Residential Rehabilitation Services (RRS) for Substance Use Disorders: ASAM Level 3.1 Clinically Managed Low Intensity Residential Services

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 Plan)
- ☐ 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 will be expected to comply with all requirements of these service-specific performance specifications. Additionally, providers must meet all BSAS contractual and regulatory requirements.

The requirements outlined within the service-specific performance specifications take precedence over those in the General performance specifications. The performance specifications contained within pertain to Residential Rehabilitation Services (RRS) for Substance Use Disorders: ASAM Level 3.1 Clinically Managed Low Intensity Residential Services.

Please refer to the performance specifications listed below for each of these specialty services:

- Residential Rehabilitation Services (RRS) for Pregnant and Post-Partum Women
- Residential Rehabilitation Services (RRS) for Youth (ages 13-17)
- Residential Rehabilitation Services (RRS) for Transitional Age Youth (ages 16-21) or Young Adults (ages 18-25)
- Family Residential Rehabilitation Services (RRS)

DEFINITION

Residential Rehabilitation Services (RRS) for Substance Use Disorders (ASAM 3.1 Clinically Managed Low Intensity Residential Services), are clinically managed low-intensity residential services that serve individuals who need a 24-hour, supervised, residential environment to fully stabilize in recovery, with the goal of successfully transitioning to a lower service setting (including outpatient counseling). Scheduled, goal-oriented clinical services are provided in conjunction with ongoing support and assistance for developing and implementing recovery skills.

Admission to RRS, ASAM Level 3.1 Clinically Managed Low Intensity Residential Services is appropriate for Members who meet the diagnostic and dimensional criteria specified in accordance with The ASAM Criteria (American Society of Addiction Medicine Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions).

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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.

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, or previous unsuccessful treatment attempts.

COMPONENTS OF SERVICE

1. At minimum, the provider complies with all provisions of the corresponding section in the General performance specifications and with all requirements of the Department of Public Health (DPH) licensure of substance abuse treatment programs (105 CMR 164) including DPH reporting requirements.
2. The provider ensures 24/7 coverage that maintains a supportive, therapeutic environment for Members, at all times. The provider ensures that Members have access to supportive, therapeutic milieu at all times, without exception.
3. The provider implements a daily schedule of activities designed to facilitate participation in the milieu and promote recovery. The provider facilitates morning meetings, a minimum of five times per week, convenes at least one communal meal per day, and convenes at least one house/community meeting per week, which provides structure for the community.

   Clinically, these activities must include a minimum of five hours of individual and/or group treatment sessions per week offered through the program. Topics for clinical and psychoeducational groups delivered in the program can include, but are not limited to, the following:
   a) Relapse and overdose prevention, recovery maintenance counseling and education, naloxone education, and administration training
   b) Mental health
   c) Stress reduction
   d) Nutrition
   e) Medication
   f) Education related to all medications approved by the FDA for the treatment of substance use disorders (SUD)
   g) Tobacco cessation
   h) HIV/AIDS, STIs, viral hepatitis
   i) Wellness topics
   j) Recovery support groups
4. For adults who give consent, the provider makes documented attempts to contact the parent/guardian/caregiver, family members, and/or significant others within one week of admission, unless clinically or legally contraindicated. The provider provides them 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.
5. The provider ensures that program staff provide individualized case management services. Program staff facilitate comprehensive support and linkages for public assistance, substance use disorder counseling, primary health care, insurance, self-help and mental health services, vocational/educational opportunities, housing, and criminal justice system support as appropriate.
6. The provider admits and has the capacity to treat Members who are currently on medication for addiction treatment (MAT)/MOUD, including education about the benefits and risks of MAT. Such capacity may take the form of documented, active affiliation agreements with a facility licensed to provide such treatments.
7. The provider has documented policies and procedures in place to allow for the safe and appropriate self-administration of medication(s) by Members.
8. The provider ensures that each Member has access to medications prescribed for physical and behavioral health conditions and documents this in the Member's chart.
9. The provider ensures that the following medication management activities are completed for each Member upon admission:
   a) Developing a list of current medications, i.e., those the Member was prescribed prior to admission to the RRS and verifies with prescriber(s).

b) Making clinical decisions based on the comparison and, when indicated, in coordination with the Member's primary care clinician (PCC); and
c) Coordinating with providers to ensure Members have access to medications that they are prescribed and coordinate any changes in medication with current prescribers
d) Overseeing medication passes
e) Communicating the new list to the Member and, with consent, to appropriate caregivers, the Member's PCC, and other treatment providers. All activities are documented in the Member's health record.

10. The provider uses medication specialist staff (MMS) to keep records of Member's medications and oversee medication management. Medication specialist staff will provide medication support services that include: 16 hours of medication specialist services and eight hours of consultation around medication support.
11. 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.
12. The provider complies with the Department of Public Health's (DPH) implementation of the Culturally and Linguistically Appropriate Services (CLAS) Standards.
13. The provider trains staff on the use of ASAM criteria

STAFFING REQUIREMENTS

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 DPH/BSAS Licensing Regulation. The program is responsible for informing the payer of any waivered requirements if the waiver is approved.

1. The provider complies with all provisions of the corresponding section in the General performance specifications. The provider complies with the staffing requirements of the applicable licensing body, and the staffing requirements outlined in 105 CMR 164 and the staffing requirements in the applicable health plan provider manual.
   - Any exceptions to staffing requirements must be approved by BSAS and communicated to the plans. The waiver process is described in the DPH/BSAS Licensing Regulation.
2. The program is staffed with a full-time program director who carries full responsibility for the administration and operations of the program, including supervision of non-clinical staff.
3. The program is staffed with a distinct, full-time clinical supervisor and who is an independently licensed clinician (for example: has completed a master's degree in a relevant field or possesses an LADC1), and has two years of supervisory experience, with at least one year working with people with substance use disorders. The clinical supervisor will supervise the staff providing treatment to individuals with both addiction and mental health needs, for every 30 licensed beds, pro-rated according to the number of licensed beds.
4. The program is staffed with one counselor or case manager, trained in addiction and mental health treatment, for every nine licensed beds.
5. The program is staffed by 2 FTE of Medication Specialists on-site, who are responsible for the oversight, storage, and coordination of self-administration of medication. Medication management includes oversight of resident self-administration, storage, and coordination of all medication prescribed during treatment.
6. The program is staffed with recovery specialists according to the following coverage parameters:
   a) No less than eight hours of awake coverage per shift per building.
   b) 16 hours of awake coverage for each day and evening shift per 30 licensed beds, prorated according to the number of licensed beds, i.e., less than 30 or more than 30
   c) Eight hours of awake coverage per overnight shift per 50 residents; 16 hours of awake coverage per overnight shift per 51 –100 residents; 24 hours of awake coverage per overnight shift per 101 –150 residents
   d) At minimum, there shall be at least two recovery specialists or case aides present for each overnight shift.
   e) Where the resident census exceeds 100 residents, the Licensed or Approved Provider shall ensure four direct care staff are present on all shifts.
7. All RRS sites must have at least one staff member assuming each of the following roles:

a) HIV/AIDS Coordinator: responsible for overseeing confidential HIV risk assessment and access to counseling and testing; staff and resident HIV/AIDS and hepatitis education; and Department requirements for admission, service planning and discharge of HIV positive residents.
b) **Tobacco Education Coordinator:** responsible for assisting staff in implementing BSAS guidelines for integrating on of tobacco assessment, education, and treatment into program services.
c) **Access Coordinator**: responsible for development and implementation of the evaluation, plan, and annual review of the site's performance in ensuring equitable access to services as required by 105 CMR 164
d) **CLAS Coordinator:** who ensures that the service meets the language and cultural needs of the patients.
e) At minimum, there is one staff person trained in CPR and Naloxone administration on duty each shift.

8. The provider ensures that all staff receive supervision consistent with their credentialing criteria.
9. The provider ensures that team members have training in evidence-based practices and are provided with opportunities to engage in continuing education to refine their skills and knowledge in emerging treatment protocols.

SERVICE, COMMUNITY AND COLLATERAL LINKAGES

1. The provider collaborates in the transfer, referral, and/or discharge planning process to ongoing recovery and/or treatment services, with Member consent, to ensure continuity of care.
2. The staff members are familiar with all the levels of care/services listed in #3 below, and are able and willing to accept referrals from, and refer to, these levels of care/services when clinically indicated.
3. The provider maintains written affiliation agreements, which may include QSOAs, MOUs, BAAs or linkage 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 Intensive Inpatient Services (ASAM Level 4)
   - Acute Treatment Services (ATS) (ASAM Level 3.7 Medically Monitored Intensive Inpatient Services)
   - Clinical Stabilization Services (CSS) (ASAM Level 3.5 Clinically Managed High Intensity Residential Services)
   - 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)
   - Behavioral health urgent care centers
   - Transitional or permanent supportive housing
   - Certified 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 other community providers.
5. When necessary, the provider arranges transportation for services required that are external to the program during the admission. The provider also makes reasonable efforts to assist Members identifying transportation options when needed, including public transportation, Prescription for Transportation (PT-1) forms, etc.
6. The provider demonstrates a capacity to work collaboratively with multiple systems, including substance use disorder treatment providers, primary health care, community-based support services, housing search services, supportive housing service providers, mental health service providers, other relevant human services, and various aspects of the criminal justice system, as appropriate.

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 rigorous 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. 1. The provider complies with all provisions specified in 105 CMR 164.000 Licensure of Substance Use Disorder Treatment Programs related to assessment and recovery planning.
2. The provider makes and documents a decision, as soon as possible, whether to admit the Member. The provider accepts admissions 24 hours per day, 7 days per week, 365 days per year.
3. The provider maintains standardized intake/admission log that tracks all applications for admission, documents admission decisions, reason for non-acceptance, and referrals made. The log shall be made available for review upon request. The provider must facilitate referrals to appropriate services and/or resources in the case of admission denials.

4. The provider utilizes evidence-based assessment tools for assessing SUD and for ASAM level of care.
5. A counselor completes an initial biopsychosocial clinical assessment using ASAM dimensions to gain an understanding of addiction severity, co-occurring mental health issues and trauma, physical health issues, family and social supports, housing stability, and other issues for each Member that includes the following elements:
   a) A history of the use of alcohol, tobacco, and other drugs, including age of onset, duration, patterns, and consequences of use; use of alcohol, tobacco, and other drugs by family members; types of and responses to previous treatment; and risk for overdose.
   b) Assessment of the Member's psychological, social, health, economic, educational/vocational status; criminal history; current legal problems; co-occurring disorders; disability status and accommodations needed, if any; trauma history; and history of compulsive behaviors, such as gambling. This assessment must be completed before a comprehensive service plan is developed.
   c) Assessment of Member's infectious disease status and risk (HIV, HCV, TB, COVID-19, etc.)
   d) Identification of key relationships (e.g., significant others) supportive to individual's treatment and recovery.
   e) A list of the Member's current medications, based on pharmacy labels, which shows the date of filling, the name and contact information of the prescribing practitioner, the name of the prescribed medication; and
   f) When indicated, providers must facilitate or make referral arrangements for necessary testing, physical examination, and/or consultation by qualified professionals.
6. The counselor/case manager works with the Member to create an individualized recovery treatment/service plan based on the clinical assessment, including, at a minimum:
   a) A statement of the Member's strengths, needs, abilities, and preferences in relation to his/her substance use disorder treatment, described in behavioral terms.
   b) The service to be provided and whether directly or through referral.
   c) The service goals, described in behavioral terms, with timelines.
   d) Clearly defined staff and resident responsibilities and assignments for implementing the plan; and
   e) A description of treatment plans and aftercare service needs.
7. The clinical supervisor reviews and approves the assessment and individualized recovery treatment/service plan.

Discharge Planning and Documentation

1. 1. The provider complies with all provisions of 105 CMR 164.000 Licensure of Substance Use Disorder Treatment Programs related to discharge planning.
2. The provider conducts discharges 7 days per week, 365 days per year.
3. The counselor/case manager works with the Member to create an individualized aftercare plan that must include:
   a) referrals to individual, group and/or family outpatient aftercare as appropriate.
   b) alcohol and drug-free living environments.
   c) vocational and educational opportunities.
   d) resources to support access to programs that address social determinants of health (SDOH), such as housing, food, benefits, etc.
   e) specify strategies to be used to follow-up with the Member after the Member leaves.
4. The counselor/case manager works with the Member to ensure that recovery maintenance strategies are in place and working effectively and that referrals to services have met intended goals.
5. The clinical supervisor reviews and approves the aftercare plan.

DOCUMENT HISTORY

- Jan 2023: MassHealth Performance Specifications Updates
- Jul. 2022: MassHealth Performance Specifications Updates
- Dec. 2020: Document created