CLINICAL STABILIZATION SERVICES (CSS) FOR SUBSTANCE USE DISORDERS (ASAM Clinically Managed High Intensity Residential Services)

PURPOSE

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

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

OVERVIEW

Clinical Stabilization Services (CSS) for Substance Use Disorders (ASAM Clinically Managed High Intensity Residential Services) consist of 24-hour, seven-day-per-week, clinically managed high-intensity residential services offered in community settings. Services are delivered by nursing, case management, clinical, and recovery support staff under the direction of a licensed medical provider (e.g., Physician, Nurse Practitioner, Physician Assistant) in collaboration with the multidisciplinary team.

Services include a multidimensional bio-psychosocial assessment, treatment planning, individual and group counseling, psychoeducational groups, case management, medication monitoring, and discharge planning.

CSS are provided to Enrollees whose symptoms of withdrawal do not require the intensity of Acute Treatment Services (ATS) for Substance Use Disorders (ASAM Medically Monitored Intensive Inpatient Services), are largely resolved or minimal, and whose multidimensional needs cannot be managed in a less intensive level of care. CSS providers are expected to manage mild medical complexities and or comorbidities. Admission to CSS (ASAM Clinically Managed High Intensity Residential Services) is

appropriate for Enrollees who meet the diagnostic and dimensional criteria specified in accordance with the American Society of Addiction Medicine Criteria®.

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.

CSS programs will provide ASAM Clinically Managed High Intensity Residential Services until:

1. Post-acute withdrawal symptoms (PAWS) 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.

SERVICE COMPONENTS

1. At minimum, the provider complies with all requirements of the Department of Public Health (DPH) Bureau of Substance Addiction Services (BSAS) 105 CMR 164, including reporting requirements.
2. The provider accepts admissions 24 hours per day, 7 days per week, 365 days per year. As part of admissions, the member must receive:
    a) A thorough physical examination, which conforms to principles established by the American Society of Addiction Medicine, is completed for all Enrollees within 24 hours of admission.
    b) A multidimensional biopsychosocial assessment is completed for all Members within 72 hours of admission.
3. Therapeutic programming is provided 7 days per week, including weekends and holidays, with sufficient professional staff to maintain and appropriate milieu and conduct the services below based on individualized Enrollee needs. The scope of required service components provided in this level of care includes, but is not limited to, the following:
    a) Clinical and medical monitoring of the individual's progress and medication administration as needed.
    b) Nursing intervention as needed.
    c) Capacity to facilitate induction onto FDA-approved Medications for Addiction Treatment/Medication for Opioid Use Disorder (MAT/MOUD) as clinically indicated and appropriate with referral for ongoing MAT at discharge.
    d) Access to psychiatric crisis evaluation and clinical services based on the biopsychosocial assessment.
    e) HIV, Hepatitis C, TB, tobacco use and other health related education programs:
        I. HIV and Viral Hepatitis risk assessments are integrated as a part of each Enrollee's medical/nursing assessment.
        II. HIV and Hepatitis C education/risk reduction education is provided for all Enrollees.
        III. Referral to HIV antibody counseling and testing sites and on-site HIV antibody counseling.
    f) Education about the benefits and risks of medication approved for addiction treatment.
    g) Opioid overdose risk and prevention.

h) Access to appropriate laboratory and toxicology tests.
i) Access to routine medications.
j) Counseling and case management which incorporates evidence-based practices, including individual, group, and family counseling.
k) Behavioral/health/medication education and planning.
l) Psycho-educational groups.
m) Peer support and/or other recovery-oriented services.
n) Development and/or updating of crisis prevention plans, or safety plans as part of Crisis Planning Tools for youth, and/or relapse prevention plans, as applicable.
o) Introduction to self-help groups and the continuum of SUD and mental health treatment.
p) Direct operational affiliations with other services especially Acute Treatment Services, Transitional Support Services (TSS), Residential Rehabilitation Services (RRS), Opioid Treatment Programs, Office Based Opioid Treatment, Community Behavioral Health Centers (CBHCs) and psychiatric services.
q) Case management that directly connects (warm handoff) to appropriate providers.
r) Basic medical care, which includes addressing non-SUD illnesses with updates to primary care providers (with consent).
s) Support services and referrals for family members and significant others.

4. The provider ensures that all Enrollees have access to prescribers specializing in addiction medicine and are educated on their options for MAT/MOUD.
5. Co-occurring psychiatric services, medication evaluation and management, and related laboratory services are offered either directly or via referral. Such services are available virtually, or on-site within 24 hours, or referred to an off-site provider within 24 hours, as appropriate to the severity and urgency of the Enrollee's mental health condition.
6. The program admits and has the capacity to treat Enrollees currently maintained on MAT/MOUD for the treatment of opioid use disorder (OUD). Such capacity may take the form of documented, active Affiliation Agreements with providers licensed to provide such treatments.
    a) The provider is responsible for updating its available capacity, once each day at a minimum, seven days per week, 365 days per year on the Massachusetts Behavioral Health Access website (www.MABHAccess.com)
    b) The provider is also responsible for keeping all administrative and contact information up to date on the website.
    c) The provider is also responsible for training staff on the use of the website to locate other services for Enrollees, particularly in planning aftercare services.
7. For adults who give consent, the provider makes documented attempts to contact the parent/guardian/caregiver, family members, and/or significant others within 48 hours of admission, unless clinically or legally contraindicated. The provider provides them with all relevant information related to maintaining contact with the program and the Enrollee, including names and phone numbers of key nursing staff, primary treatment staff, social worker/case manager/discharge planner, etc. If contact is not made, the Enrollee's health record documents the rationale.
8. The provider is responsible for ensuring that each Enrollee has access to medications prescribed for physical and behavioral health conditions, and documents so in the Enrollee's health record.
9. Prior to medication prescribing or administration, the provider engages in a medication reconciliation process in order to avoid inadvertent interactions in medication prescribing that

may occur in transition of an Enrollee from one care setting to another. The provider does this by reviewing the Enrollee's complete medication regimen at the time of admission (e.g., transfer and/or discharge from another setting or prescriber) and comparing it with the regimen being considered in the CSS. The provider engages in the process of comparing the Enrollee's newly issued medication orders by the CSS prescriber to all medications that he/she has been taking to avoid medication errors. This involves:

a) Developing a list of current medications, i.e., those the Enrollee was prescribed prior to admission to the CSS,
b) Reviewing Massachusetts Prescription Awareness Tool (MassPAT),
c) Developing a list of medications to be prescribed in the CSS,
d) Making clinical decisions based on the comparison and, when indicated, in coordination with the Enrollee's primary care provider (PCP); and
e) Communicating the new list to the Enrollee and, with consent, to appropriate caregivers, the Enrollee's PCP, and other treatment providers. All activities are documented in the Enrollee's health record.

11. All urgent consultation services resulting from the intake evaluation and physical exam, or as subsequently identified during the admission, are provided in a timely manner for these services. Non-urgent consultation services related to the assessment and treatment of the Enrollee while in the CSS 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 CSS program is brief. All services are documented in the Enrollee's health record.
12. The milieu does not physically segregate individuals with co-occurring disorders.
13. A handbook specific to the program is given to the Enrollee and partner/parent/guardian/caregiver at the time of admission. The handbook includes but is not limited to Enrollee rights and responsibilities, services available, treatment schedule, grievance procedures, discharge criteria, and information about family support and peer and recovery-oriented services.
14. For pregnant patients, the CSS is expected to provide coordination with OB/GYN, pediatrics, and any other appropriate medical and social services providers and state agencies.
15. The CSS will facilitate access to recovery support navigator services and/or peer recovery coach services either directly or through referral.
16. 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 co-occurring disorders, 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.
17. The provider complies with the Department of Public Health's (DPH) implementation of the Culturally and Linguistically Appropriate Services (CLAS) Standards.
18. The provider provides access to peer support and recovery-oriented activities.
19. Provider is responsible for ensuring all staff at site are trained in ASAM criteria ®.

STAFFING REQUIREMENTS

If program is experiencing a hardship in meeting these specifications, BSAS has a process for waiving regulatory and contractual requirements. The waiver process is described in the Department of Public Health (DPH) Bureau of Substance Addiction Services (BSAS) 105 CMR. The program is responsible for informing the payer of any waivered requirements if the waiver is approved. Providers are additionally responsible for communicating hardships that are not regulatory in nature to payers.

1. The provider complies with the staffing requirements of the applicable licensing body, and the staffing requirements outlined in 105 CMR 164 *Licensure of Substance Use Disorder Treatment Programs* and the staffing requirements in the applicable Plan provider manual.
2. The provider utilizes a multi-disciplinary staff including nurses, counselors, physicians, psychiatrists, care coordination staff, recovery specialist staff, and clinical staff with skills, training, and/or expertise in established treatment protocols for Enrollees with substance use disorders.
    a) A Medical Director who is responsible for all medical services performed by the program, either by performing them directly or by delegating specific responsibilities to qualified healthcare professionals such as a nurse practitioner and physician assistant functioning under the Medical Director's supervision. The medical director or designee will ensure 24- hour medical coverage, 7 days per week either onsite, via telehealth, or through a Qualified Service Organization Agreement in compliance with 105 CMR 164., for consultation, to examine, and assess Enrollees within 24 hours of admission. The Medical Director should have demonstrated clinical experience treating substance use disorders and especially opioid use disorders.
    b) Nursing staff: A minimum of 40 hours of nursing per week, including weekends and holidays to support medication compliance and monitoring of symptoms. Nurse time must be flexed according to case mix, acute/complex clinical acuity, and the needs of Enrollees in the program. Licensed practical nurses (LPNs) may be used in combination with an RN, to supplement nursing/Enrollee coverage, if requested, reviewed, and approved by the covering plan for programs serving a larger than average number of Enrollees.
    c) A full-time Program Manager (1 FTE) who will carry full responsibility for the administration and operations of the program.
    d) A full-time Clinical Director (1 FTE) who minimally meets the requirements of 105 CMR 164 criteria for Senior Clinician or Clinical Supervisor. A clinical director is the designated authority responsible for ensuring that adequate and quality behavioral treatment is being provided.
    e) Counseling: 1:8 Counselor-to-Enrollee ratio, 7 days per week for 12 hours per day (excluding overnight). Counselors have a CAC, CADAC, LADCI, or LADCII credential, or the equivalent as defined by BSAS.
    f) Recovery Specialist: 1:16 specialist-to-Enrollee ratio on day and evening shifts, and 1:20 ratio on overnight shifts (24/7/365). Recovery specialists must have a minimum of a high school diploma, or the equivalent as defined by BSAS.
    g) Case Manager: A program must designate one case manager 12 hours each day, seven days a week. Case Managers must minimally meet the requirements of 105 CMR 164.

The case manager is responsible for helping clients obtain medically necessary services by providing information, referral coordination, discharge planning, and follow-up.

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

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

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

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

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

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

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

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

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

SERVICE, COMMUNITY AND OTHER LINKAGES

1. The provider complies with all provisions of 105 CMR 164.000 *Licensure of Substance Use Disorder Treatment Programs* related to community connections and collateral linkages.
2. With Enrollee consent, if an Enrollee is referred to another treatment setting, the provider collaborates in the transfer, referral, and/or discharge planning process to ensure continuity of care.
3. Staff members are familiar with all levels of care/services necessary to meet the needs of Enrollees, and are able and willing to accept referrals from, and refer to, these levels of care/services when clinically indicated. The provider must maintain written Affiliation Agreements with local providers of these levels of care that refer a high volume of Enrollees to

its program and/or to which the program refers a high volume of Enrollees. Such agreements include the referral process, as well as transition, aftercare, and discharge processes.

4. When necessary, the provider provides or arranges transportation for Enrollees for services required external to the program during the admission.
5. With Enrollee consent, the provider collaborates with the Enrollee's primary care provider and other community providers.
6. As needed, the provider also directly provides or arranges transportation 7 days per week for the Enrollee to attend aftercare interviews, transitional appointments, residential placements, the next level of care or next step placement, community-based peer support and recovery-oriented meetings, and medical and psychiatric visits. The provider also makes reasonable efforts to assist Enrollees upon discharge to the community and/or non-24-hour levels of care with identifying transportation options when needed, including public transportation, Prescription for Transportation (PT- I) forms, etc.

PROCESS SPECIFICATIONS

Assessment, Treatment Planning and Documentation

1. The provider complies with all provisions specified in 105 CMR 164.000: *Licensure of Substance Use Disorder Treatment Programs* related to assessment and recovery planning.
2. The provider has a policy regarding the speed at which they will inform the referral source/individual seeking admission (ideally within the hour after receipt of referral). The provider accepts admissions 24 hours per day, 7 days per week, 365 days per year. Every admission declination must be documented and include reason for declination and referrals provided.
3. The provider determines at the time of admission the medical and psychiatric appropriateness of all self-referred Enrollees, based on medical necessity criteria for CSS, and documents such in the Enrollee's health record.
4. The provider ensures that a physical examination is completed for all Enrollees within 24 hours of admission. If the examination is conducted by a qualified health professional who is not a physician, the results and any recommendations arising from the examination are reviewed by the nursing supervisor prior to implementation.
5. The counselor/case manager works with the Enrollee to create an individualized recovery treatment/service plan based on the biopsychosocial assessment, including, at a minimum:
    a) A statement of the Enrollee'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.
6. 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 has documented policies and procedures that require contacting the Enrollee's PCP in the event of non-emergency illness and for calling emergency services when deemed appropriate for primary care coordination.
8. The provider must document any missed sessions and attempts to make follow-up contact, the reason(s) given for absence, and if necessary, the staff's rationale for continuation or discontinuation of CSS.
9. The provider assigns a multi-disciplinary treatment team to each Enrollee within 24 hours of admission. The nursing or counseling staff develops and reviews the assessment and individualized initial treatment/recovery and initial discharge plans with the Enrollee within 48 hours of admission.
10. The treatment/recovery and discharge plans are reviewed by the multi-disciplinary treatment team with each Enrollee at least every 48 hours (a maximum of 72 hours between reviews on weekends), and are updated accordingly, based on each Enrollee's individualized needs. All assessments, treatment and discharge plans, reviews, and updates are documented in the Enrollee's health record.
11. For anyone who could become pregnant, a pregnancy test is administered prior to the administration of any medications.
12. For anyone who is pregnant, the provider coordinates care with her PCP and OB/GYN and consults with those physicians as needed.
13. The provider makes arrangements to obtain appropriate drug screens/tests, urine analysis, and laboratory work as clinically indicated, and documents these activities in the Enrollee's health record.
14. The provider ensures continuous assessment of the Enrollee's mental status throughout the Enrollee's treatment episode and documents such in the Enrollee's health record.

Discharge Planning and Documentation

1. The provider complies with all provisions of 105 CMR 164.000: *Licensure of Substance Use Disorder Treatment Programs* related to discharge planning.
2. The provider conducts discharges 7 days per week, 365 days per year.
3. At the time of discharge, and as clinically indicated, the provider ensures that the Enrollee has a current crisis prevention plan, and/or safety plan, and/or relapse prevention plan in place that includes access to Naloxone and that he/she has a copy of it. The provider works with the Enrollee to update the existing plan, or, if one was not available, develops one with the Enrollee prior to discharge. With Enrollee consent and as applicable, the provider may contact the Enrollee's local Adult or Youth Mobile Crisis Intervention program (AMCI/YMCI) to request assistance with developing or updating the plan. With Enrollee consent, the provider sends a copy to the AMCI/YMCI Director at the Enrollee's local AMCI/YMCI.
4. Prior to discharge, the provider assists Enrollees in obtaining post-discharge appointments, as follows: within seven (7) calendar days of discharge for lower levels of care, such as RRS or 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. This function may not be designated to aftercare providers or to the Enrollee to be completed before or after the Enrollee's discharge. These activities are documented in the Enrollee's health record.

5. The provider ensures active, post-discharge follow-up plans, supports, and referrals by care coordinators to strengthen and sustain gains made while in this service, and to ensure successful engagement at the next level of care or within other ongoing services.

QUALITY MANAGEMENT

1. The provider will develop and maintain a quality management plan that is consistent with their contractual responsibilities to Optum, and which utilizes appropriate procedures to monitor, measure, and improve the activities and services it provides.
    a) Specifically, the provider will work to improve these outcomes within their patient population receiving SUD treatment:
        I. Increase in MAT/MOUD induction and continuation
        II. Decrease in readmissions to ED and inpatient services
        III. Increase in referrals and transitions to lower levels of care
        IV. Increase in program's capacities to admit and treat individuals with behavioral health and co-occurring physical health conditions
    b) Providers will be required to report Enterprise Service Management (ESM) data to BSAS at admission and discharge per DPH/BSAS Licensing Regulation.
    c) The provider will collect data to measure the quality of their services.
2. The provider must have a continuous QI process to evaluate the care provided and review adherence to policies and procedures within the sites. Data may be collected via satisfaction surveys, electronic medical records, and other forms.
3. Clinical outcomes data must be made available to Optum upon request and must be consistent with the performance specifications of this service.
4. Providers must report any adverse incidents and other reportable events that occur to the relevant authorities.