Acute Treatment Services (ATS) for Substance Use Disorders: ASAM Level 3.7 Medically Monitored Intensive Inpatient Services Performance Specifications

These performance specifications apply to the following Tufts Health Plan products:

- ☐ Tufts Health Plan Commercial[1]
- ☐ Tufts Medicare Preferred HMO (a Medicare Advantage product)[2]
- ☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)[2]

These performance specifications apply to the following Tufts Health Public Plans products:

- ☐ Tufts Health Direct (a Massachusetts Qualified Health Plan (QHP) (a commercial product)
- ☒ Tufts Health Together (a MassHealth MCO Plan and Accountable Care Partnership Plans)
- ☐ Tufts Health RITogether (a Rhode Island Medicaid Plan)
- ☒ Tufts Health Unify (OneCare Plan; a dual-eligible product)

Providers contracted for this level of care or service are expected to comply with all requirements of these service-specific performance specifications. The requirements outlined within these service-specific performance specifications take precedence over previous performance specifications. Additionally, providers must meet all Department of Public Health/Bureau of Substance Addiction Services (DPH/BSAS) contractual and regulatory requirements within 105 CMR 164.000 Licensure of Substance Use Disorder Treatment Programs.

The performance specifications contained within pertain to the following services:

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

DEFINITION

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

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

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[1] Commercial products include HMO, POS, PPO, and CareLink℠ when Tufts Health Plan is the primary administrator.

[2] Tufts Medicare Preferred and Tufts Health Plan SCO are collectively referred to in this payment policy as Senior Products.

It is expected that members with co-occurring disorders will receive specialized services within the Acute Treatment Services (ATS) for Individuals with Co-occurring Mental Health and Substance Use Disorders to ensure treatment for their co-occurring psychiatric conditions, and pregnant women receive specialized services within Acute Treatment Services (ATS) for Pregnant Women to ensure substance use disorder treatment and obstetrical care. These services are provided in licensed freestanding or hospital-based programs.

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

ATS programs will provide ASAM's Medically Monitored Intensive Inpatient Services (Level 3.7) until:

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

COMPONENTS OF SERVICE

1. At minimum, the provider complies with all provisions of the corresponding General performance specifications and requirements of the Department of Public Health (DPH) Bureau of Substance Addiction Services (BSAS) 105 CMR 164 Licensure of Substance Use Disorder Treatment Programs, including reporting requirements.
2. The provider accepts admissions 24 hours per day, 7 days per week, 365 days per year.
   a) A thorough physical examination, which conforms to principles established by the American Society of Addiction Medicine, is completed for all patients as part of the admission process.
   b) Medical and nursing care based on a comprehensive biopsychosocial assessment that was performed within 24 hours of patient's admission.
3. Therapeutic programming is provided seven days per week, including weekends and holidays, with sufficient professional staff to maintain an appropriate milieu and conduct the services below based on individualized Member needs. The scope of required service components provided in this level of care includes, but is not limited to, the following.
   a) Medical monitoring of the individual's progress and medication administration as needed.
   b) Induction onto FDA-approved medications for addiction treatment (MAT)/Medication for Opioid Use Disorder (MOUD) as clinically indicated and appropriate with referral for ongoing MAT at discharge.
   c) Psychiatric crisis evaluation and clinical services based on the biopsychosocial assessment.
   d) HIV, Hepatitis C, TB, tobacco use and other health related education programs:
      - HIV and Viral Hepatitis risk assessments are integrated as a part of each member's medical/nursing assessment.
      - HIV and Hepatitis C education/risk reduction education is provided for all members.
      - Referral to HIV antibody counseling and testing sites and on-site HIV antibody counseling.
   e) Education about the benefits and risks of medication approved for addiction treatment.
   f) Opioid overdose risk and prevention.
   g) Access to appropriate laboratory and toxicology tests.
   h) Routine medications.
   i) Counseling and case management which incorporates evidence-based practices, including individual, group, and family therapy.
      a. Resource Center | SAMHSA
   j) Behavioral/health/medication education and planning.
   k) Psycho-educational groups.
   l) Peer support and/or other recovery-oriented services.
   m) Development and/or updating of crisis prevention plans, or safety plans as part of Crisis Planning Tools, and/or relapse prevention plans, as applicable
   n) Introduction to self-help groups and the continuum of SUD and mental health treatment.
   o) Direct operational affiliations with other services especially Clinical Stabilization Services, Transitional Support Services, Residential Rehabilitation Services, Opioid Treatment

Programs, Office Based Opioid Treatment, Community Behavioral Health Centers (CBHCs), and psychiatric services.

p) Case management that directly connects (warm handoff) to appropriate providers.
q) Health services including primary care and oral care; with updates with primary care providers (with consent); and
r) Support services and referrals for family members and significant others.

4. The provider provides a comprehensive, formal, structured treatment program which incorporates the effects of substance use disorders, mental health disorders, and recovery, including the complications associated with dual recovery, and provides a minimum of four hours of service programming per day. At least two hours of psycho-educational group time per week is dedicated to the discussion of HIV/AIDS, Hepatitis C, and other health issues.
5. The provider ensures that all members have access to prescribers specializing in addiction medicine and are educated on their options for MAT/MOUD.
6. The provider has the capacity to treat Members with alcohol and/or other substance use disorders who are assessed to be at a mild to moderate risk of medical complications during withdrawal.
7. The program admits and has the capacity to treat Members currently maintained on MAT/MOUD for the treatment of opioid use disorder. Such capacity may take the form of documented, active Affiliation Agreements with providers licensed to provide such treatments.
8. Substance-specific withdrawal management protocols are individualized, documented, and available on-site. At minimum, these include withdrawal management protocols for alcohol, stimulants, opioids, and sedative hypnotics (including benzodiazepines) with capacity to use all FDA-approved medications.
9. With Member consent and the establishment of the clinical need for such communication, the provider makes documented attempts to contact the following: the parent/guardian/caregiver, family members, and/or significant others, primary care physician (PCP), other prescribers, other team members involved in Member's care, within 48 hours of admission, unless clinically or legally contraindicated.

   The provider (with appropriate consent from the Member) provides the above with all relevant information related to maintaining contact with the program and the Member, including names and phone numbers of key nursing staff, primary treatment staff, social worker/case manager/discharge planner, etc. If contact is not made, the Member's health record documents the rationale.
10. The provider is responsible for ensuring that each Member has access to medications prescribed for physical and behavioral health conditions, and documents so in the Member's health record.
11. Prior to medication dispensing, the provider engages in a medication reconciliation process in order to avoid inadvertent inconsistencies in medication prescribing that may occur in transition of a Member from one care setting to another. The provider does this by reviewing the Member's complete medication regimen at the time of admission (e.g., transfer and/or discharge from another setting or prescriber) and comparing it with the regimen being considered in the ATS. The provider engages in the process of comparing the Member's medication orders newly issued by the ATS prescriber to all of the medications that he/she has been taking to avoid medication errors. This involves:
    a) Developing a list of current medications, i.e., those the Member was prescribed prior to admission to the ATS.
    b) Reviewing Massachusetts Prescription Awareness Tool (MassPAT)
    c) Developing a list of medications to be prescribed in the ATS.
    d) Comparing the medications on the two lists.
    e) Making clinical decisions based on the comparison and, when indicated, in coordination with the Member's primary care clinician (PCC); and
    f) Communicating the new list to the Member and, with consent, to appropriate caregivers, DMH, BH-CPs, the Member's PCC, and other treatment providers. All activities are documented in the Member's health record.
12. All urgent consultation services resulting from the intake evaluation and physical exam, or as subsequently identified during the admission, are provided within a timely manner for these services. Non-urgent consultation services related to the assessment and treatment of the

Member while in the ATS program are provided in a timely manner, commensurate with the level of need. Routine medical care (not required for the diagnosis related to the presenting problem) may be deferred, when appropriate, if the length of stay in the ATS program is brief. All of these services are documented in the Member's health record.

13. The milieu does not physically segregate individuals with co-occurring disorders.
14. A handbook specific to the program is given to the Member and parent/guardian/caregiver at the time of admission. The handbook includes but is not limited to Member rights and responsibilities, services available, treatment schedule, grievance procedures, discharge criteria, and information about family support and peer and recovery-oriented services.
15. The provider is responsible for updating its available capacity, once each day at a minimum, seven days per week, 365 days per year on the Massachusetts Behavioral Health Access website (MABHAccess.com) The provider is also responsible for keeping all administrative and contact information up to date on the website. The provider is also responsible for training staff on the use of the website to locate other services for Members, particularly in planning aftercare services.
16. Co-occurring psychiatric services, medication evaluation and management, and related laboratory services are offered. Such services are available virtually, or on-site within 8 hours, or referred to an off-site provider within 24 hours, as appropriate to the severity and urgency of the member's mental health condition.
17. The provider trains all staff at the site on the use of ASAM Criteria.
18. The provider complies with the Department of Public Health's (DPH) implementation of the Culturally and Linguistically Appropriate Services (CLAS) Standards.

STAFFING REQUIREMENTS

1. If program feels they cannot meet these specifications, BSAS has a waiver process for certain of the requirements. The waiver process is described in the Department of Public Health (DPH) Bureau of Substance Addiction Services (BSAS) 105 CMR 164. The program is responsible for informing the payer of any waivered requirements if the waiver is approved.
2. The provider complies with the staffing requirements of the applicable licensing body and the staffing requirements outlined in 105 CMR 164 Licensure of Substance Use Disorder Treatment Programs. The program is staffed with sufficient appropriate personnel to accept admissions 24 hours per day, 7 days per week, 365 days per year, and to conduct discharges 7 days per week, 365 days per year. The provider utilizes a multi-disciplinary staff.
    a. Staffing must include nurses, counseling staff, physicians for psychiatric and pharmacological consultation, and clinical assistant/nurses' aide staff, all with established skills, training, and/or expertise in the treatment of individuals with substance use disorders, including:
3. A **Medical Director** responsible for all medical services performed by the program, either by performing them directly or by delegating specific responsibilities to qualified healthcare professionals such as a nurse practitioner and physician assistant functioning under the Medical Director's direct supervision. They will ensure 24-hour clinical coverage, 7 days per week and themselves provide on-site coverage of 8 hours on-site seven days per week to examine and assess members within 24 hours of admission. The Medical Director should have demonstrated clinical experience treating substance use disorders and opioid use disorders in particular.
4. Nursing coverage must be flexed according to case mix, acute/complex clinical acuity, and the needs of Members in the program, on-site 24/7. There must be a minimum of one nurse per 16 Members, per shift. One of the nurses on each shift must be a **Registered Nurse**.
5. A **Nurse Manager**, including on-site 24/7 nurses to support medication compliance and monitoring of symptoms.
6. A full-time **Program Director** who carries full responsibility for the administration and operations of the program;
7. A **Clinical Director**, who meets the criteria in 105 CMR 164 for Senior Clinician and/or Clinical Supervisor. A Clinical Director is the designated authority responsible for ensuring adequate and quality behavioral treatment is being provided.
8. One **recovery support staff** person per 16 Members, per shift. The recovery support staff person provides recovery-oriented supports the form of psychoeducation, peer supports, introduction to self-help groups, etc.

9. One **case manager** per 8 patients, per 12 hours per 7 days per week responsible for assisting clients to obtain needed services by providing information, referral coordination, discharge planning and follow-up.
10. A **psychiatrist** on staff or available through a qualified service organization agreement for psychiatric evaluation and consultation, 24 hours, 7 days a week.
11. There is an **obstetrician/gynecologist** on staff or available through a qualified service organization agreement (QSOA) to accommodate pregnant patients

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

- **HIV/AIDS Coordinator**: responsible for overseeing confidential HIV risk assessment and access to counseling and testing; staff and resident HIV/AIDS and hepatitis education; and Department requirements for admission, service planning and discharge of HIV positive residents.
- **Tobacco Education Coordinator**: responsible for assisting staff in implementing BSAS guidelines for integrating on of tobacco assessment, education and treatment into program services.
- **Access Coordinator**: responsible for development and implementation of the evaluation, plan and annual review of the site's performance in ensuring equitable access to services.
- **CLAS (Culturally and Linguistically Appropriate Services) Coordinator** ensures that the service meets the language and cultural needs of the patients.
- At minimum, there is one staff person trained in CPR and Naloxone administration on duty each shift.

12. The provider ensures that Members have access to supportive staff 24 hours per day, 365 days per year.

SERVICE, COMMUNITY AND COLLATERAL LINKAGES

1. The provider complies with all provisions of the 105 CMR 164 related to community connections and/or collateral linkages.
2. With Member consent, if a Member is referred to another treatment setting, the provider collaborates in the transfer, referral, and/or discharge planning process to ensure continuity of care.
3. The staff members are familiar with all of the following levels of care/services, and are able and willing to accept referrals from, and refer to, these levels of care/services when clinically indicated. The provider maintains written Affiliation Agreements with local providers of these levels of care that refer a high volume of Members to its program and/or to which the program refers a high volume of Members. Such agreements include the referral process, as well as transition, aftercare, and discharge processes.
    - Inpatient psychiatric hospitals
    - General hospitals
    - Emergency Services Program (ESP)
    - Emergency Departments (ED)
    - Medically Managed Withdrawal Management (ASAM Level 4)
    - Clinical Stabilization Services (CSS) (ASAM Level 3.5 Clinically Managed High Intensity Residential Services) Community Overdose Prevention Programs
    - Community Overdose Prevention Programs
    - Co-Occurring Capable Residential Rehabilitation Services (RRS) (ASAM Clinically Managed Low Intensity Residential Services); Co-Occurring Enhanced Residential Rehabilitation Services (COE RRS) (ASAM Clinically Managed Low Intensity Residential Services)
    - Structured Outpatient Addiction Program (SOAP)/Day Treatment
    - Partial Hospitalization Programs
    - Community Crisis Stabilization (CCS)
    - Regional court clinics – (Drug Court Programs, Family Drug Court Programs)
    - Medication-Assisted Treatment/ Medication Addiction Treatment, including Opioid Treatment Programs and Office-Based Opioid Treatment
    - Community Behavioral Health Centers (CBHCs)
    - Community Mental Health Centers (CMHCs)
    - CMHCs designated as Behavioral health urgent care centers (BHUCs)
    - Transitional or permanent supportive housing

- Sober housing
- Substance use disorder outpatient clinics
- Recovery support centers
- Shelter programs
- Criminal justice system
- Outreach sites
- Massachusetts rehabilitation services
- Community health centers
- Adult Community Clinical Services (ACCS)
- Behavioral Health Community Partners (BH CP)
- Recovery Learning Centers
- Organizations that provide recovery coaching services
- Organizations that provide recovery support navigators
- Community Support Program (CSP)
- Mutual Aid programs including SMART Recovery, Alcoholics Anonymous and Narcotics Anonymous
- Department of Mental Health (DMH) residential programs
- Community Support Programs, including: Chronically Homeless Individuals (CSP-CHI), Community Support Program-Justice Involved Individuals (CSP-JI), and Program of Assertive Community Treatment (PACT)

4. With Member consent, the provider collaborates with the Member's primary care provider and othe community providers.
5. When necessary, the provider provides or arranges transportation for services required external to the program during the admission and, upon discharge, for placement into a step-down 24-hour level of care, if applicable. The provider also makes reasonable efforts to assist Members upon discharge to the community and/or non-24-hour levels of care with identifying transportation options when needed, including public transportation, Prescription for Transportation (PT-1) forms, etc.

EXPECTED OUTCOMES AND QUALITY MEASUREMENT

The provider complies with all provisions of the corresponding section in the General performance specifications. The provider will implement strategies to improve outcomes within their patient population receiving SUD treatment. Specifically, the provider will work to improve these outcomes:

- Increase in MAT/MOUD induction and continuation.
- Decrease in readmission to ED and inpatient services.
- Increase in referrals and transitions to lower levels of care.
- Increase in program's capacities to admit and treat individuals with behavioral health and co-occurring physical health conditions.

Providers will be required to report Enterprise Service Management (ESM) data to BSAS at admission and discharge in compliance with 105 CMR 164.000 Licensure of Substance Use Disorder Treatment Programs.

The provider will collect data to measure the quality of their services. The provider must have a continuous QI process to evaluate the care provided and review adherence to policies and procedures within the sites. Data may be collected via satisfaction surveys, electronic medical records, and other forms. The provider must develop and maintain a quality management plan.

The provider must report any adverse events that occur to the relevant authorities.

PROCESS SPECIFICATIONS ASSESSMENT, TREATMENT/RECOVERY PLANNING, AND DOCUMENTATION

1. The provider complies with all provisions specified in 105 CMR 164 related to assessment and recovery planning.
2. The provider has a policy regarding the speed at which they will inform the referral source/individual seeking admission (ideally within the hour after receipt of referral). The provider accepts admissions 24 hours per day, 7 days per week, 365 days per year. Every admission declination must be documented and include reason for declination and referrals provided

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

Discharge Planning and Documentation

1. The provider complies with all provisions of 105 CMR 164 related to discharge planning.
2. The provider conducts discharges 7 days per week, 365 days per year.
3. At the time of discharge, and as clinically indicated, the provider ensures that the Member has a current crisis prevention plan, and/or safety plan, and/or relapse prevention plan in place and that they have a copy of it. The provider works with the Member to update the existing plan, or, if one was not available, develops one with the Member prior to discharge. With Member consent and as applicable, the provider may contact the Member's local Adult or Youth Mobile Crisis Intervention (AMCI/YMCI) to request assistance with developing or updating the plan. With Member consent, the provider sends a copy to the AMCI Director/YMCI at the Member's local AMCI/YMCI.
4. The provider engages the Member in developing and implementing an aftercare plan when the Member meets the discharge criteria established in their treatment/recovery plan. The provider

provides the Member with a copy of the plan upon their discharge and documents these activities and the plan in the Member's health record.

5. Prior to discharge, the provider assists Members in obtaining post-discharge appointments, as follows: within 7 calendar days of discharge for outpatient therapy services (which may be an intake appointment for therapy services), if necessary; and within 14 calendar days of discharge for medication monitoring, if necessary. In the event of a discharge against medical advice (AMA), providers must ensure patients are given resources to reconnect with services.

   This function may not be designated to aftercare providers or to the Member to be completed before or after the Member's discharge. These discharge planning activities, including the specific aftercare appointment date/time/location(s), are documented in the Member's health record.

DOCUMENT HISTORY

- January 2023: MassHealth Performance Specifications Update
- July 2020: Template updates