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

Providers contracted for this level of care are expected to comply with all requirements of this service-specific performance specifications. The requirements within this service-specific performance specification take precedence over previous performance specifications. Providers must meet all Department of Public Health/Bureau of Substance Addiction Services (DPH/BSAS) contractual regulatory requirements within 105 CMR 164.00 Licensure of Substance Use Disorder Treatment Programs.

Acute Treatment Services (ATS) for Substance Use Disorder: American Society of Addiction Medicine (ASAM®) Criteria Medically Monitored Intensive Inpatient Services aka ASAM® Level 3.7) provides services consisting of 24/7, medically monitored inpatient services that 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; psychoeducational groups; case management; medication monitoring and discharge planning.

Members who are appropriate for Acute Treatment Services are experiencing, or at high/or significant risk of developing, an uncomplicated acute withdrawal syndrome as a result of alcohol and/or other substance use disorder. These Members require 24-hour 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 treated in a less intensive outpatient level of care. Admissions to Acute Treatment Services is appropriate for Members who meet diagnostic and dimensional admission criteria specified in accordance with the ASAM® Criteria. Referrals for ATS can originate from self-referral, physicians, Commonwealth Care Alliance (CCA) clinical staff, emergency rooms, state agencies or other ancillary providers.

Members with co-occurring disorders are expected to receive specialized services within the ATS for individuals with co-occurring mental health and substance use disorders to ensure treatment for their co-occurring psychiatric conditions. Pregnant individuals receive specialized services within the ATS to ensure substance use disorder treatment and obstetrical care are treated concurrently. ATS 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 Medication for Opioid Use Disorder (MOUD), compliance with medications, lack of prescription refills, or previous unsuccessful treatment attempts.
ATS programs will provide ASAM® Medically Monitored Intensive Inpatient Services (ASAM® 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 requirements of the Department of Public Health (DPH) and 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 confirms to principles established by the ASAM®, is completed within 24 hours for all patients as part of the admissions process.
    b. Medical and nursing care based on comprehensive biopsychosocial assessment that was performed within 48 hours of Member's admission.
    c. The provider notifies CCA Behavioral Health and Utilization Management and Transitions of Care department within 48 hours of admission by calling 866- 420-9332.
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.
        - 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.
    b. Access to psychiatric crisis evaluation and clinical services based on biopsychosocial assessment.
    c. HIV, Hepatitis C, TB, tobacco use and other health related education programs:
        - HIV and viral Hepatitis risk assessment are integrated as part of each Member's medical/nursing assessment.
        - HIV and Hepatitis C education/risk reduction is provided for all Members.
        - Referral to HIV antibody counseling and testing sites and on-site HIV antibody counseling
    d. Education about the benefits and risk of medication approved for addiction treatment.
    e. Opioid overdose risk and prevention
    f. Access to appropriate laboratory and toxicology tests
    g. Routine medications
    h. Counseling and case management which incorporates evidence-based practices, including individual, group, and family therapy.
    i. Behavioral/health/medication education and planning
    j. Psycho-education groups
    k. Peer support and/or other recovery-oriented services
    l. Developmental and/or updating crisis prevention, or safety plans as part of crisis planning tools, and/or relapse prevention plans, as applicable.
    m. Introduction to self-help groups and the continuum of SUD and mental health treatment.
    n. Direct operational affiliations with other services especially Clinical Stabilization Services (CSS), Transition Support Services (TSS), Residential Rehabilitation Services (RRS), Opioid Treatment Programs (OTPs), Office-Based Opioid Treatment (OBOT), Community Behavioral Health Centers (CBHCs) and psychiatric services
    o. Case management that directly connects (warm handoff) to appropriate providers
    p. Health services including primary care and oral care; with updates with primary care providers (with Member's consent); and
    q. 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, include the complications associated with dual recovery, and provides 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 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 disorders. 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 establishment of clinical need for such communication, the provider makes documented attempts to contact the following: the guardian/caregiver, family members, and or significant other, primary care physician (PCP), other prescribers, CCA Behavioral Health Transitions of Care team, within 48 hours of admission, unless clinically or legally contraindicated.
10. 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 the 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.
11. 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.
12. Prior to medication dispensing, the provider engages in medication reconciliation process in order to avoid inadvertent inconsistencies in medication prescribing that may occur in transition of Member form one care setting to another. The provider does this by reviewing the Member's complete medication regimen at the time of admission (i.e., transfer/ or discharge from another setting or prescriber) and comparing it with the regimen being considered at the ATS. The provider engages in the process of comparing the Member's medication orders newly issued by the ATS prescriber to all the medications that they have 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 medication to be prescribed at the ATS
    d. Comparing the medication on the two lists
    e. Making clinical decisions based on the comparison and, when indicated, in coordination with the Member's primary care physician (PCP); and
    f. Communicating the new list to the Member and, with consent, to appropriate caregivers, DMH, CCA Care Team, the PCP and other treatment providers. All activities are documented in the Member's health record
13. All urgent consultation services resulting from the intake evaluation and physical exam, or subsequently identified during the admission, are provided within a timely manner for this service. 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 is the ATS program is brief. All of these services are documented in the Member's health record.
14. The milieu does not physically segregate Members with co-occurring disorders.
15. A handbook specific to the program is given to the Member and 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.
16. 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 (https://www.mabhaccess.com/). The provider is also responsible for keeping all administrative and contact information up to date on the website. The provider is responsible for training staff on the use of the website to locate other services for Members, particularly in planning aftercare services.
17. Co-occurring psychiatric services, medication evaluation and management, and related laboratory services are offered either directly on-site or virtually within 24 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.

18. The ATS will ensure that for pregnant Members, coordination with OB/GYN, pediatrics, and other appropriate medical, social services providers, and state agencies will be provided.
19. The ATS will facilitate access to recovery support navigator services and/or peer recovery coach services either directly or through referral.
20. The provider trains all staff at the site on the use of ASAM® criteria.
21. The provider complies with the Department of Public Health's (DPH) implementation of the Culturally and Linguistically Appropriate Services (CLAS) standards.

EXPECTATIONS OF TRANSGENDER INCLUSIVE AND AFFIRMING POLICIES FOR OVERNIGHT LEVELS OF CARE

It is the expectation of CCA that all contracted providers will provide inclusive and affirming care to our transgender/non-binary/gender diverse Members. For overnight levels of care this expectation is inclusive of, but not limited to:

1. Consistently using the name and pronouns that the Member uses for themselves, even if this is not the name and/or pronoun set reflected in the Member's legal identification and/or CCA insurance card
2. Making admission decisions without regard to the Member's gender identity
3. Making rooming decisions based on the Member's clinical needs and preferences, and the recommendation of the Member and their ongoing clinical team (e.g.: not mandating that a transgender Member requires a single room based solely on their gender)
4. Making determinations about access to any gender-based/gender separated service based on the gender with which the Member identifies, even if this is not the gender reflected in the Member's legal identification and/or CCA insurance card
5. Ensuring that staff are regularly trained in best practices in delivering LGBTQIA+ inclusive and affirming— and, specifically, transgender inclusive and affirming— behavioral health and medical care

STAFFING REQUIREMENTS:

1. If the program feels they cannot meet these specific 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 164. The provider is responsible for informing CCA of any waivered requirements if the waiver is approved. Providers are additionally responsible for communicating hardships that are not regulatory in nature to CCA.
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.
3. The provider ensures that staffing includes a multidisciplinary treatment team consisting of nurses, counseling staff, physicians for psychiatric and pharmacological consultation, and clinical assistant/nurses' aid staff, all with established skills, training, and/or expertise in treatment of individuals with substance use disorders, including:
    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 clinical coverage, seven days per week on-site or remotely, for consultation, to examine, and assess Members within 24 hours of admission. The medical director must be available to be on site during any hours of the program operation, as needed. The medical director should have demonstrated clinical experience treating substance use disorders and opioid use disorders in particular.
    b. 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 nursing coverage. There must be a minimum of one nurse per 16 members, per shift. One of the nurses on the day and evening shifts must be a Registered Nurse
    c. A nurse manager, who provides direct and continuous supervision of nursing staff, is responsible for ensuring on-site 24/7 nursing coverage. Nursing staff support medication and monitoring of

symptoms.

d. A full-time Program Director who carries full responsibility for the administration and operations of the program
e. A Clinical Director, who meets the criteria in 105 CMR 164 for Senior Clinician and/or Clinical Supervisor. A clinical director is designated authority responsible for ensuring adequate and quality behavioral treatment is being provided.
f. One recovery specialist per 16 members, per shift. The recovery specialist provides recovery-oriented supports the form of psychoeducation, peer supports, introduction to self-help groups, etc.
g. Two Case Managers, 12 hours each day, per 7 days per week who are responsible for assisting Members to obtain medically necessary services by providing information, referral coordination, discharge planning and follow-up.
h. A Psychiatrist or Psychiatric Nurse Practitioner on staff or available through a qualified service organization agreement for psychiatric evaluation and consultation, 24 hours, 7 days week, to address the needs of Members with co-occurring disorders and
i. An Obstetrician/Gynecologist on staff or available through qualified service organization agreement (QSOA) to accommodate pregnant Members.

4. All ATS 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 Members
    b. **Tobacco Education Coordinator:** responsible for assisting staff in implementing BSAS guidelines for integrating 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 sites' performance in ensuring equitable access to services.
    d. **CLAS (Culturally and Linguistically Appropriate Services) Coordinator:** ensures that the services meet the language and cultural needs of the Members.
    e. At a minimum, there is one staff person trained in CPR and Naloxone administration on duty each shift.
5. The provider ensures Members have access to supportive staff and nursing staff 24 hours per day, 7 days per week, 365 days per year. Members also have access to case management staff 12 hours a day.

SERVICE, COMMUNITY AND COLLATERAL LINKAGES:

1. The provider complies with all the provisions of 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. With Member consent, the provider will work with the local Adult Mobile Crisis Intervention (AMCI) to collaborate on including the Members Crisis plan into the AMCI EMR if the Member is at high risk for self-harm.
4. Elements of the discharge plan incorporate the Member's identified Social Determinants of Health (SDOH) needs and concerns including, but not limited to, housing, finances, healthcare, transportation, familial, occupational, educational, and social supports.
5. The provider will maintain formal active Affiliation Agreements for service linkages with all of the following levels of care, including at a minimum an effective referral process as well as the transition aftercare and discharge process, and must be able and willing to accept referrals from and refer to these levels when clinically indicated:
    a. Adult Mobile Crisis Intervention (AMCI)
    b. Psychiatric inpatient services
    c. Medically Managed Withdrawal Management (ASAM® Level 4)
    d. Clinical Stabilization Services (CSS) (ASAM® Level 3.5 Clinically Managed High Intensity Residential

Services)
e. Structured Outpatient Addiction Programs (SOAP)
f. Partial Hospital Program (PHP)
g. Residential Rehabilitation Services (RRS) or Co-Occurring Enhanced RRS (ASAM® Level 3.1 Clinically Managed Low Intensity Residential Services)
h. Medication-Assisted treatment/Medication Addiction Treatment (MAT)
i. Opioid Treatment Programs (OTPs)
j. Office-Based Opioid Treatment (OBOT)
k. Substance Use Disorder outpatient clinics.
l. Community Behavioral Health Centers (CBHCs)
m. Community Mental Health Centers (CMHCs)
n. Transitional or permanent supportive housing
o. Sober Homes
p. Recovery Coach and Recovery Support Navigator services
q. Outpatient Counseling & Medication management
r. Community Support Program (CSP) and or the CSP Specialized Programs (CSP for Homeless Individuals, CSP for Justice Involved Individuals, CSP-Tenancy Preservation Program)
s. Recovery Support Centers
t. Community Overdose Prevention programs
u. Mutal Aid programs including SMART Recovery, Alcoholics Anonymous and Narcotics Anonymous
v. Department of Mental Health residential programs, Adult Community Support Services, and Program of Assertive Community Treatment (PACT)

PROCESS SPECIFICATIONS ASSESSMENT, TREATMENT, RECOVERY PLANNING, AND DOCUMENTATION:

1. The provider complies with all provisions specified in105 CMR 164 related to assessment and recovery planning.
2. Ensure that behavioral health clinicians conduct behavioral health clinical assessments and are documented, dated, and signed, at a minimum include the following:
    a. Clinical formulation, rationale for admission or continuance of care, discussion of any possible diversionary or lower levels of care, recommendations, and Member's strengths.
3. 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 the admissions 24 hours per day, 7 days per week, 365 days per year. Every admission declination must be documented and include reason for the declination and referrals provided to the declined individual.
4. A comprehensive nursing assessment is conducted at the time of admission, which includes obtaining a Clinical Institute Withdrawal Assessment (CIWA) score and/or Clinical Opiate Withdrawal Scale (COWS). Results are documented in the Member's health record.
5. A registered nurse (RN) evaluated each Member within 3 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.
6. The provider ensures that physical examination which confirms to the principles established by the ASAM® is completed for all Members within 24 hours of admission. If the examination is documented by a qualified health professional who is not physician, the results and any recommendations arising from the examination are reviewed by the nursing supervisor prior to implementation.
7. 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 physician (PCP) and behavioral health providers, family members, guardians, caregivers, and/or significant others in the treatment planning process.
8. The provider assigns a multidisciplinary treatment team to each Member within 24 hours of admission. The multidisciplinary 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 play

may be developed by an abbreviated treatment team, with a review by the full treatment team on the next business day.

9. The provider must document any missed sessions and attempts to make follow-up contact, the reason(s) given for absence, and if necessary, the staff's rationale for continuation or discontinuation of ATS documented in the Member's health record.
10. The treatment/recovery and discharge plans are reviewed by the multidisciplinary treatment team which each Member at least every 48 hours (maximum 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 Member's health record.
11. The assigned case manager under the supervision of the Clinical Director meets with the Member daily for the purpose of assessment, counseling, treatment, case management, and discharge planning. All activities are documented in the Member's health record.
12. With Member consent and establishment of the clinical need for such communication, coordination with family members/significant others/legal guardians, and other treatment providers, including PCP 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.
13. For any individual who could become pregnant, a pregnancy test is administered prior to the administration of any medication(s).
14. For any individual who is pregnant, the provider coordinates care with their PCP and OB/GYN and consults with those physicians as needed.
15. 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.
16. The provider ensures the continuous assessment of the Member's mental health status throughout the Member's treatment episode and documents such in Member's health record.

DISCHARGE PLANNING AND DOCUMENTATION:

1. The provider complies with 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, as clinically indicated, the provider ensures that the Member has a current relapse prevention plan, and/or crisis prevention plan, and/or safety plan in place and that they have a copy of it. The provider works with the Member to update the existing plan(s), or if one is 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 Mobile Crisis Intervention (AMCI) to request assistance with developing or updating the plan. With Member consent, the providers sends a copy to the AMCI Director at the Member's local AMCI.
4. The provider engages Member in developing and implement aftercare plan when 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 pan in the Member's health record.
5. Prior to discharge, the provider assists Members in obtaining post-discharge appointments as follows:
    a. An outpatient therapy appointment scheduled within 7 days of discharge from ATS (this appointment could be an intake appointment for therapy services)
    b. An appointment for medication management (as indicated) within 14 days of discharge from the facility.
    c. Other referrals, including but not limited, to recovery support, referrals to self-help groups, housing, etc. will be included in the aftercare plan.
    d. All referrals will be documented in the Member's records.
    e. In the event of a discharge against medical advice (AMA), providers must ensure patients are given resources to reconnect with services.
6. This function may not be designated to aftercare providers or to the Member to be completed before or after the Member's discharge. These discharge planning activities, including the specific aftercare appointment(s) date/time/location(s), are documented in the Member's health record.

EXPECTED OUTCOMES AND QUALITY MANAGEMENT:

1. The provider complies with all provisions of the corresponding section in the General performance specifications.
2. The provider will implement strategies to improve outcomes within their patient population receiving ATS treatment. Specifically, the provider will work to improve these outcomes:
    a. Increase MAT/MOUD induction and engagement
    b. Decrease readmission to ED and inpatient services
    c. Increase referrals and transitions to lower levels of care
    d. Increase in program's capacities to admit and treat individuals with behavioral health and co-occurring physical health conditions
3. Providers will be required to report Enterprise Service Management (ESM) data to BSAS at admission and discharge in compliance with 105 CMR 164: Licensure of Substance Use Disorder Treatment Programs.
4. The provider will collect data to measure the quality of their services. The provider must have a continuous Quality Improvement (QI) process to evaluation the care provided and review. adherence to policies and procedures within the site sites. Data may be collected via satisfaction surveys, electronic medical records, and other forms. The provider must develop and maintain a quality management plan.
5. Providers are required to collect and measure outcome data and incorporate the data in treatment plans in the medical records and inform clinical programming.
6. Clinical outcomes data must be made available to Commonwealth Care Alliance (CCA) upon request and must be consistent with CCA' s performance standards for this level of care for quality management and Network Management purposes.
7. All reportable adverse incidents will be reported to within one business day of their occurrence per policy and DMH licensing requirements. A reportable adverse incident is an occurrence that represents actual or potential harm to the well-being of a Member, or to others by action of a Member, who is receiving services, or has recently been discharged from services.
8. Providers will comply with all applicable laws and regulations including but not limited to any and all applicable Medicare and/or Medicaid laws, regulations, and instructions of CMS and/or EOHHS relating to addressing and reporting Serious Reportable Events (SREs) and Adverse Incidents.
9. Reportable adverse incidents must be reported to CCA and MassHealth Office of Behavioral Health within one business day as per policy and DMH licensing requirements. Providers must follow all laws and regulations for reporting Adverse Incidents (per MassHealth per MassHealth All Provider Bulletin 316).
10. Network providers will comply with all requirements contained in their contract with CCA including any corrective actions required by CCA or applicable regulatory agencies.

DOCUMENT UPDATES:

- November 2024: Revised template and updated content to align with performance specification with MassHealth standards and guidelines that became effective on 4/1/2023.