Clinical Stabilization Services (CSS) for Substance Use Disorders
ASAM® Level 3.5 Clinically Managed High-Intensity Residential 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.

Clinical Stabilization Services (CSS) for Substance Use Disorders: American Society of Addiction Medicine (ASAM®) criteria Clinically Managed High-Intensity Residential Services aka ASAM® Level 3.5) provides 24-hour, 7 days per week, clinically managed high-intensity residential treatment offered in a community setting. Services are delivered by nursing, case, management, clinical and recovery specialist under the direction of a licensed medical provider (Physician, Nurse Practitioner, Physician Assistant) in collaboration with the multidisciplinary team. CSS can usually be completed in less than 30 days.

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

CSS are provided to Members whose symptoms of withdrawal do not require intensity of Acute Treatment Services (ATS), but are largely resolved or minimal, and whose multidimensional needs cannot be managed in a less restrictive environment. CSS services providers are expected to manage mild medical complexities and or comorbidities. Admission to CSS is appropriate for Members who meet the diagnostic criteria specified in accordance with ASAM® criteria.

Exclusion criteria must be based on clinical presentation and must not include automatic exclusions based on stable medical conditions, homelessness, medication 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 restrictive environment.
3. Induction onto FDA-approved medication has been initiated, and the Member is stabilized.

COMPONENTS OF SERVICES:

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. As part of admissions, the Member must receive:
    a. A thorough physical examination, which confirms to principles established by the ASAM®, is completed for all Members within 24 admissions.
    b. A multidimensional biopsychosocial assessment is completed for all Members within 72 hours of 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. CSS therapeutic programming is provided 7 days per week, 4 hours a day, including weekends and holidays with sufficient professional staff to maintain an appropriate milieu and conduct the services below based on the individualized Member needs. The scope of services required on site include but are not limited to:
    a. Clinical and medical monitoring of the individual's progress and medication administration as needed.
    b. Nursing interventions as needed.
    c. Capacity to facilitate 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/MOUD at discharge.
    d. Access to psychiatric crisis evaluations 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 Member's medical/nursing assessment.
        ii. HIV and Hepatitis C education/risk reduction education is provided for all Members; and
        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 relapse prevention plans, safety plans and/or crisis 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 (ATS), Residential Rehabilitation Services (RRS), Transitional Support Services (TSS), Opioid Treatment Programs (OTPs), Office-Based Treatment (OBOT), 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.
s. Support services and referrals for family members and significant others.

4. The provider is responsible for ensuring that each Member has access to prescribers specializing in addiction medicine. Members are educated on their options for MAT/MOUD. Provider must document education in the Member's health record.
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 Member's mental health condition.
6. The program admits and has the capacity to treat Members currently maintained on MAT/MOUD for the treatment of Opioid Use Disorder (OUD). Such capacity make take the form of documented, active Affiliation Agreements with providers licensed to provide such treatments.
7. 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.
8. For Members who give consent, the provider makes documented attempts to contact the 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 Member and the program, 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 rationale.
9. Prior medication prescribing or administration, the provider engages in medication reconciliation process in order to avoid inadvertent inconsistencies in medication prescribing that may occur in transition of Member from one care setting to another. The provider does this by reviewing the Member's complete medication regimen at the time of admission and comparing it with regimen being considered in the CSS. The provider engages in the process of comparing the Member's medication orders newly issued by the CSS prescriber to all the medications that Member has been taking in order 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 CSS.
    b. Reviewing Massachusetts Prescription Awareness Tool (MassPAT)
    c. Developing a list of medication to be prescribed at the CSS.
    d. Making clinical decisions based on the comparison and, when indicated, in coordination with the Member's primary care physician (PCP); and
    e. 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.
10. 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 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 is the CSS program is brief. All of these services are documented in the Member's health record.

11. The milieu does not physically segregate Members with co-occurring disorders.
12. 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.
13. For pregnant Members, the CSS is expected to provide coordination with OB/GYN, pediatrics, and any other appropriate medical and social services providers and state agencies.
14. The CSS will facilitate access to recovery support navigator services and/or peer recovery coach services either directly or through referral.
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 (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.
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 4 hours of service programming per day. At least 2 hours of psycho-education group time per week is dedicated to the discussion of HIV/AIDS, Hepatitis C, and other health issues (i.e., tobacco cessation).
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. The provider is responsible for ensuring all staff at site are trained in ASAM® criteria.

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:

- 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
- Making admission decisions without regard to the Member's gender identity
- 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)
- 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.

- 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 is experiencing 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 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 all provisions of corresponding section in the General performance specifications. The provider complies with staffing requirements of the applicable licensing body, the staffing requirements are outlined in 105 CMR 164: Licensure of Substance Use Disorder Treatment Programs
3. The provider utilized a multidisciplinary 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 Members with SUD.
    a. **Medical Director**: 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, via Telehealth, or through a Qualified Service Organization Agreement in compliance with 105 CMR 164, for consultation, to examine and assess Members within 24 hours of admission. The medical director should have demonstrated clinical experience treating SUD and OUD in particular.
    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 Member sin the program. Licensed Practical Nurses (LPNs) may be used in combination with an RN, to supplement nursing/Member coverage, if requested, reviewed, and approved by the covering plan for programs serving a larger than average number of Members
    c. **Program Manager**: 1 FTE who will carry full responsibility for administration and operations of the program.
    d. **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 health treatment is being provided.

e. **Counseling:** Under 130 CMR 418.410 (C)(2)(e) Substance Use Disorder Treatment Services, CSS programs must schedule counseling staff 12 hours a day and 7 days a week. CSS programs may meet this requirement by scheduling, at a minimum, the full-time equivalent of 2.5 counseling staff members to be present 12 hours a day, 7 days a week. Counselors have a CAC, CADAC, LADC I, or LADC II credentials, or equivalent as defined by BSAS.
f. **Recovery Specialist:** 1:16 specialist-to-Member ratio on day and evening shifts, and 1:20 ratio on overnight shifts (24/7/365). Recovery specialist must have a minimum of a high school diploma or the equivalent as defined by DPH Bureau of Substance Abuse Services (BSAS) and
g. **Case Manager Coordinator:** Under 130 CMR 418.410 (C)(2)(g) Substance Use Disorder Treatment Services, CSS programs must designate one case manager to cover 12 hours each day, 7 days a week. Notwithstanding this requirement, effective January 1, 2023, CSS programs may fulfill this minimum staffing requirement by scheduling a case manager or care coordinator, at minimum, on a full-time basis, 5 days week.

4. All CSS 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. There is an OB/GYN on staff or available through a qualified services organization agreement (QSOA) to accommodate pregnant Members.
6. There is a Psychiatrist or Psychiatric Nurse Practitioner on staff or available through a QSOA for psychiatric evaluation and consultation, as needed to address the needs of Members with co-occurring disorders.
7. The provider ensures that Members have access to a supportive milieu 24/7/365. Members also have access to clinical staff 12 hours a day and daily access to nursing staff.
8. The provider ensures that all staff receive supervision consistent with payers credentialing criteria.
9. The provider ensures that team members have all trainings required by regulation, including training in evidence-based practice, 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 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. Staff members are familiar with all the levels of care/services necessary to meet the needs of Members and are able and willing to accept referrals from, and refer to, these levels of care/services when clinically indicated. The provider must maintain 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 process.
4. When necessary, the provider provides or arranges transportation for Members for services required external to the program during admission.
5. With Member consent, the provider collaborates with the Member's primary care physician and other community providers.
6. As needed, the provider also directly provides or arranges transportation 7 days per week for Member to attend aftercare interviews, transitional appointments, residential appointments, the next level of care or next step in treatment, community-based peer support and recovery-oriented meetings and medical and psychiatric visits. 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 or CCA transportation benefit.

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. 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, seven 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 Members, based on medical necessity criteria for CSS, and documents such in the Member's health record.
4. The provider ensures that a physical examination 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.
5. The Counselor/Case Manager collaborates with the Member to create an individualized recovery. treatment/service plan based on the biopsychosocial assessment, including at a minimum:
    a. A statement of the Member's strengths, needs, abilities, and preferences in relation to their SUD 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 physician (PCP) and behavioral health providers, family members, guardians/caregivers, and/or significant others in the treatment planning process.
7. The provider has documented policies and procedures that require contacting the Member'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 Member 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 Member within 48 hours of admission.
10. 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 needs. All assessments, treatment, and discharge plans, reviews, and updates are documented in the Member's health record.
11. For all women of childbearing age, a pregnancy test is administered prior to the administration of any medication(s).
12. The provider makes arrangements to obtain appropriate drug screens/tests, urine analysis, and laboratory work as clinically indicated and documents these activities in the Member's health record.
13. The provider ensures 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 164.000related to discharge planning.
2. The provider conducts discharges seven 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 that includes access to Naloxone and that they have a copy of it. The provider collaborates 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 Mobile Crisis Intervention program (AMCI) to request assistance with developing or updating the plan. With Member consent, the provider sends a copy to the AMCI Director at the Member's local AMCI.
4. Prior to discharge, the provider assists Members in obtaining post-discharge appointments, as follows:

a. An appointment within seven **(7)** calendar days of discharge for outpatient therapy services (which may be an intake appointment for therapy services)
b. An appointment within **14** calendar days of discharge for medication monitoring, if necessary
c. All discharge planning activities are documented in the Member's health record and clearly written on the discharge plan and reviewed with the Member prior to discharge.

This function may not be designated to aftercare providers or to the Member to be completed before or after the Member's discharge.

5. The provider ensures active, post-discharge follow-up plans, recovery 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.
    a. The **Provider notifies CCA BH Transitions of Care (TOC) specialist to alert CCA of Members discharge date and discharge plan. TOC specialist can be contacted at 866-420-9332.**
    b. If there are barriers to accessing covered services, the provider **notifies CCA' s Behavioral Health TOC specialists by calling at 866-420-9332**.

EXPECTED OUTCOMES AND QUALITY MANAGEMENT:

1. 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 CSS 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.
2. 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.
3. 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.
4. 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.
5. 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).

6. 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 4/1/23.