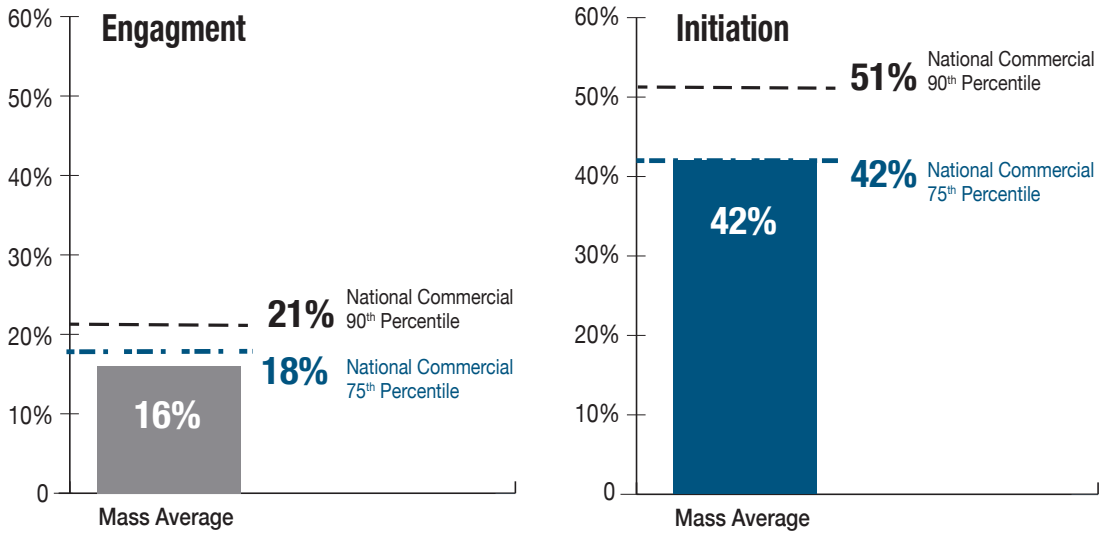
There appears to be variation in treatment intensity based on plan type and benefit coverage. Plans serving both MassHealth and commercial enrollees tend to provide more care through freestanding ATS, CSS and outpatient SUD visits, as compared to plans serving only commercial members, which tend to provide a greater share of hospital-based ATS services, partial hospital and intensive outpatient programs[156] – although it is difficult to make direct comparisons between these plan types regarding member's outpatient service utilization, as most commercial plan were not covering methadone maintenance during this time period.

While it is important for individuals to receive treatment quickly after discharge to improve overall treatment outcomes,[157] many individuals leave ATS services without having a place to go or being linked to treatment. A recent study of continuity of care after detoxification found that only 21% of individuals discharged from detoxification services received any treatment within 14 days after discharge.[158]

Both commercial and MassHealth plans measure SUD treatment access using two measures included in the Healthcare Effectiveness Data and Information Set (HEDIS) measures. These measures look at initiation of alcohol and other dependence (AOD) treatment[159] and engagement in AOD treatment.[160] Massachusetts plans perform at or above the national average on both these measures of access.[161]

Figure 3.4 compares SUD initiation and engagement rates for Massachusetts commercial managed care organizations (MCOs) and preferred provider organizations (PPOs) to the top 25% and the top 10% of all MCOs and PPOs reporting HEDIS data nationally.[162] On average, Massachusetts commercial health plans performed at or near the national 75th percentile on measures of initiation and engagement.

Figure 3.2 HEDIS Performance for Massachusetts Health Plans Compared to Health Plans Nationally



Source: National Committee for Quality Assurance, Improving Quality and Patient Experience: The State of Health Care Quality, October 2013

156 Division of Insurance, 2012, HMO Behavioral Health Utilization for MA Residents.

157 Lee MT, Horgan, CM, Garnick DW et al. A performance measure for continuity of care after detoxification: Relationship with outcomes. J*ournal of substance abuse treatment*. 2014;47(2):130-139; see also Mark, T.L., Vandivort-Warren, R & Montejano, L.B. (2006). Factors affecting detoxification readmissions: Analysis of public sector data from three states. *Journal of substance abuse treatment*, 2006: 31, 439-445.

158 Lee MT, Horgan, CM, Garnick DW et al. A performance measure for continuity of care after detoxification: Relationship with outcomes. *Journal of substance abuse treatment*. 2014;47(2):130-139. This national study included Massachusetts data.

159 AOD Treatment Initiation is the percentage of members who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

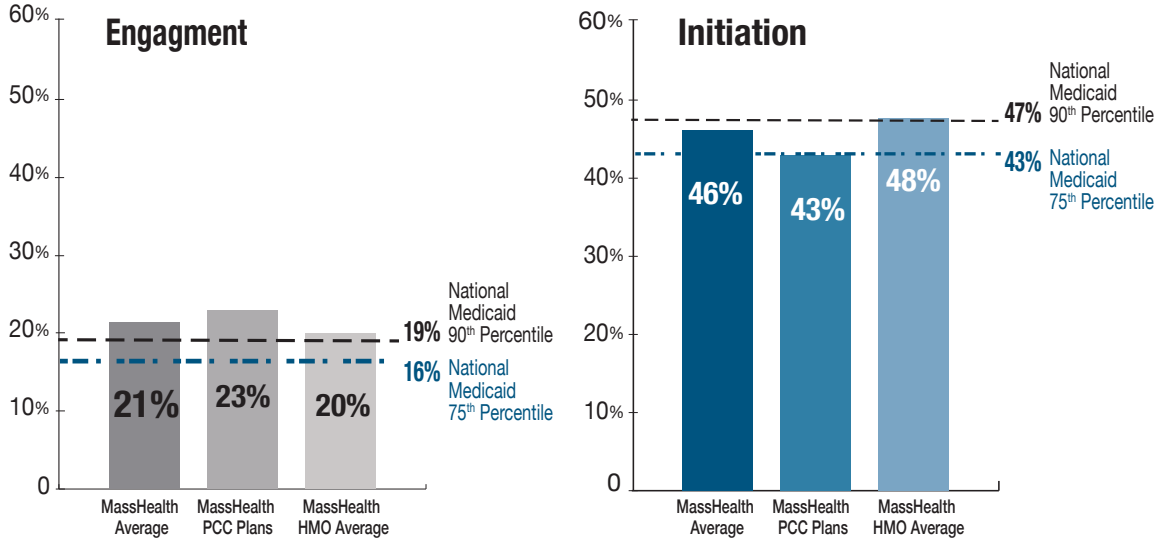
160 AOD Treatment Engagement is the percentage of members with an AOD diagnosis who initiated treatment and had two or more additional services within 30 days of the initiation visit.

161 National Committee for Quality Assurance (NCQA); Quality Compass; 2013 Health Plan Data.

162 The top 25% of plans are represented by the 2013 National 75th percentile, and the top 10% are represented by the 2013 National 90th percentile.

Similarly, the MassHealth managed care programs (including the state-administered Primary Care Clinician Plan (PCC))[163] performed at the National Medicaid 75th percentile, as shown in Figure 3.3. While the plans score well compared to other plans nationally, the rates show significant room for improvement in both initiation rates and engagement rates.[164]

Figure 3.3 HEDIS Performance for MassHealth Managed Care Plans Compared to Medicaid Health Plans Nationally



Source: National Committee for Quality Assurance, Improving Quality and Patient Experience: The State of Health Care Quality, October 2013

While Massachusetts performs relatively well in initiating and engaging individuals in treatment, compared to the nation, a recent study found that those in treatment in Massachusetts were considerably less likely to complete treatment than those in treatment nationally.[165] The study also showed greater differences in completion rates between racial and ethnic groups in Massachusetts than nationally.[166]

3.5 MANAGED CARE TOOLS

Ideally, managed care tools are used by health plans to ensure that care is being delivered efficiently and in a manner consistent with evidence-based principles. While these tools can be effective instruments in assuring appropriate care and guarding against over-utilization, they can also potentially present barriers to accessing services. Managed care tools have been empirically demonstrated to decrease spending on ATS/CSS services, which must stem from some difference in criteria applied by health plans and providers when managed care tools are in place.[167,168]

163 Substance abuse treatment services for the MassHealth PCC Plan are administered and managed by the Massachusetts Behavioral Health Partnership (MBHP), the PCC Plan's behavioral health contractor.

164 National Committee for Quality Assurance Health Insurance Plan Rankings 2011-2012: *Top 20 Private Health Insurance Plans* accessable at: http://www.ncqa.org/tabid/1243/Default.aspx.

165 *Op. cit*, Alegria et. al

166 *Ibid*.

167 Compass Health Analytics, Inc. (2014). Actuarial Assessment of Chapter 258 of the Acts of 2014: "An Act to increase opportunities for long-term substance abuse recovery". Acute Treatment and Clinical Stabilization Services and Substance Abuse Treatment Preauthorization, Center for Health Information and Analysis.

168 "Utilization Review" is defined by statute as: "a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Such techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review." Section 1, M.G.L. Chapter 176O.

3.5.1 MEDICAL NECESSITY CRITERIA

The combination of mental health parity and essential health benefits requirements in Massachusetts and nationally ensure that a basic set of SUD services are widely covered by health insurance carriers. Under parity laws, medical necessity criteria may be established to ensure that health care services are consistent with generally accepted principles of professional medical practice[169] and are derived as required under M.G.L. c. 176O. Medical necessity criteria may differ across carriers and from the criteria applied by providers for treatment. While both plans and providers report being guided by the ASAM assessment criteria, commercial health plans appear to place greater emphasis on criteria for clinical indications of acute withdrawal and medical stabilization, while providers appear to place greater emphasis on motivation for treatment and the degree to which the patient's living environment is supportive of recovery.[170,171] Both providers and consumers report concerns about the variation in medical necessity criteria used across plans and carrier authorization of services based on these varied criteria.[172] Particular concerns around these discrepancies arise in conjunction with utilization review and fail-first policies, two non-quantitative treatment limits that parity laws hold should not be applied in a more restrictive manner than how they are applied to medical/surgical care.[173] A 2013 national study examining health benefits after MHPAEA was enacted but before final regulations were issued found multiple examples of NQTLs that were applied more strictly for behavioral health services than for medical/surgical services.[174,175] This national study may inform discussions of parity compliance in Massachusetts, but it is important to note that the study's findings cannot be directly applied to the current Massachusetts healthcare market, as it was based on a nationally representative sample of large employer benefits in 2010. Massachusetts health plans annually file descriptions of their policies and procedures with regard to mental health parity compliance with the Division of Insurance and the Attorney General's Office, including the application of non-quantitative treatment limits. To date, not a single violation of parity has been processed by either the DOI or the AGO as a result of these filings.

169 MHPAEA: Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, Pub. L. No. 110-343, §§ 511-512 (2008).

170 Compass Health Analytics, Inc. (2014). Actuarial Assessment of Chapter 258 of the Acts of 2014: "An Act to increase opportunities for long-term substance abuse recovery". Acute Treatment and Clinical Stabilization Services and Substance Abuse Treatment Preauthorization, Center for Health Information and Analysis.

171 Generalization as to whether carrier or provider criteria are more appropriate cannot be made, since decisions about appropriate care must be made based on an individual's particular needs and circumstances.

172 ATS Provider Focus Group, December 2014. Consumer Advocate Focus Group, December 2014.

173 MHPAEA: Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, Pub. L. No. 110-343, §§ 511-512 (2008).

174 Between passage of MHPAEA in 2008 and the release of final regulations during November 2013, some carriers showed improvement in parity compliance but not perfect compliance. *Consistency of Large Employer and Group Health Plan Benefits With Requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act Of 2008,* November 2013 accessible at: http://www.dol.gov/ebsa/pdf/hhswellstonedomenicimhpaealargeemployerandghpbconsistency.pdf.

175 A national analyses of 2010 large employer benefits found multiple examples of NQTLs that were stricter for MH/SUD than for medical/surgical services. Some of the most common NQTLs include MH/SUD precertification requirements that were more stringent than medical/surgical requirements (28% of tested plans), medical necessity criteria that were applied to MH/SUD benefits but not to medical/surgical benefits (8% of tested plans), the use of routine retrospective reviews for MH/SUD services, and not for medical/surgical services, and reimbursement rates that were based on lower percentages of UCR rates for MH/SUD services than those provided for medical/surgical services. Mercer's 2010 employer survey found that 8% of employers reported adding or increasing their use of utilization management techniques in response to MHPAEA. http://www.dol.gov/ebsa/pdf/hhswellstonedomenicimhpaealargeemployerandghpbconsistency.pdf.

The prior authorization process will be eliminated in the fully-insured market as of October 2015 for patients seeking acute treatment services and clinical stabilization services administered by DPH-licensed providers.[176] However, providers will be required to notify commercial plans and MassHealth of a member stay within a specified time period and the plans will be able to conduct continuing stay/concurrent reviews.[177] Appendix Two includes detailed information on the current prior authorization and continued stay/concurrent reviews conducted by commercial health insurers and MassHealth managed care plans.[178] Fail-first policies restrict coverage for higher levels of care unless a patient has attempted and "failed" at a lower level of care already. As with continued stay reviews any fail-first policies must be applied in a non-discriminatory way, and not more frequently or stringently for SUD treatment than for medical or surgical treatment.[179] Although fail-first policies are designed to ensure that members receive the most appropriate level of care, participants in the consumer advocate focus group report frustration with the requirement that patients must undertake a lower-intensity level of treatment than they believe is necessary.[180]

3.5.2 COPAYMENTS

The coverage that a member has through a commercial carrier, whether obtained through an employer or by individual purchase, may require member cost sharing in the form of meeting a deductible or copayments before services are carried under the health coverage. Depending on the commercial plan, copayments vary considerably.[181] These cost sharing requirements may become a barrier to access, particularly in the context of services that require a daily copayment, such as methadone treatment. For example, 17 health plans represented by the Massachusetts Association of Health Plans announced that they will expand overage to include methadone treatment,[182] but the extent to which this coverage expansion will increase access may depend on the magnitude of cost sharing for this daily service as well as accompanying medical necessity criteria. MassHealth does not allow co payments for SUD hospital services.[183] Providers of BSAS-funded services may impose a fee relative to a sliding fee scale for methadone and residential recovery homes.

176 Massachusetts Acts of 2014, Chapter 258, "An Act to Increase Opportunities for Long-Term Substance Abuse Recovery", Sections 9, 21, 23, 25, and 27; accessible at: https://malegislature.gov/Laws/SessionLaws/Acts/2014/Chapter258.

177 Section 30 of Chapter 258 of the Acts of 2014, "An Act to increase opportunities for long-term substance abuse recovery."

178 For additional information on utilization review, see Appendix Two.

179 MHPAEA: Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, Pub. L. No. 110-343, §§ 511-512 (2008).

180 Consumer Advocate Focus Group, December 2014.

181 Health Insurance Carrier Survey, December 2014.

182 MAHP Member Health Plans Aggressively Move to Address Opioid Crisis, Press Release, February 6, 2015; accessible at: http://www.mahp.com/unify-files/MAHPMethadoneCoverageRelease.pdf.

183 http://www.mass.gov/eohhs/provider/insurance/masshealth/claims/customer-services/copayments-faqs.html#q1, retrieved March 25, 2015.

IV. SUMMARY

This report was prepared pursuant to Section 30 of Chapter 258 of the Acts of 2014, "An Act to increase opportunities for long-term substance abuse recovery." Key findings of the report center on service capacity and design, benefit coverage, education around the full range of appropriate SUD treatment options, and cultural competency of the health system treating patients with SUD. This report is filed with the House and Senate Committees on Ways and Means, and with the Health Policy Commission. Pursuant to Section 31 of Chapter 258, the Health Policy Commission will issue a report recommending policies intended to ensure access to and coverage for SUD treatment throughout the Commonwealth.

V. ABOUT THIS REPORT

5.1 SECTION 30 OF CHAPTER 258 OF THE ACTS OF 2014

Section 30 of Chapter 258 of the Acts of 2014, "An Act to increase opportunities for long-term substance abuse recovery" directs the Center for Health Information and Analysis (CHIA) to conduct a review and issue a report on accessibility of substance use treatment in the Commonwealth. This report comes at a time when there is heightened focus on the substance use disorder treatment system in Massachusetts following a projected 46% increase in opioid overdose deaths from 2012 to 2013.[184] In 2014, both the Legislature and the Patrick Administration undertook efforts to identify the underlying causes leading to increases in opioid usage and related deaths. These efforts led to increased investment to expand capacity within the SUD treatment system, and legislatively mandated insurance benefits related to treatment. Since taking office in January, Governor Baker and his administration continue to advance these efforts. The Baker administration released county-level overdose data and convened the Opioid Addiction Working Group, chaired by Secretary of HHS, Marylou Sudders, and Attorney General Maura Healey. The increased attention to the misuse of opioids has stimulated a broader evaluation of the accessibility of substance use treatment for all drugs of abuse, including alcohol, cocaine, benzodiazepines, marijuana and other drugs.

As required by Section 30, this report provides a review of the continuum of care for SUD treatment, and evaluates coverage for those services across payers, including commercial health insurance,[185] MassHealth and the Department of Public Health's Bureaus of Substance Abuse Services (BSAS). It also examines the accessibility of those services based on provider availability and cost-sharing requirements. Finally, the report provides a description of specific barriers to treatment access and considerations for addressing them.

5.2 METHODOLOGY

To assist in the development of this report, CHIA contracted with DMA Health Strategies and leveraged a number of existing resources both in Massachusetts and nationally. Recently completed Massachusetts reports[186] that were reviewed include:

- Findings of the Opioid Task Force and DPH Recommendations on Priorities for Investments in Prevention, Intervention, Treatment and Recovery Supports (2014)
- State Health Plan: Behavioral Health (2014)
- Mandated Benefits Review Reports (2014)[187] related to SUD treatment services, including:
  - Medication Assisted Opioid Treatment
  - Mental Health and Substance Use Disorder Screening
  - An Act to Increase Opportunities for Long-Term Substance Abuse Recovery

184 Governor Baker Announces Initial Steps to Combat Opioid Addiction Coverage, Press Release from Governor Baker, February 19, 2015.

185 This report reflects the commercial health insurance market that is fully-insured. However, it is important to understand that the majority (58%) of employer-sponsored health insurance is self-insured. See http://chiamass.gov/enrollment-in-health-insurance/. Self-insured plans are often administered by commercial health insurers and often utilize the same benefit package and approach to coverage as the fully-insured market. However, self-insured plans are not required to meet state mandated benefit requirements.

186 Appendix One provides a summary of recent Massachusetts efforts to address SUD access and treatment.

187 These reports were prepared for CHIA by Compass Health Analytics, Inc.

In addition to the review of the above reports, DMA Health Strategies surveyed health insurance carriers and providers, and hosted consumer and provider focus groups about SUD treatment services. Ten health insurance carriers in Massachusetts provided comprehensive responses to the survey which addressed coverage guidelines, wait times for services and provider performance standards for both commercial and MassHealth members. Similarly, the provider survey addressed patient wait times, treatment access, and access barriers for certain levels of care. In total 43 providers from across the Commonwealth responded to the survey, including acute treatment services (ATS) providers, outpatient providers, methadone treatment service providers, clinical stabilization services (CSS) providers, and outpatient treatment program providers.

Provider Survey 12/2/14- 12/29/14	Sent	Received	Response Rate
Total Agencies	94	43	45.7%
ATS Providers	19	13	68.4%
CSS Providers	11	7	63.6%
SUD OP Providers	88	38	43.2%
IOP Providers	unknown*	20	unknown
Methadone Providers	11	9	81.8%

** Sent to 88 SUD OP providers, an unknown # of whom offer IOP*

Two provider focus groups – one hosted by the Association of Behavioral Health (ABH) that included four multi-service provider organizations and the other with five residential rehabilitation providers – were held. One consumer focus group was organized by the Massachusetts Organization for Addiction Recovery (MOAR) and included six consumer advocates. In addition, DMA Health Strategies conducted key informant interviews with representatives from BSAS and MassHealth, and reviewed MassHealth's managed care contracts and provider manuals.

A provider survey and focus groups with providers and consumer advocates were conducted specifically for this report, since no comparable data was otherwise available concerning the perspectives of these stakeholders on access to services in the SUD continuum. It is important to note that the opinions expressed in the provider survey and in the focus groups conducted for this report may not represent the opinions of all providers or consumer advocates across the commonwealth.

Finally, DMA Health Strategies conducted a quantitative analysis of state and national data to analyze the timeliness, availability and utilization of SUD services. Data reviewed as part of this analysis included:

- The National Committee for Quality Assurance's (NCQA's) Healthcare Effectiveness Data and Information Set (HEDIS). Measures on the percentage of people using SUD inpatient, intermediate and outpatient services, and rates of SUD treatment initiation and engagement in SUD treatment (2013);
- The Massachusetts Division of Insurance's reports on Health Maintenance Organization data for 2011, 2012, and 2013 on the units of SUD inpatient, intermediate, and outpatient services used;[188]
- The Massachusetts Behavioral Health Partnership's Bed Tracking System for ATS bed availability data, by day for four dates in 2014; and
- BSAS Helpline data on number of requests for services.

188 Commercial insurers, MassHealth and BSAS do not use consistent terminology for the types of services provided for those in need of SUD treatment. Where a service is not included or labeled differently by the different payers, we will point that out. For example, "intermediate services" is a term used by commercial insurers, but not by BSAS.

APPENDIX ONE: SUMMARY OF RECENT MASSACHUSETTS EFFORTS TO ADDRESS SUD ACCESS AND TREATMENT

1. RESPONSE TO OPIOID ADDICTION EPIDEMIC

On March 27, 2014, Gov. Deval Patrick declared a public health emergency in response to the growing opioid addiction epidemic, and directed DPH to take immediate actions to combat overdoses, prevent the epidemic from getting worse, and help those already addicted find a path to recovery.[189] In addition, Gov. Patrick charged DPH with developing a long-term solution to end the statewide opioid epidemic.

Following the emergency declaration, DPH issued a public health advisory to increase education and awareness around available treatment options to prevent opioid addiction.[190] In addition, DPH convened an emergency session of the Public Health Council which agreed to:

- Permit all first responders to administer the overdose prevention drug naloxone (Narcan) and to make the drug available through standing order in pharmacies.
- Enforce a now mandatory Prescription Monitoring Program (PMP) for physicians and pharmacies aimed at curtailing opioid abuse by limiting "doctor shopping" for prescriptions. As of November, approximately 25,000 users were enrolled.[191]
- Charge the Commonwealth's Interagency Council on Substance Abuse and Prevention (Interagency Council) with making recommendations on improving service coordination, ensuring a full range of treatment regardless of insurance, and diverting non-violent criminal defendants with addiction into treatment.[192]

In response to the rise in opioid deaths, the Massachusetts Legislature established a $10M Substance Abuse Trust Fund to expand capacity for treatment services across Massachusetts.[193] Additional funds were also appropriated for new intake systems and infrastructure to support individuals in recovery.

1.1 BUREAU OF SUBSTANCE ABUSE SERVICES

BSAS has a number of prevention initiatives and treatments that address the opioid crisis.

- The BSAS-funded Massachusetts Technical Assistance Partnership for Prevention provides substance abuse prevention support and resources for communities and coalitions across the state, including a 2013 guidance document on Prevention and Reduction of Opioid Misuse in Massachusetts.[194]
- The Massachusetts Opioid Abuse Prevention Collaborative grant program aims "to implement local policy, practice, systems and environmental change to prevent the use/abuse of opioids, prevent/reduce fatal and non-fatal opioid overdoses, and increase both the number and capacity of municipalities across the Commonwealth addressing these issues." [195]

189 *Op. Cit*. 11 Opioid Overdose Response Strategies in Massachusetts.

190 *Ibid*.

191 State Capitol Briefs, Lunch Edition, Wednesday, November 12, 2014. State House News Service.

192 *Op. Cit*. 11 Opioid Overdose Response Strategies in Massachusetts.

193 Bureau of Substance Abuse Services, Substance Abuse Trust Fund – FY2015 Quarterly Report Department of Public Health – Bureau of Substance Abuse Services Abuse Services; accessible at: http://www.mass.gov/eohhs/docs/dph/substance-abuse/substance-abuse-trust-fund-fy2015.pdf.

194 Massachusetts Technical Assistance Partnership for Prevention, 2013, Prevention and Reduction of Opioid Misuse in Massachusetts; available at: http://masstapp.edc.org/massachusetts-opioid-abuse-prevention-collaborative.

195 *Ibid*.

- BSAS received a SAMHSA SPF- Partnerships for Success II grant "to address prescription drug misuse and abuse among persons aged 12 to 25 in high-need Massachusetts communities," an issue also prioritized by the Governor's Interagency Council and the Massachusetts Epidemiological Workgroup.[196]

BSAS administers the DPH's Overdose Education and Naloxone Distribution (OEND) program, a pilot program to distribute intra-nasal Narcan along with opioid overdose prevention materials, available in multiple languages, to opioid users and "trusted people in their lives."[197] OEND programs have "documented over 2,655 opioid overdose reversals" between December 2007 and March 2014.[198]

In addition to covering Methadone treatment for people who are uninsured, BSAS funds 14 Office-Based Opioid Treatment Programs (OBOT) in health centers. OBOT with Buprenorphine (OBOTB) is a primary care model offering evidence-based treatment for patients with opioid addiction. OBOT patients receive integrated medical and addiction care.[199]

DPH is also promoting Screening, Brief Intervention, and Referral to Treatment (SBIRT) programs, which have been proven "to reduce unhealthy substance use, and to save lives and money."[200]

1.2 OPIOID TASK FORCE

In response to the public health emergency declaration, DPH used the Executive Committee of the Interagency Council to create an Opioid Task Force, which was charged with: making recommendations to strengthen opioid abuse prevention and treatment systems to reduce overdoses, preventing opioid misuse and addiction, increasing the number of people seeking treatment, and supporting people recovering from addiction. A number of this report's findings have relevance for understanding access to SUD services,[201] including:

- Long waits for insurance coverage;
- Lack of clear understanding among people in need and their families about how to access services;
- The need to call multiple programs to find available services;
- Lack of sufficient services for youth and young adults, and families with children;
- Restrictive policies for authorizing services by insurers;
- Physician reluctance to get authorized to administer buprenorphine, restricting access to this promising level of care;
- Loss of foster care placement for youth placed in residential care;
- Housing issues; and
- Lack of drug free shelters.

Task Force Recommendations called for the following system-wide investments:

- A central navigation system to facilitate locating appropriate services and pilot regional assessment centers that provide assessment, liaison with central intake, and group sessions on a same day basis;
- A public facing dashboard to help consumers select a service provider;
- Additional ATS and CSS beds, and TSS beds for the long-term homeless;

196 *Op. Cit.* 11 Opioid Overdose Response Strategies in Massachusetts.

197 The Official Website of the Executive Office of Health and Human Services (EOHHS). Opiod overdose prevention. Accessible at: http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/prevention/opioid-overdose-prevention.html#MassachusettsOpioidAbusePreventionCollaborative.

198 *Op. Cit.* 11 Opioid Overdose Response Strategies in Massachusetts.

199 *Ibid.*

200 *Ibid.*

201 Massachusetts Department of Public Health, 2014, Findings of the Opioid Task Force and Department of Public Health Recommendations on Priorities for Investments in Prevention, Intervention, Treatment and Recovery.

- Specialized services for youth and young adults, including community-based and residential treatment;
- Specialized residential services for families, adults with children, Hispanics, and for services in Franklin County, MA;
- Additional capacity for office-based opioid treatment in community health centers, including long acting naltrexone;
- Development of eight additional specialty courts to directly address substance abuse issues related to non-violent charges; and
- Provision of injectable naltrexone for people discharged from jail.

2. MOVING TOWARD INTEGRATED HEALTH CARE

As in much of the country, Massachusetts SUD treatment system has not had enough coordination among mental health, substance use and primary care services.[202] Despite high prevalence of behavioral health issues, "relatively few physicians routinely screen for mental illness or substance use disorders."[203] Primary care integration efforts promise closer doctor-patient relationships with improvements in care coordination that should lead to improved overall health outcomes.[204] In addition, research suggests that improvements in integrated care have the potential to reduce overall health care costs, increase access and reduce costs.[205]

2.1 BEHAVIORAL HEALTH INTEGRATION TASK FORCE

Section 275 of Chapter 224 of the Acts and Resolves of 2012 established a "special task force to examine behavioral, substance use disorder, and mental health treatment, service delivery, integration of behavioral health with primary care, and behavioral, substance use disorder and mental health reimbursement systems."[206] The Behavioral Health Integration Task Force, which issued a final report and recommendations to the Legislature and Health Policy Commission in July 2013, made several recommendations pertaining to SUD services, including:

- Recommendation 8: Medical necessity criteria of commercial plans should be transparent and should be expanded to include payment for services for attaining and maintaining functioning.
- Recommendation 9: Eliminate pre-approval for admission to inpatient detoxification and clinical stabilization services.
- Recommendation 11: Allow first behavioral health visits without pre-approval.[207]

The Task Force also found numerous reimbursement issues inhibiting integration and issued the following recommendations, some of which may require additional resources:

- Follow the guiding principle that all services listed and implied as part of primary care integration be sustainable, transparent, support service delivery and infrastructure development in all service settings.
- Increase Medicaid reimbursement to equal Medicare payment rates (as required for primary care physicians and other specialty providers under the ACA).
- Include behavioral health services in alternative payment methodologies.

202 Abt Associates and Technical Assistance Collaborative Massachusetts General Court Mental Health Advisory Committee Report Phase I and Phase II: Final. June 2014.

203 Massachusetts Department of Public Health, 2014, Issue Briefs: Massachusetts Behavioral Health Analysis.

204 See http://www.integration.samhsa.gov/integrated-care-models/list.

205 *Op. cit*. Massachusetts DPH Issue Briefs, 2014.

206 Section 275 of Chapter 224 of the Acts and Resolves of 2012, enacted August 2012.

207 Behavioral Health Integration Task Force. 2013 Report to the Legislature and the Health Policy Commission. Accessible at: http://www.massneuropsych.org/wp-content/uploads/2013/06/Behavioral-Health-Integration-Task-Force-Final-Report-and-Recommendations_July-2013.pdf.

2.2 PATIENT CENTERED MEDICAL HOME INITIATIVE

Following the work of the Task Force, the Executive Office of Health and Human Services (EHS) initiated a Massachusetts' Patient-Centered Medical Home Initiative (PCMHI). The PCMHI was a demonstration program that sought to implement the Patient-Centered Medical Home model in a number of primary care practices, including community health centers, across Massachusetts with the goal of furthering Massachusetts' efforts in health care reform. EHS worked with public and private health care payers to develop a payment model that would support the additional work, including aspects of behavioral health care that primary care practices take on in order to function as an integrated medical home.[208]

2.3 PRIMARY CARE INTEGRATION INITIATIVE

BSAS support of providers in the medical system to expand and improve their identification and early intervention of SUD problems through the use of Screening, Brief Intervention and Referral to Treatment (SBIRT) is consistent with the goal of integrating behavioral health and primary care. BSAS is also collaborating with DPH's Division of Health Quality "to facilitate licensure of primary care clinics in substance abuse treatment setting and substance abuse clinic licenses in Federally Qualified Health Centers."[209] MassHealth is in the process of developing alternative payment models, and Primary Care Payment Reform is one methodology, aimed at improving access, quality, efficiency, and patient experience through care management and coordination and integration of behavioral health with primary care.[210] Massachusetts Health Quality Partners (MHQP) was selected by the Agency for Healthcare Research in Quality to participate in the Partners in Integrated Care model, which aim to increase SUD identification and treatment through the use of SBIRT.[211]

3. COMPONENTS OF CHAPTER 258

Chapter 258 required a number of activities that address different aspects of health system improvements necessary to effectively meet the state's behavioral health problems.

3.1 BEHAVIORAL HEALTH ACCESS WEBSITE COMMISSION

Chapter 258 stipulated the formation of a special commission to "investigate the expansion and enhancement" of the Massachusetts Behavioral Health Access (MABHA) website, managed by MBHP.[212] The nine member Commission was charged with making recommendations on improving search capabilities to enable real-time identification of inpatient beds, services and placements for individuals requiring mental health and substance abuse treatment.

The Commission was charged with submitting its findings and recommendations to several Legislative committees by December 31, 2014. Among the most significant issues covered, the Commission focused on improving access to inpatient 24 hour psychiatric and substance abuse care, with the goal of reducing emergency department (ED) boarding times by expediting admission to the next appropriate level of care.

While Commission members recognized that MABHA improvement website will not in itself resolve issues of ED boarding, enhancing website search capabilities and expanding the scope of available information may contribute to the Commonwealth's efforts to improve treatment access.

208 *Op. cit*. Massachusetts DPH Issue Briefs, 2014.

209 *Ibid*.

210 Commonwealth of Massachusetts, Executive Office of Health and Human Services: Office of Medicaid. Primary Care Payment Reform Request for Information. August 9, 2012.

211 Massachusetts Health Quality Partners website accessed December, 2014: http://www.mhqp.org/collaboration/pic.asp?nav=063800.

212 *Op. cit*. Massachusetts Acts of 2014, Chapter 258.

3.2 INTERAGENCY AGENCY COUNCIL ON SUBSTANCE ABUSE AND PREVENTION

Chapter 258 also strengthened the role of the Massachusetts Interagency Council on Substance Abuse and Prevention by establishing it in statute. The Legislation charged the Interagency Council with: 1) supporting DPH's substance abuse and prevention efforts; 2) overseeing implementation of substance abuse related initiatives and programs; 3) develop and recommend policies aimed at coordinating and efficiently using state resources; 4) produce an annual report for the governor detailing activities and recommending future efforts and resource needs; and 5) review the roles and functions of the Advisory Council on Alcoholism and the Rehabilitation Advisory Board and recommend any changes necessary.[213] The Interagency Council, which meets quarterly, is overseen by an 11-member executive committee.

3.3 MANDATED BENEFIT REVIEWS

When the legislature mandated aspects of SUD benefits in Chapter 258, it also charged CHIA with conducting a review of the cost and medical efficacy of the mandated benefits. In addition, the legislature requested such reviews of benefits under consideration for legislative mandate.[214] In December, CHIA issued the Mandated Benefit Review of Chapter 258 of the Acts of 2014: An Act to Increase Opportunities for Long-Term Substance Abuse Recovery. The report outlines three benefit provisions scheduled to go into effect on October 1, 2015: 1) Abuse-deterrent Opioids; 2) Licensed Alcohol and Drug Counselors I; 3) Abuse Treatment and Clinical Stabilization Services; and 4) Substance Abuse Treatment Preauthorization. Among the key findings, the report concludes that the total per member estimated average annual cost increase of implementing these four mandated benefit provisions for monthly commercial health insurance premiums is between $0.17 and $1.55. The percentage premium increase ranges from 0.03% and 0.28%.[215]

Under Chapter 258, SUD providers licensed or certified by the Department of Health become responsible for making medical necessity determinations for the first 14 days of treatment. With respect to inpatient admissions, "Chapter 258 shifts the balance of decision-making about admission to substance abuse services from the insurer to the provider; under the new law, the provider will determine into which level of service a patient is admitted without need for prior authorization from the insurer."

4. RECENT BEHAVIORAL HEALTH PLANNING PROJECTS

4.1 HEALTH PLANNING COUNCIL

In accordance with Chapter 224, the Massachusetts 2012 health care cost containment law, the Health Policy Council is responsible for producing the State Health Resource Plan, which assesses the health care needs and resources available to Commonwealth residents and informs statewide health care policymaking priorities. The Council selected behavioral health as one of the first service lines to examine and key recommendations include:

- Expanding data collection and reporting on service capacity.
- Continuing analysis of outpatient and All Payer Claims Database data.
- Implementing a Behavioral Health Data Planning group, consisting of staff from DPH, DMH, MassHealth, CHIA, and the Health Policy Commission.
- Continuing to work with DPH's Behavioral Health Integration Committee to address remaining barriers challenging primary care integration efforts.
- Supporting health care reform's behavioral health integration efforts by expanding data collection and continuing iterative health planning.
- Facilitating "a robust community system" to: "1) keep people healthier, prevent the need for more acute levels of care, 2) divert patients from emergency departments and inpatient services, when clinically appropriate, 3) provide patients with strong post-discharge sup[ports, thus enabling timely discharges, and 4) provide timely post-discharge follow-up care." [216]

213 *Ibid*.

214 Center for Health Information and Analysis, 2014, *An Overview of Health Benefit Mandates*.

215 *Op. cit*. CHIA, 2014 Mandated Benefit Review of Chapter 258.

216 Massachusetts Department of Public Health, 2014, Health Planning Council: Behavioral Health Analysis Project- Public Hearings.

APPENDIX TWO: UTILIZATION REVIEW PRACTICES BY PLAN TYPE AND LEVEL OF CARE

	Commercial Plans			MassHealth Plans		
Service	**Prior Authorization**	**Continued Stay (CS)**	**CS Frequency**	**Prior Authorization**	**Continued Stay (CS)**	**CS Frequency**
Inpatient						
Acute Treatment Services – Hospital	8 of 10	All	2 -3 days (1 plan)	5 of 6	All	1- 3 days (3 plans)
Intermediate – Residential						
Acute Treatment Services – Freestanding	8 of 10	All	2 -3 days (1 plan)	None for ATS 2 of 6 for enhanced ATS	All	4-5 days (3 plans)
Clinical Stabilization Services	8 of 9 (1 plan does not cover CSS)	All		3 of 6		after 10 days (3 plans)
Intermediate – Outpatient[217]						
Partial Hospitalization Services	9 of 10	All	Every 5-10 days (1 plan)	4 of 6	All	After 12 units (2 plans) Every 5 days (1 plan)
Intensive Outpatient Services	9 of 10	All	Every 5-10 days (1 plan)	4 of 6	All	After 12 units (2 plans) 4-7 weeks (1 plan)
Outpatient						
Outpatient SUD Counseling	None. 8 to 12 initial encounters (4 plans)	8 of 10	Frequency not specified	None. 12 to 24 initial encounters	Mixed	After 24 visits (2 plans) Every 3 months (1 plan)
Medication Assisted Treatment						
Opioid Treatment Program (Methadone)	1 to 3 of 5	No or N/A		None	None	N/A
Office Based Opioid Treatment (Buprenorphine)*	6-9 of 10 (2 report that PA varies, 1 reports PA on generic)	6 of 10	Every 6 months (3 plans) 1-3 months (1 plan)	3 of 6, 1 just for certain formulations	All	After 3 months (1 plan) 6 months (1 plan) or 12 months (1 plan)
Naltrexone*	2-4 of 10 (2 report that PA varies, but mostly no)	4 of 10	1-3 months (1 plan)	2 of 6	Not clear	After 1-3 months (1 plan) Annually (1 plan)

217 These services are not licensed by BSAS and may include both mental health and/or SUD treatment.

	Commercial Plans			MassHealth Plans		
Service	**Prior Authorization**	**Continued Stay (CS)**	**CS Frequency**	**Prior Authorization**	**Continued Stay (CS)**	**CS Frequency**
Residential Rehabilitation						
Residential Rehabilitation	4 of 4	Yes	Not specified	N/A	N/A	N/A
Community Support						
Community Support Program	N/A	N/A		None for up to 45 hours (5 plans); or 60 hours (1 plan)	Yes	Every 3 months (1 plan)

**Authorization information pertains to prescription only.*

Sources: Health Insurance Carrier Survey, December 2014; Compass Health Analytics, Inc. (2014). Actuarial Assessment of Chapter 258 of the Acts of 2014: "An Act to increase opportunities for long-term substance abuse recovery". Acute Treatment and Clinical Stabilization Services and Substance Abuse Treatment Preauthorization, Center for Health Information and Analysis

APPENDIX THREE: SUD SERVICES COVERED OR OFFERED BY PAYER TYPE

Service	Commercial Plans	MassHealth Plans	BSAS
Inpatient			
Acute Treatment Services - Hospital	Y	Y	N
Intermediate – Residential			
Acute Treatment Services – Freestanding	Y (also youth ATS)	Y (also enhanced ATS and youth ATS)	Y (also youth ATS)
Clinical Stabilization Services	Y for 10 of 11 (also youth CSS)	Y (also youth CSS)	Y (also youth CSS)
Intermediate – Outpatient			
Partial Hospitalization Services	Y	Y	N
Intensive Outpatient Services	Y	Y	Y
Outpatient			
Outpatient SUD Counseling	Y	Y	Y
Medication Assisted Treatment*			
Opioid Treatment Programs (Methadone)	5 of 10	Y	Y
Buprenorphine (Medication)	8 of 10	Y	Y (support for staff)
Naltrexone (Medication)	8 of 10	Y	N
Residential Rehabilitation			
Transitional Support Services	1 of 10	N	Y
Licensed Residential Rehabilitation	4 of 10 cover intermediate residential 1 of 10 cover, halfway house	N	Y
Community Support			
Case Management	2 of 10	N	Y
Community Support Program (CSP)	4 of 10	Y	N
Peer Support	N	N	Y
Recovery Support Centers	N	N	Y
Recovery High Schools	N	N	Y
Early Intervention			
SUD Screening	7 of 10	Y (youth)	Sponsors Training
SUD Brief Intervention	5 of 10	Y	

Sources: Health Insurance Carrier Survey. BSAS Inventory of Licensed Services as of 11/15/2014.

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APPENDIX FOUR: MASSACHUSETTS CONTINUUM OF SUD CARE

Service	Description	ASAM Level	BSAS Licensed
Inpatient Services			
Acute Treatment Services (ATS)	Hospital medically managed acute detoxification	4.0	Y
Intermediate Services - Residential			
Acute Treatment Services (ATS)	Medically monitored detoxification in a 24-hour setting, including enhanced programs for dual diagnosis or pregnancy	3.7	Y
Clinical Stabilization Services (CSS)	Clinically managed detoxification and high intensity residential treatment and stabilization services	3.5	Y
Intermediate Services – Outpatient			
Partial Hospitalization Services	Partial hospitalization (stabilization and treatment)	2.5	N
Intensive Outpatient Services	Intensive outpatient (stabilization and treatment) (also called Day Treatment and Structured Outpatient Addiction Program)	2.1	Y
Outpatient Services			
Outpatient SUD Counseling	Outpatient treatment and counseling by licensed professionals	1.0	Y
Medication Assisted Treatment (MAT)*	Treatment with methadone (Opioid Treatment Program – OTP), buprenorphine or naltrexone		OTP only
Residential Rehabilitation and Support			
Transitional Support Services	Clinically managed, low intensity residential stabilization and treatment services	3.3	Y
Licensed Residential Rehabilitation	Levels of residential services include: recovery homes for different populations (e.g., adults, family, pregnant women, youth; therapeutic communities; and social model programs)	3.1	Y
Recovery Supports			
Community Support	Chapter 35 case management		Y
	Community support program (CSP)		N
Peer Support	Recovery coaching		N
Recovery-oriented Services	Recovery support centers		N
	Recovery high schools		N
Early Intervention			
Early Intervention	SUD screening and brief intervention	0.5	N

**Coverage of methadone indicates that the services provided in an Opioid Treatment Program are covered. Coverage of buprenorphine and naltrexone indicates that these medications are covered when prescribed by an authorized prescriber.*

APPENDIX FIVE: ORGANIZATIONS INTERVIEWED IN FOCUS GROUPS

Consumer Advocate Focus Group

Massachusetts Organization for Addiction and Recovery

Learn2Cope

Casa Esperanza

Real You Revolution

Acute Treatment Services Provider Focus Group

Community HealthLink

High Point

Spectrum

Bay Care

Association for Behavioral Healthcare

Residential Provider Focus Group

South Shore Recovery

Lowell House

ServiceNet

Meridian House

APPENDIX SIX: LIST OF SURVEYED HEALTH PLANS

	Commercial – Compass as part of Mandated Benefit Reviews	Commercial – DMA for SUD Access Report	MassHealth – DMA for SUD Access Report
Aetna	Y	Y	N
Blue Cross Blue Shield of Massachusetts	Y	Y	N
Boston Medical Center Health Plan	Y	Y	Y
CeltiCare	Y	N	N
Cenpatico	N	Y	N
ConnectCare	Y	N	N
Fallon	Y	Y	Y
Harvard Pilgrim Health Care	Y	Y	N
Health New England	N	Y	Y
Massachusetts Benefit Health Partners	N	N	Y
Neighborhood Health Plan	Y	Y	Y
Optum/United	Y	Y	N
Tufts Health Plan	Y	Y	Y (Network Health)
Unicare	N	Y	Y, but N/A as Unicare does not have a MassHealth product.

"Y" indicates that carrier did submit response.

"N" indicates that carrier did not submit response.

For the MBR survey:

- Compass did not survey Cenpatico or Massachusetts Benefit Health Partners.
- Unicare responded, but since they don't underwrite (except for the GIC) in MA, responses were very limited. They did include medical necessity criteria.

APPENDIX SEVEN: GLOSSARY OF ABBREVIATIONS

ABH	Association of Behavioral Health
AOD	Alcohol and Other Dependence
ASAM	American Society of Addiction Medicine
ATS	Acute Treatment Services
BSAS	Bureau of Substance Abuse Services
CEPAC	Comparative Effectiveness Public Advisory Council
CHIA	Center for Health Information and Analysis
CS	Continued Stay
CSP	Community Support Programs
CSS	Clinical Stabilization Services
DOI	Division of Insurance
ED	Emergency Department
EHS	Executive Office of Health and Human Services
FDA	Federal Drug Administration
FQHC	Federally Qualified Health Center
FTE	Full-Time Equivalent
HEDIS	Healthcare Effectiveness Data and Information Set
LADC-I	Licensed Alcohol and Drug Counselors I
MABHA	Massachusetts Behavioral Health Access
MAHP	Massachusetts Association of Health Plans
MAT	Medication Assisted Treatment
MHPAEA	Mental Health Parity and Addiction Equity Act
MCO	Managed Care Organization
MHQP	MassHealth Quality Partners
MOAR	Massachusetts Organization for Addiction Recovery
NCQA	National Committee for Quality Assurance
NIDA	National Institute of Drug Abuse
NQTL	Non-Quantitative Treatment Limits
OBOT	Office-Based Opioid Treatment Programs
OBOTB	Office-Based Opioid Treatment Program with Buprenorphine
OEND	Overdose Education and Naloxone Distribution
OTP	Opioid Treatment Programs
PCC	Primary Care Clinician
PCMHI	Patient-Centered Medical Home Initiative
PMP	Prescription Monitoring Program
PPO	Preferred Provider Organization
RHS	Recovery High Schools
RSC	Recovery Support Centers
SAMHSA	Substance Abuse and Mental Health Services Administration
SBIRT	Screening and Brief Interventions
SUD	Substance Use Disorder
TSS	Transitional Support Services

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