

**CENTER FOR HEALTH  
INFORMATION AND ANALYSIS**

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**MANDATED BENEFIT REVIEW OF HOUSE BILL 3264  
SUBMITTED TO THE 189TH GENERAL COURT:  
AN ACT RELATIVE TO REHABILITATION  
PERIODS FOR SUBSTANCE ABUSERS**

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## BENEFIT MANDATE OVERVIEW: H.B. 3264: AN ACT RELATIVE TO REHABILITATION PERIOD FOR SUBSTANCE ABUSERS

### HISTORY OF THE BILL

The Joint Committee on Mental Health and Substance Abuse referred House Bill (H.B.) 3264, *An Act Relative to Rehabilitation Periods for Substance Abusers*, sponsored by Rep. Brady of Brockton in the 189th General Court, to the Center for Health Information and Analysis (CHIA) for review.<sup>1</sup> Massachusetts General Laws, Chapter 3, Section 38C requires CHIA to review and evaluate the potential fiscal impact of each mandated benefit bill referred to the agency by a legislative committee.

### WHAT DOES THE BILL PROPOSE?

Chapter 258 of the Acts of 2014, *An Act to Increase Opportunities for Long-Term Substance Abuse Recovery*,<sup>2</sup> requires insurers to cover medically-necessary acute treatment services (ATS) and clinical stabilization services (CSS) for up to a total of 14 days and provides that the medical necessity of such treatment be determined by the treating clinician. H.B. 3264 proposes to amend specified sections of Chapter 258 by increasing from 14 to 30 the number of days for which coverage for medically-necessary ATS and CSS is required.

### MEDICAL EFFICACY OF H.B. 3264

No research is available specifically to measure the impact of increasing the duration of ATS or CSS, and Chapter 258 was implemented too recently for its effects to be measured. However, in general, if the provisions of H.B. 3264 allow additional patients access to adequately-available, medically-necessary treatment of appropriate, and in some cases longer, duration, and to be continuously engaged in recovery, then the bill should improve the effectiveness of substance use disorder (SUD) treatment.

Several factors might mitigate H.B. 3264's clinical impact. Provider capacity for many of the components of the spectrum of substance abuse treatment will constrain the number of patients able to access these services, patients' ability to transition between service levels in a timely manner, and the length of treatment episodes. Improvements in outcomes will also depend on how providers use the discretion the proposed mandate grants them in delivering adequate and appropriate care for commercially-insured patients, and whether or not these decisions improve on decisions currently made by carriers.

### CURRENT COVERAGE

With the implementation of the relevant provisions of Chapter 258 on October 1, 2015, insurers must cover ATS and CSS for a total of 14 days per episode. Before that implementation, some insurers would not admit patients to the CSS level of care regardless of circumstances, while others would admit to CSS only as a step-down from ATS, or after outpatient treatment was attempted and proven inadequate.<sup>3</sup> Analysis of claims in the Massachusetts All Payer Claim Database confirmed very small amounts of CSS claims were paid for under fully-insured commercial insurance plans prior to the implementation of Chapter 258.

## **COST OF IMPLEMENTING THE BILL**

Requiring coverage by fully-insured health plans for a greater number of days of ATS and CSS under H.B. 3264 would have an insignificant effect on health insurance premiums. CSS capacity in Massachusetts is fully-occupied, and increasing the average length of stay in CSS beds would require admitting fewer individuals, resulting in no net change in overall bed utilization.

For H.B. 3264 to result in significant cost, assuming utilization levels in the scenarios of the Chapter 258 study, CSS bed capacity would have to increase by 170 percent over the estimate in the Chapter 258 analysis, which was already set at levels higher than BSAS has indicated they expect to increase bed capacity. With this far larger increase, capacity would meet demand, and only with additional increases beyond that level could longer lengths of stay increase costs (as long as demand exceeds supply longer lengths of stay result in fewer admissions with no change in bed days). BSAS currently expects an increase of 282 beds, including recently brought on-line and projected beds. The Chapter 258 study assumed an increase of 384 beds by 2019 but capacity would have to increase much more than that (adding about 637 beds) to meet demand and thereby allow H.B. 3264 to have an incremental effect on utilization. Even if this analysis assumed capacity increases that large, an unrealistic scenario, the potential increase in premiums would be small, under 0.1 percent.

The Massachusetts Division of Insurance and the Health Connector are responsible for determining any potential state liability associated with the proposed mandate under Section 1311 of the Affordable Care Act (ACA).

## **PLANS AFFECTED BY THE PROPOSED BENEFIT MANDATE**

Commercial fully-insured health insurance plans, including individual and group accident and sickness insurance policies, corporate group insurance policies, and HMO coverage issued pursuant to Massachusetts General Laws, and both fully-insured and self-insured plans operated by the Group Insurance Commission (GIC) for the benefit of public employees and their dependents would be subject to this proposed mandate. The proposed mandate would apply to members covered under the relevant plans, regardless of whether they reside within the Commonwealth or merely have their principal place of employment in the Commonwealth. The proposed mandate also affects Medicaid/MassHealth, which provides coverage to a large portion of the population receiving substance abuse treatment; however, CHIA's analysis does not estimate the effect of the mandate on Medicaid expenditures.

## **PLANS NOT AFFECTED BY THE PROPOSED BENEFIT MANDATE**

Self-insured plans (i.e., where the employer or policyholder retains the risk for medical expenses and uses a third-party administrator or insurer only to provide administrative functions), except for those provided by the GIC, are not subject to state-level health insurance mandates. State mandates do not apply to Medicare and Medicare Advantage plans, the benefits of which are qualified by Medicare; this analysis excludes members of commercial fully-insured plans over 64 years of age. These mandates also do not apply to federally-funded plans including TRICARE (covering military personnel and dependents), the Veterans Administration, and the Federal Employee's Health Benefit Plan.

## MEDICAL EFFICACY ASSESSMENT: ACUTE TREATMENT AND CLINICAL STABILIZATION SERVICES

H.B. 3264 amends specified sections of Chapter 258 of the Acts of 2014, An Act to Increase Opportunities for Long-Term Substance Abuse Recovery<sup>4</sup> by increasing the minimally-covered medically necessary length of stay for ATS and CSS from 14 to 30 days.

Massachusetts General Laws Chapter 3, Section 38C charges CHIA with reviewing the medical efficacy of proposed mandated health insurance benefits. Medical efficacy reviews summarize current literature on the effectiveness and use of the mandated treatment or service, and describe the potential impact of a mandated benefit on the quality of patient care and the health status of the population. A detailed explanation of the relevant provisions of Chapter 258 can be found in CHIA’s Mandated Benefit Review of Chapter 258 of the Acts of 2014: An Act to Increase Opportunities for Long-Term Substance Abuse Recovery.<sup>1</sup>

### SUBSTANCE ABUSE, DEPENDENCE, ADDICTION, AND WITHDRAWAL

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association, “substance use disorder” (SUD) is a “cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems.”<sup>5</sup> Symptoms may include some combination of “impaired control, social impairment, risky use and [tolerance and/or withdrawal].”<sup>6</sup> While not applied as a diagnostic term in the DSM, addiction, as defined by the National Institute of Drug Abuse (NIDA), is a chronic illness affecting “multiple brain circuits, including those involved in reward and motivation, learning and memory, and inhibitory control over behavior.”<sup>7</sup> The likelihood of relapse for someone with this illness is similar to that of other chronic illnesses with both behavioral and physiological components, such as diabetes, hypertension, and asthma.<sup>8</sup>

#### Acute Withdrawal

When a patient abruptly discontinues use of a psychoactive substance,<sup>9</sup> he or she will experience “the onset of a predictable constellation of signs and symptoms...”<sup>10</sup> Generally the symptoms are the “opposite of the intoxication effects of the particular substance,” and can begin within hours or days of last use.<sup>11</sup> The symptoms, as well as the timeframe for withdrawal, vary by the substance used as well as by the individual; Table 1 shows general acute withdrawal timeframes.<sup>12</sup>

Table 1: Acute Withdrawal Timeframes for Specific Substances

Substance	Acute Withdrawal Timeframe
Alcohol	5-7 days
Benzodiazepines	1-4 weeks; 3-5 weeks with gradual dosage reduction (tapering)
Cannabis (Marijuana)	5 days
Opioids	4-10 days (14-21 days for methadone)
Stimulants (e.g. amphetamines, methamphetamines, cocaine)	1-2 weeks

i Portions of this document have been previously published in CHIA’s Mandated Benefit Review of Chapter 258 of the Acts of 2014: An Act to Increase Opportunities for Long-Term Substance Abuse Recovery. Published December 2014: <http://www.chiamass.gov/assets/Uploads/Substance-Abuse-Mandates-Chapter-258-of-the-Acts-of-2014.pdf>.

## Post-Acute Withdrawal

After the end of these timeframes, many patients experience continuing symptoms, as well as “non-substance-specific signs and symptoms that persist, evolve, or appear well past the expected timeframe for acute withdrawal.”<sup>13</sup> This is known as protracted withdrawal, or post-acute withdrawal syndrome (PAWS). Given its variability and limited research on these symptoms for substances other than alcohol, no consensus definition exists for PAWS.<sup>14</sup> However, clinical reporting of the syndrome is widespread, and it is important to treat, as “[t]hese symptoms may lead clients to seek relief by returning to substance use.”<sup>15</sup> The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) has issued an advisory on PAWS to provide information on best practices for behavioral health providers.<sup>16,17</sup>

Chronic use of psychoactive substances changes the molecular, cellular, and neurologic circuitry of the brain, as well as a patient’s central nervous system. This affects a person’s emotions and behavior in ways which may persist after acute withdrawal, with symptoms varying by the substance used. In addition to acute withdrawal symptoms, patients may experience symptoms including anxiety, depression, mood swings, disinterest in sex, insomnia, memory problems, and pain, among others. Impulsive behavior, alcohol or drug cravings, and difficulties with decision making, concentration and problem-solving are also common, and especially problematic in early recovery.

According to SAMHSA’s advisory, “[c]lients affected by [PAWS] may want to alleviate those symptoms by returning to substance use at a time when they have a weakened ability to resist such impulses.” Additionally, while these symptoms may be substance-use related and may resolve over time, they may indicate a co-occurring medical or behavioral disorder, making diagnosis and treatment for an SUD patient especially challenging. Specifically for PAWS, SAMHSA states that providers “can improve their clients’ chances for long-term recovery by educating clients about [PAWS], offering support and understanding, monitoring them regularly, and intervening early with clients who seem headed for relapse.”<sup>18</sup>

## SERVICES FOR DETOXIFICATION AND WITHDRAWAL: ATS AND CSS

Treatment for substance use disorders generally falls along a spectrum of services, including, from most to least intensive: inpatient acute detoxification and medically managed withdrawal (referred to as ATS), CSS, residential rehabilitation (including transitional support services or TSS, as well as other types of long-term residential rehabilitation), intensive outpatient and partial hospitalization, outpatient (including Medication Assisted Treatment), and early intervention. (See Appendix A for a more detailed description of these levels.) Comprehensive, effective treatment provides access to the full spectrum of services medically necessary for the individual patient, and focuses on long-term, sustained abstinence and recovery from this chronic illness. Chapter 258 establishes minimum coverage requirements for a portion of that spectrum (ATS and CSS); H.B. 3264 builds upon Chapter 258 by extending the number of days for which minimum coverage is mandated from the currently required 14 to 30.

NIDA reports that most patients begin treatment for substance use disorders with detoxification and medically-managed withdrawal. Detoxification is “the process by which the body clears itself of drugs, [and] is designed to manage the acute and potentially dangerous physiological effects of stopping drug use.”<sup>19</sup> Patients whose acute withdrawal requires inpatient detoxification and medical management or monitoring may enter ATS, characterized by 24-hour nursing or medical care in a facility that can manage severe biomedical, emotional, behavioral, or cognitive problems. Not all patients require this level of service; appropriate treatment depends on each patient’s health and co-occurring conditions, the substance used, the length of use, and other individual factors.

Detoxification includes reducing physiological and psychological withdrawal symptoms, as well as interrupting compulsive use.<sup>20</sup> This compulsion, and the difficulty of overcoming it, often requires “a greater intensity of services initially [in this phase of treatment] to establish participation in treatment activities...”<sup>21</sup> Patients who need additional inpatient treatment for medical and behavioral symptoms following acute detoxification may be referred to CSS; as with ATS, whether a patient needs this level of treatment will depend on the substance used and his/her individual needs. CSS provide a less-medically-intense inpatient level of treatment for patients who do not require acute medical detoxification, but who still require clinical supervision and nursing care to stabilize their symptoms. Patients are supervised for 24 hours daily, and are provided with at least four hours of nursing care in addition to other services. According to the Massachusetts Bureau of Substance Abuse Services (BSAS), CSS is “designed to stabilize clients and increase retention in treatment.”<sup>22</sup>

It is important to distinguish between detoxification<sup>23</sup> and the broader realm of substance abuse treatment,<sup>24</sup> as “[d]etoxification, in and of itself, does not constitute complete substance abuse treatment.”<sup>25</sup> According to NIDA, “detoxification alone does not address the psychological, social, and behavioral problems associated with addiction and therefore does not typically produce lasting behavioral changes necessary for recovery.”<sup>26</sup> The process of detoxification focuses on helping a patient to withdraw safely from acute intoxication or dependency, and includes evaluation, stabilization, and preparation for entry into treatment, but does not necessarily wholly encompass substance abuse treatment.<sup>27</sup>

## MEDICAL EFFICACY OF SUBSTANCE ABUSE TREATMENT

According to NIDA, substance abuse is a chronic condition for which effective treatment is long-term, holistic, and tailored to the needs and situation of the individual.<sup>28,29</sup> Sustained abstinence and recovery requires repeated episodes of care, and a variety of treatment approaches and strategies over time.<sup>30</sup> Organizations such as NIDA, SAMHSA, and the American Society of Addiction Medicine (ASAM) recommend that the level of care and length of any treatment be flexible, respond to the needs of the individual, and depend on the patient’s overall situation, illness, response, progress, and outcomes.<sup>31,32,33</sup> No one treatment program, duration, or progression is appropriate for all patients; each will need different services and supports of various lengths and intensities at various times as part of an adaptive treatment for this chronic illness. Instead, research has shown that effective treatment is based on a set of principles that should underpin any individual’s recovery services (See Appendix B for an outline of NIDA’s Principles of Effective Treatment).

In general, substance abuse treatment has been evaluated and found to be effective compared to non-treatment. A meta-analysis combined the effects of 78 studies of drug treatment and “...analyses indicated that drug abuse treatment has both a statistically significant and a clinically meaningful effect in reducing drug use and crime.”<sup>34</sup> Extensive literature exists on the characteristics of effective treatment, including treatment duration, treatment continuity, and patient-specific characteristics related to health and living situation.

Duration and continuity of treatment are associated with patient outcomes. Overall, studies have found that clients retained for longer periods in substance abuse treatment have better outcomes than those with shorter treatment duration.<sup>35,36</sup> Program specifics, including lengths of appropriate treatment, will vary in part on the type of substance used. One study found that longer residential stays resulted in lower readmission rates for substance abuse treatment.<sup>37</sup> Research, including studies of patients abusing a range of substances including alcohol and opioids, has shown that continuing treatment and program flexibility along the spectrum of services, individualized to a patient’s specific needs, is beneficial, finding that “retention, duration, and increased aftercare” were important to the effectiveness of inpatient substance abuse treatment.<sup>38,39,40</sup>

There is also clear evidence that patient characteristics are an important aspect of appropriate treatment, with effectiveness depending in part on the individual patient’s overall health and social support system.<sup>41,42</sup> In general, patients with more conditions at the start of treatment, including co-occurring psychiatric and substance abuse diagnoses and/or psychosocial problems, have been found to experience better outcomes with longer and more intensive treatment.<sup>43</sup> Other research found that “[p]atients with high psychiatric severity and/or a poor social support system are predicted to have a better outcome in inpatient treatment, while patients with low psychiatric severity and/or a good social support system may do well as outpatients without incurring the higher costs of inpatient treatment.”<sup>44</sup> These findings highlight the importance of an individualized approach to treatment, including consideration of co-occurring conditions and the patient’s living environment and social situation.

Overall, evidence indicates that effective treatment for substance abuse and addiction must recognize the chronic nature of the illness, the likelihood of relapse, and the social factors affecting the progression of the disease and recovery. Furthermore, it suggests that better treatment is flexible and individualized along a spectrum of services, with consideration given to the patient’s individual characteristics, co-occurring conditions, the substance used, social, emotional, and behavioral health, and social support system. For some patients, longer treatment is central to recovery. Continuity of treatment at the appropriate level tailored to the needs of the individual patient is associated with better outcomes.

There are many types of substance abuse treatment, with endless variations of specific services and supports within each program, as well as significant variability in the characteristics of the populations and individuals receiving each type of treatment. Medical efficacy studies that review the impact of providing insurance coverage for specific lengths of inpatient detoxification treatment, and the effect on utilization or average length of stay, have not been published. However, while these studies are not available, there is evidence that the services offered and concepts underlying their provision are effective in improving outcomes for certain patients.

### **MEDICAL EFFICACY OF CHANGES TO COVERAGE UNDER H.B. 3264**

Isolating the effect of H.B. 3264 on the health status of the commercially-insured population—beyond the effect of Chapter 258 itself—is complex. As noted, the general efficacy of SUD treatment—employing the full spectrum of services in a way that recognizes the needs of the individual patient—is well-established. Furthermore, within a well-integrated spectrum of care, longer treatment periods have been shown to be more effective, especially for patients with co-occurring problems or with a less supportive living situation.

The 30-day minimum coverage requirement in H.B. 3264 may result in increased average lengths of stay, especially in CSS, beyond the level that will evolve under the 14-day minimum coverage mandated by Chapter 258; providers will have greater latitude in determining the length of stay medically necessary for the patient. However, no research is available specifically to measure the impact of increasing the duration of ATS or CSS beyond that mandated by Chapter 258. Other service types—more or less intensive and/or of longer or shorter duration—may be appropriate for some individuals at various times in a treatment and recovery cycle. Because the proposed mandate does not require a standard length of stay for ATS or CSS, and presumably allows providers more flexibility in delivering specific medically-necessary services of length sufficient to address individual needs, the mandate may improve outcomes if services are adjusted by patient to adhere to the evidence-based principles of substance use disorder treatment.

Moreover, given the evidence cited previously, it is possible that reducing insurance-imposed limitations to care recommended solely at the provider's discretion might improve the chances that more commercially-insured patients will gain access to individualized, full-spectrum treatment options of sufficient duration, thus increasing the potential for successful recovery. Yet even with this possibility, several factors might mitigate H.B. 3264's impact on population health status.

First, provider capacity for many of the components of the spectrum of services—CSS, TSS, residential rehabilitation, outpatient services, and medication-assisted treatment—will constrain the number of patients able to access these services, patients' ability to transition between service levels in a timely manner, and the length of treatment episodes, further diminishing the effectiveness of H.B. 3264.<sup>45</sup> Given the extensive waitlist for patients for CSS, TSS, and residential rehabilitation, providers currently have little incentive to keep patients in treatment for longer than medically necessary, as their beds are always full. However, capacity constraints across various levels of the treatment spectrum may lead providers to keep patients in more intensive levels of treatment than is medically necessary rather than discharge them and risk a lapse in treatment and support resulting in relapse. According to the CHIA report *Access to Substance Abuse Treatment in Massachusetts* published in April 2015, there are currently nearly three times the number of ATS beds in Massachusetts as there are CSS or TSS beds.<sup>46</sup> And as the length of stay for ATS is shorter than for CSS or TSS, the number of patients leaving ATS is higher than the number of CSS or TSS beds vacated and available for placement at any time.<sup>47</sup> The lack of capacity at various points along the continuum of care may further increase lengths of stay at more intensive levels. For example, a patient may not need ATS and/or CSS care for a full 30 days but may need residential rehabilitation. If a placement is not available, the patient may remain in CSS longer than clinically necessary as he/she is also not ready for non-residential treatment. On the other hand, patients discharged from a level of service without timely access to the next appropriate level remain at risk of relapse.

Second, prior to the implementation of Chapter 258, CSS has generally not been covered for the commercial population. When commercial coverage for CSS begins in October 2015 under Chapter 258, more commercial patients will be referred to CSS. If the supply of accessible CSS beds remains unchanged, increased use by commercial patients (for which higher payment rates are sometimes available<sup>48</sup>) might displace other patients—such as Medicaid patients—from these services. The impact of H.B. 3264 and potential longer lengths of stay may result in even further displacement, as commercial patients remain in CSS beds for even longer periods, preventing admission of those with other coverage.

Any improvements in outcomes resulting from the specific mechanisms in this bill—increasing minimum coverage for ATS and CSS—will depend on how providers use the discretion the mandate grants them in delivering adequate and appropriate care for commercially-insured patients, and whether or not these decisions improve on decisions currently made by carriers. Should the proposed mandate lead to overutilization/overly-long stays in ATS/CSS—stays not justified by medical necessity or the individual patient's social condition, but within the 30-day minimum—and patients do not receive the most appropriate treatment, the result may be repeated utilization of certain services (e.g., readmission for detoxification) without related recovery.

In general, if the provisions of H.B. 3264—increasing the minimum covered days for ATS/CSS—allow additional patients access to adequately available treatment of appropriate, and in some cases longer, duration, and to be continuously engaged in recovery, then H.B. 3264 should improve SUD treatment effectiveness. The extent to which the potential mitigating factors identified previously will offset this general conclusion is not measurable from available evidence.

## APPENDIX A: SUBSTANCE ABUSE LEVELS OF CARE SPECTRUM AND DESCRIPTION

Chapter 258 defines substance abuse treatment similarly to the spectrum of services outlined by ASAM.<sup>49</sup> In the law, substance abuse treatment includes early intervention, outpatient, intensive outpatient and partial hospitalization, residential or inpatient, and medically-managed intensive inpatient services. Chapter 258 also includes specific provisions regarding crisis stabilization services and acute treatment services.

The following is a general mapping of the levels of care described in Chapter 258 cross-referenced to the ASAM criteria, provided as an aid to the reader not familiar with substance abuse treatment. This is not intended as a definitive or detailed explanation or reconciliation of the two sources.

Chapter 258 Substance Abuse Services <sup>50</sup>	ASAM Levels of Care <sup>51</sup>	Services Subject to S.B.1502
Early Intervention	Level 0.5 Early Intervention	
Outpatient	Level 1 Outpatient	
Intensive Outpatient and Partial Hospitalization	Level 2.1 Intensive Outpatient	
	Level 2.5 Partial Hospitalization	
Residential or Inpatient	Level 3.1 Clinically Managed Low-Intensity Residential Services	Transitional Support Services (proposed mandate)
	Level 3.3 Clinically Managed Population-Specific High-Intensity Residential Services (Adults only)	
	Level 3.5 Clinically Managed High-Intensity Residential Services (Adults)	Clinical Stabilization Services (CSS)
	Clinically Managed Medium-Intensity Residential Services (Adolescents)	
	Level 3.7 Medically Monitored Intensive Inpatient Services (Adults)	Acute Treatment Services (ATS)
Medically Monitored High-Intensity Inpatient Services (Adolescents)		
Medically Managed Intensive Inpatient	Level 4 Medically Managed Intensive Inpatient Services	

Early intervention services are not defined in the Massachusetts Department of Public Health Licensure of Substance Abuse Treatment Programs (Licensure of SATP) regulations, but have been defined by the state Division of Insurance to include screening, brief intervention and referral to treatment (SBIRT), as well as programs licensed under 105 CMR 164.200 (Outpatient) and 164.211 (First Offender Driver Alcohol Education).<sup>52</sup> Clarification of services in the legislation is made for “Acute treatment services” and “Clinical stabilization services.” According to officials at BSAS, the state agency that licenses substance abuse treatment programs and facilities, “Acute treatment services” are equivalent to ASAM Levels of Care 3.7 and 4.0, while “Clinical stabilization services” are equivalent to ASAM Level of Care 3.5.<sup>53</sup> Licensing regulations term these services differently than both Chapter 258 and the ASAM Criteria.<sup>54</sup> All programs are required to provide Minimum Treatment Services (Appendix C) in addition to those specified for each level of care.

Service	ASAM Level	MA DPH Licensing Regulations: 105 CMR 164 <sup>55</sup>	
Early Intervention	0.5		Various licensing regulations may apply to these levels of care
		211	First Offender Driver Alcohol Education
Outpatient	1	200	Outpatient Services
		221	Outpatient
		223	Operating Under the Influence Second and Multiple Offenders for Aftercare Treatment Services
		231	Day Treatment
		300	Opioid Treatment
Intensive Outpatient	2.1		Various licensing regulations may apply to these levels of care depending on the specific services provided
Partial Hospitalization	2.5		
Residential Rehabilitation Adults	3.1	440	Adolescents
		423(B)	Transitional Support Services
		423(C)	Social Model Recovery Home
		423(D)	Recovery Home
		423(E)	Therapeutic Community
		430	Adults with Families
		450	Operating Under the Influence Second Offenders
Clinical Stabilization	3.5	133(A)(1)(c)	Clinically Managed Detoxification
Acute Treatment	3.7	133(A)(1)(b)	Medically Monitored Inpatient Detoxification
	4	133(A)(1)(a)	Medically Managed Intensive Inpatient Detoxification

## EARLY INTERVENTION

Early intervention, ASAM Level of Care 0.5, is for individuals who are at specific risk of developing substance abuse problems, but whose behaviors have not reached the level sufficient to diagnose an addictive disorder.<sup>56</sup> Individuals have no risk of withdrawal symptoms, and have either no or stable co-occurring biomedical, emotional, behavioral or cognitive conditions. The goal is to help the individual gain an understanding of high-risk behaviors related to substance abuse, as well as the skills needed to change.<sup>57</sup> Services can be offered in a variety of settings, including primary care physician offices or hospital emergency rooms, as well as schools, work sites, and community centers.<sup>58</sup>

One form of early intervention is an evidence-based practice known as Screening, Brief Intervention, and Referral to Treatment (SBIRT). Based on a US Institute of Medicine recommendation calling for community-based screening to reduce health risk behaviors, this service is intended to intervene early with those who are not yet addicted but who exhibit such behaviors, and to identify those who do have a substance use disorder and need referral to more formal treatment.<sup>59,60</sup>

A recent bulletin issued through the Massachusetts Office of Consumer Affairs and Business Regulation (OCABR) defines early intervention as follows:

Early intervention services: American Society of Addiction Medicine (ASAM) level of care level 0.5 - services provided to a person in a variety of settings designed to identify and address problems or risk factors that appear to be related to substance use and addictive behavior. Examples of early intervention services include screening, brief intervention and referral to treatment (SBIRT), first offender driver alcohol education, and programs licensed under 105 CMR 164.200 or 105 CMR 164.211.<sup>61</sup>

Because of the nature of these community-based screenings, the types of healthcare professionals who may conduct the services, and the variety of settings in which they may be provided, various licensure rules may apply in Massachusetts for early intervention, except for CMR 164.211, which defines the specific licensure requirements for First Offender Driver Alcohol Education.<sup>62</sup> Patients receiving these services are not required to have a substance use disorder diagnosis, and are referred by a Massachusetts court, or by the Registrar of Motor Vehicles if the client is under age 21.<sup>63</sup> Treatment is to include appropriate group education sessions, or alternative or special programming as needed, and development of an individual treatment plan.<sup>64,65</sup>

## OUTPATIENT SERVICES

Outpatient services are categorized by ASAM as Level 1, and are delivered in a variety of settings to patients whose illness severity and level of function do not warrant more intensive levels of treatment.<sup>66</sup> Patients may enter directly into outpatient treatment, may step down from more intensive care levels, may use outpatient treatment for chronic disease management for their substance use disorder, or may be unwilling or unable to accept placement into a more intensive level of care.<sup>67</sup> Following a “defined set of policies and procedures or clinical protocols,” ASAM advises that “[s]uch services are provided in regularly scheduled sessions of (usually) fewer than nine contact hours a week for adults and fewer than six hours for adolescents.<sup>68</sup> Services include individual and group counseling, psychotherapy, motivation enhancement, family and occupational therapy, educational groups, and medication management,

among others.<sup>69</sup>

According to Licensure of SATP regulations,

Outpatient Services encompass levels of care to persons not at risk of suffering withdrawal symptoms, and who can participate in organized ambulatory services including intensive day treatment services, counseling, and educational services...<sup>70</sup>

Outpatient services licensed in Massachusetts include several different types of treatment:

- Outpatient Detoxification is for patients whose current and potential withdrawal symptoms are not severe enough to require inpatient detoxification (ATS or CSS), but who “need a structured program with frequent contact in order to engage in treatment,” and for whom an assessment disproves that “the community in which the client resides poses a threat to the client’s abstinence.”<sup>71</sup> Regulations require treatment in these programs to include at least nine hours of service programming each week.<sup>72</sup>
- Outpatient counseling is for patients who are found to have no withdrawal symptoms, who have the ability to engage and remain in treatment, and for whom community support for withdrawal is available.<sup>73</sup> Treatment is to include individual, group, couple, and family therapy as needed.<sup>74,75</sup>
- Operating Under the Influence Second and Multiple Offenders for Aftercare Treatment Services (SOA) is for patients who have been convicted of more than one charge of operating a motor vehicle under the influence, and who have either completed a 14-day residential driving under the influence program, or are awaiting placement in such a program.<sup>76</sup> Counseling services are required to emphasize the consequences of operating a motor vehicle under the influence of drug or alcohol, and random alcohol and drug screenings are required.<sup>77</sup> Providers report to the referring court or other agency, and patients are required to remain in outpatient treatment for one year.<sup>78</sup>
- Day treatment is for patients whose substance use disorder, absence of withdrawal risk, and presence of substantial relapse risk indicate the patient’s “need for a structured program in order to engage and remain in treatment.”<sup>79</sup> Regulations outline that treatment must include 3½ hours of services daily in programs that must be open and available to deliver services up to five days per week (individualized client treatment plans may not recommend or reflect participation five days per week, as the intensity of services is based on the client’s need), including “counseling, psychoeducational groups, and family counseling,” as well as case management to include referrals and aftercare service planning.<sup>80</sup>
- Opioid treatment comprises both detoxification and maintenance for opioid addicted individuals.<sup>81</sup> Regulations state that opioid agonist treatment medication and counseling services must both be provided.<sup>82</sup> According to ASAM, individuals in opioid treatment programs are “[r]eady to change the negative effects of opioid use, but [are] not ready for total abstinence...”<sup>83</sup>

## INTENSIVE OUTPATIENT/PARTIAL HOSPITALIZATION

ASAM defines intensive outpatient treatment as Level 2.1, providing between 9 and 19 hours per week of structured programming for adults and between 6 and 19 hours for adolescents.<sup>84</sup> Services include individual and group counseling, family and occupational therapy, educational groups, and medication management.<sup>85</sup> Patients admitted to this level of care have a minimal risk of severe withdrawal, and either do not experience co-occurring biomedical complications and conditions, or these conditions are manageable.<sup>86</sup> Emotional, behavioral or cognitive complications and conditions are mild for these patients, but need to be monitored.<sup>87</sup> Patients admitted to intensive outpatient treatment have variably engaged in their treatment, and are often

ambivalent about change, or “lack awareness of the substance use or mental health problem.”<sup>88</sup>

Partial hospitalization, ASAM Level 2.5, provides 20 or more hours of weekly “clinically intensive programming” which is similar in scope to that described for intensive outpatient treatment.<sup>89</sup> When compared to intensive outpatient, partial hospitalization programs have increased capability to treat patients with unstable physical or psychiatric problems which require daily monitoring and management through direct access to psychiatric, hospital, and laboratory services.<sup>90</sup> Patients admitted to this level of care have a moderate risk of withdrawal, and either do not experience co-occurring biomedical complications and conditions, or these conditions are manageable.<sup>91</sup> Emotional, behavioral or cognitive complications and conditions may be moderate for these patients, and must be stabilized.<sup>92</sup> Patients admitted to partial hospitalization programs have “poor engagement in treatment,” are significantly ambivalent toward change, or “lack awareness of the substance use or mental health problem.”<sup>93</sup>

Settings vary for intensive outpatient and partial hospitalization programs, with some providing overnight housing for patients with problematic home environments or transportation needs.<sup>94</sup> However, this differs from residential rehabilitation in that the living environment is not necessarily supervised 24 hours per day.<sup>95</sup>

Intensive outpatient and partial hospitalization services are not defined in Massachusetts regulations, and are not licensed or funded by BSAS as a specific level of service. However, some providers in the state do offer these levels of service which are licensed under various regulatory sections depending on the specific program or services provided.

## RESIDENTIAL REHABILITATION

The Massachusetts Department of Public Health licenses four different types of residential rehabilitation service programs, including: adult individuals,<sup>96</sup> adults with their families,<sup>97</sup> adolescents,<sup>98</sup> and operating under the influence second offenders.<sup>99</sup> Each of these types offers “organized substance abuse treatment and education services” through structured and supportive programs in permanent, 24-hour residential facilities where clients reside temporarily to develop recovery skills in “safe and stable living environments.”<sup>100</sup>

Residential rehabilitation programs for adults are for patients “in the early stages of substance abuse recovery.”<sup>101</sup> These programs provide:

“(1) daily clinical services to improve residents’ ability to structure and organize the tasks of daily living and recovery, such as personal responsibility, personal appearance and punctuality; and (2) advocacy and ombudsman services to support residents in obtaining needed resources and services and actively promote residents’ interests.”<sup>102</sup>

In Massachusetts, there are four types of residential rehabilitation programs for adults. These include three types of programs that BSAS identifies as residential treatment over 30 days,<sup>103</sup> including Social Model Recovery Homes,<sup>104</sup> Recovery Homes,<sup>105</sup> Therapeutic Communities,<sup>106</sup> and Transitional Support Services,<sup>107</sup> a type of residential treatment under 30 days.<sup>108</sup>

According to ASAM, residential services are generally provided in community-based facilities to patients whose living/recovery environment is “dangerous,” but for whom recovery is possible with 24-hour structure and supervision.<sup>109</sup> Programs are geared to demonstrate to patients “aspects of a positive recovery environment,” and to help them to apply recovery, relapse, and coping skills while

promoting “personal responsibility and reintegration...into...work, education, and family life.”<sup>110</sup>

Designated as ASAM Level 3.1, or Clinically Managed Low-Intensity Residential Services, residential rehabilitation is “qualitatively different in that it is a 24-hour supportive living environment whereas the other sublevels<sup>111</sup> [CSS and ATS] are 24-hour treatment settings.”<sup>112</sup> Comparatively, ASAM-defined Level 3.1 programs provide at minimum only 5 hours of treatment per week.<sup>113</sup> Admitted patients have no or minimal withdrawal risk, and either no co-occurring biomedical conditions or complications, or they are receiving medical monitoring for stable conditions, such that on-site medical services are not required at this level of care.<sup>114</sup> According to ASAM criteria, patients admitted to residential rehabilitation most often have emotional, behavioral or cognitive conditions that are either absent, minimal or stabilized.<sup>115</sup> Treatment at this level of care may include psychoeducation, medication management, and individual, group, and/or family therapy.<sup>116</sup>

While no length of stay recommendation is made by ASAM for Level 3.1 residential treatment, guidelines state that stays “tend to be longer than in more intensive residential levels of care. Longer exposure to monitoring, supervision, and low-intensity treatment interventions is necessary for patients to practice basic living skills and to master the application of coping and recovery skills.”<sup>117</sup>

### Transitional Support Services

BSAS has designated TSS as ASAM Level 3.1. The programs are required to provide 24-hour services structured “to actively engage consumers in the day, afternoon, and evening” in a “daily schedule of mandatory and optional activities.”<sup>118</sup> These services must include “intensive case management, structured psycho-education, and recovery-oriented milieu management.”<sup>119,120</sup> Programs must also provide four hours of nursing services daily, as this type of treatment is more clinically focused than other types of residential rehabilitation; daily transportation services;<sup>121</sup> health monitoring, education and crisis services; and post-discharge referral and follow-up for other appropriate substance abuse treatment services.<sup>122</sup> Psycho-education sessions must be provided for a minimum of three hours daily on twenty-one different topics per week that relate to treatment options, in addition to any self-help, resident, or administrative meetings.<sup>123</sup>

Additionally, patients collaborate with a case manager to continue to develop and review an Individual Service Plan (ISP), which is “designed to facilitate consumer access to appropriate next step resources” that may include “residential rehabilitation services, supportive transitional and/or permanent housing programs, or community-based treatment and/or recovery options.”<sup>124</sup> The ISP also incorporates consumer service planning elements, including “assessment of physical and emotional status/needs, occupational, housing and educational needs; family, social and community supports; consideration of legal, child care, and custody issues; and the identification and removal of barriers to next step placement.”<sup>125</sup> According to BSAS, a patient completes a TSS stay when: they are stabilized in terms of their readiness to change, their potential for relapse, and their recovery/living environment;<sup>126</sup> barriers to subsequent care have been “eliminated or overcome”; the patient has met their immediate ISP goals; and a placement in aftercare is available.<sup>127</sup>

### CLINICAL STABILIZATION SERVICES

As described in a recent Request for Response (RFR) document prepared by BSAS:<sup>128</sup>

CSS services are designed to stabilize clients and increase their retention in treatment. CSS programs can include adults, who have completed a medical detoxification, as well as adults who do not meet criteria for medical detoxification but have other substance use disorders and other, current, related complications. The goal of the CSS is to provide the needed service interventions and program supports to enable clients to engage in a structured process and to plan and implement any services needed for a successful transition to the next level of substance use disorder treatment or other care, based on an assessment process tailored to each client. CSS services enable clients to focus on recovery, increase treatment acceptance and readiness to change, and identify skills and strategies to prevent continued use and/or to reduce risk of harm due to continued use... The CSS recovery oriented services and supports can help transition the client to

appropriate next step care in the substance use disorder treatment continuum.

Patients admitted to CSS, defined as Clinically Managed Detoxification by state licensing regulations, do not have severe withdrawal symptoms and are supervised for 24-hours per day in a “non-medical setting,” with at least four hours of daily nursing care, along with other services as described in Appendix C.<sup>129</sup> There are currently 12 providers managing 331 licensed adult beds in the state at this level of service.<sup>130</sup>

ASAM’s criteria outline counseling as the primary treatment at this level of care, which is designed to serve patients who “need safe and stable living environments in order to develop...sufficient recovery skills so that they do not immediately relapse or continue to use.... [CSS] assists individuals whose addiction is currently [such] that they need a 24-hour supportive treatment environment to initiate or continue a recovery process that has failed to progress.”<sup>131</sup> Patients admitted to this level of care are at minimal risk for severe withdrawal symptoms, and either have no or stable co-occurring biomedical conditions, or these are sufficiently monitored.<sup>132</sup> However, patient’s emotional, behavioral or cognitive conditions may demonstrate the patient’s “inability to control impulses, or [their] unstable and dangerous signs/symptoms require stabilization.”<sup>133</sup> The recovery/living environment may also be found to be dangerous, and the patient lacks the skills to prevent relapse outside of a “highly structured 24-hour setting.”<sup>134</sup>

The focus of the treatments offered through CSS is on a patient’s social, emotional, behavioral, cognitive, and living conditions.<sup>135</sup> ASAM further states that a patient’s “limitations require comprehensive, multifaceted treatment that can address all of the patient’s interrelated problems.”<sup>136</sup> For such patients, “standard rehabilitation methods are inadequate.”<sup>137</sup> Goals of CSS treatment include substance use abstinence, improvement of other addictive or antisocial behaviors, and creating positive change in other elements of patients’ “lifestyles, attitudes, and values.”<sup>138</sup> CSS is designed to foster and reinforce “prosocial” values and skill development in a supportive and stable living environment in order to ensure successful “reintegration into family living,” especially when a patient’s current living situation is not entirely supportive of recovery.<sup>139</sup>

According to interviews with several CSS providers throughout the state, depending on their insurance coverage, some privately-insured patients are currently admitted to this level of care as a “step-down” from more intensive detoxification treatments, or as a “step-up” when outpatient rehabilitation treatments prove inadequate to help patients achieve and sustain sobriety and abstinence.<sup>140</sup>

## ACUTE TREATMENT SERVICES

ATS are inpatient detoxification services spanning two different levels of care. The lower level of ATS, defined in state regulations as Medically Monitored Inpatient Detoxification Services, is provided in a freestanding medical (as opposed to hospital) setting and includes 24-hour nursing care and medical supervision, in addition to those services outlined in Appendix C.<sup>141</sup> Patients are admitted to this level of care when their health and well-being are at risk, and when withdrawal symptoms require medical monitoring.<sup>142</sup> Different from the Medically Managed level of ATS, physician care is not required 24-hours per day, but must be available as needed. There are currently 22 providers managing 750 licensed adult beds in the state at this level of service.<sup>143</sup>

According to ASAM, this level of care is appropriate “for patients whose subacute biomedical and emotional, behavioral, or cognitive problems are so severe that they require inpatient treatment, but who do not need the full resources of an acute care general hospital or a medically managed inpatient treatment program.”<sup>144</sup> Services are focused on withdrawal, co-occurring biomedical conditions, or emotional, behavioral, or cognitive complications.<sup>145</sup> Patients admitted to this level of care may have

poor impulse control and a low interest in treatment, may be “[u]nable to control use, with imminently dangerous consequences,” and their living/recovery environment may be dangerous.<sup>146</sup>

The higher level of ATS, defined by state licensing regulations as Medically Managed Intensive Inpatient Detoxification Services, is provided in an acute care hospital setting and includes daily physician medical management and nursing care 24 hours per day, in addition to the services outlined in Appendix C.<sup>147</sup> Patients are admitted when their health and well-being are at risk, and when withdrawal symptoms are severe enough to require “frequent medical attention.”<sup>148</sup> There are currently five providers managing 164 licensed adult beds in Massachusetts at this level of service.<sup>149,150</sup>

As Medically Managed Intensive Inpatient Services are delivered in an acute care hospital setting with all of its available resources, ASAM has defined it as an appropriate level of care “for patients whose acute biomedical, emotional, and cognitive problems are so severe that they require primary medical and nursing care.”<sup>151</sup> The patient’s readiness to change, relapse risk, and living environment are not considered as part of the criteria for entry to this level of service; rather, patients require 24 hour medical and nursing care for their biomedical and or psychiatric problems. According to ASAM, as the length of stay for these services “typically is sufficient only to stabilize the patient’s acute signs and symptoms, a primary focus...is case management and coordination...to continuing treatment at another level of care.”<sup>152</sup>

## APPENDIX B: PRINCIPLES OF EFFECTIVE TREATMENT

National Institute of Drug Abuse, National Institutes of Health, U.S. Department of Health and Human Services (NIDA). Principles of Drug Addiction Treatment: A Research-Based Guide, Third Edition. NIH Publication No. 12-4180.

1. Addiction is a complex but treatable disease that affects brain function and behavior.
2. No single treatment is appropriate for everyone.
3. Treatment needs to be readily available.
4. Effective treatment attends to multiple needs of the individual, not just his or her drug abuse.
5. Remaining in treatment for an adequate period of time is critical.
6. Behavioral therapies—including individual, family, or group counseling—are the most commonly used forms of drug abuse treatment.
7. Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.
8. An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs.
9. Many drug-addicted individuals also have other mental disorders.
10. Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug abuse.
11. Treatment does not need to be voluntary to be effective.
12. Drug use during treatment must be monitored continuously, as lapses during treatment do occur.
13. Treatment programs should test patients for the presence of HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases, as well as provide targeted risk-reduction counseling, linking patients to treatment if necessary.

## APPENDIX C: MINIMUM TREATMENT SERVICE REQUIREMENTS

Massachusetts Department of Health, Licensure of Substance Abuse Treatment Programs (105 CMR 164.074). Applicable to all licensees, in addition to services described for specific levels of service.

Provided directly by licensee:

- Substance abuse therapies, counseling, and education which conform to accepted standards of care
- Tobacco education and counseling
- Case management including referrals based on continuum of care and client educational, vocational, financial, legal, and housing needs
- Relapse prevention and recovery maintenance counseling and education
- Planning for client's completion of treatment provided by licensee, and identification of transitional, discharge, and aftercare supports the client may require

Provided directly by licensee or through Qualified Service Organization Agreement:

- HIV education and counseling
- TB screening, education, and treatment
- Mental health services, including psychopharmacological services, for individuals with co-occurring disorders
- Health services, including family planning services requested by the client
- Services for individuals with compulsive behaviors such as compulsive gambling

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## APPENDIX D: LIST OF STUDY ACRONYMS

ASAM:	American Society for Addiction Medicine
ATS:	Acute Treatment Services
BSAS:	Bureau of Substance Abuse Services
CHIA:	Center for Health Information and Analysis
CSS:	Clinical Stabilization Services
DSM:	Diagnostic and Statistical Manual of Mental Disorders
HIV:	Human Immunodeficiency Virus
ISP:	Individual Service Plan
MAT:	Medically Assisted Treatment
NIDA:	National Institute for Drug Abuse
PAWS:	Post-Acute Withdrawal Syndrome
RFR:	Request for Response
SAMHSA:	Substance Abuse and Mental Health Services Administration
SATP:	Substance Abuse Treatment Program
SB:	Senate Bill
SBIRT:	Screening, Brief Intervention, and Referral to Treatment
SUD:	Substance Use Disorder
TB:	Tuberculosis
TSS:	Transitional Support Services

## ENDNOTES

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 “Psychoactive substances are substances that, when taken in or administered into one’s system, affect mental processes, e.g. cognition or affect. This term and its equivalent, psychotropic drug, are the most neutral and descriptive term for the whole class of substances, licit and illicit, of interest to drug policy. ‘Psychoactive’ does not necessarily imply dependence-producing, and in common parlance, the term is often left unstated, as in ‘drug use’ or ‘substance abuse’.”
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- 70 *Op. cit. 105 CMR 164.200: Outpatient Services.*
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- 72 *Op. cit. 105 CMR 164.123(C): Outpatient Detoxification, Provision of Services, Treatment.*
- 73 *Op. cit. 105 CMR 164.221(A): Outpatient Counseling, Provision of Services, Admission.*
- 74 *Op. cit. 105 CMR 164.221(C): Outpatient Counseling, Provision of Services, Treatment.*
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- 79 *Op. cit. 105 CMR 164.232(A): Day Treatment, Provision of Services, Admission.*
- 80 *Op. cit. 105 CMR 164.232(C): Day Treatment, Provision of Services, Treatment.*
- 81 To be admitted, individuals must consent to treatment, and have been addicted for at least one year, or are pregnant, seeking opioid detoxification, or have been released from prison within the previous six months or discharged from opioid treatment within the past two years. *Op. cit. 105 CMR 164.302(A): Opioid Treatment, Provision of Services – All Opioid Treatment Programs, Admission.*
- 82 *Op. cit. 105 CMR 164.300: Opioid Treatment.*
- 83 *Op. cit. ASAM Criteria, Level of Care Placement.*
- 84 *Op. cit. The ASAM Criteria, Level 2.1.*
- 85 *Op. cit. The ASAM Criteria, Level 2.1, Therapies.*
- 86 *Op. cit. The ASAM Criteria, Level of Care Placement.*
- 87 *Op. cit. The ASAM Criteria, Level of Care Placement.*
- 88 *Op. cit. The ASAM Criteria, Level of Care Placement.*
- 89 *Op. cit. The ASAM Criteria, Level 2.5, Therapies.*
- 90 *Op. cit. The ASAM Criteria, Level 2.5.*
- 91 *Op. cit. The ASAM Criteria, Level of Care Placement.*
- 92 *Op. cit. The ASAM Criteria, Level of Care Placement.*

- <sup>93</sup> *Op. cit. The ASAM Criteria, Level of Care Placement.*
- <sup>94</sup> *Op. cit. The ASAM Criteria, Level 2.*
- <sup>95</sup> *Op. cit. The ASAM Criteria, Level 2.*
- <sup>96</sup> Admission to programs for individual adults is open to those age 18 and older who are “open to recovery and can understand relapse” but whose “home, community or social environment...is unsupportive of recovery or constitutes a risk to maintenance of abstinence.” (105 CMR 164.422) Daily clinical services are provided to “improve residents’ ability to structure and organize the tasks of daily living and recovery...” as well as advocacy and ombudsman services. (105 CMR 164.423) Four different models of treatment are included within programs for individual adults, including Transitional Support Services (105 CMR 164.423(B)), Social Model Recovery Homes (105 CMR 164.423(C)), Recovery Homes (105 CMR 164.423(D)) and Therapeutic Communities (105 CMR 164.423(E)). Transitional Support Services is the only model to require medical services, in that four hours of nursing services are available daily (105 CMR 164.423(B) and 164.424). Adult individual programs may also have approval to provide services to pregnant and post-partum women and infants.
- <sup>97</sup> Programs for adults with their families admit parents age 18 or older who are pregnant, have custody of at least one child, or for whom reunification is planned within 30 days of admission; further, the family must be homeless or living in an environment that constitutes a risk to abstinence or does not support recovery (105 CMR 164.432(A)). Services must include 24 hour a day crisis intervention, and treatment plans must in part address domestic violence, child welfare, parent-child relationships and family life (105 CMR 164.432(C)). Specific services must also be provided to children residing in the program (105 CMR 164.432(H)).
- <sup>98</sup> Residential Rehabilitation programs for Adolescents admit patients between 13 and 17 years old who do not require 24-hour daily nursing care, when consent for service is given by both patients and their parents; this level of care explicitly references patient placement criteria defined by ASAM for Clinically Managed Residential Treatment for adolescents (105 CMR 164.442(A)). Programs must provide developmentally appropriate services which include components focused on education as well as family involvement in treatment (105 CMR 164.442(E) and (F)).
- <sup>99</sup> Programs for Operating Under the Influence Second Offenders are provided to those referred by the court (105 CMR 164.452(A)). Structured for at least 14 consecutive days of programming, services are more strictly defined in the state regulations, including the type, number and length of individual and group counseling sessions, written curriculum and physical education (105 CMR 164.452(B) and (C)).
- <sup>100</sup> *Op. cit. 105 CMR 164.400: Residential Rehabilitation.*
- <sup>101</sup> *Op. cit. 105 CMR 164.421: Scope.*
- <sup>102</sup> *Op. cit. 105 CMR 164.432(A): Program Components.*
- <sup>103</sup> Massachusetts Department of Public Health, Bureau of Substance Abuse Services (DPH-BSAS): Substance Abuse Services Descriptions. Accessed 4 August 2015: <http://www.mass.gov/eohhs/gov/departments/dph/programs/substance-abuse/providers/substance-abuse-services.html#30days>.
- <sup>104</sup> *Op. cit. 105 CMR 164.423(C): Social Model Recovery Homes.*
- <sup>105</sup> *Op. cit. 105 CMR 164.423(D): Recovery Homes.*
- <sup>106</sup> *Op. cit. 105 CMR 164.423(E): Therapeutic Communities.*
- <sup>107</sup> *Op. cit. 105 CMR 164.423(B): Transitional Support Services.*
- <sup>108</sup> *Op. cit. DPH-BSAS: Substance Abuse Services Descriptions.*
- <sup>109</sup> *Op. cit. ASAM Criteria, Level of Care Placement.*
- <sup>110</sup> *Op. cit. ASAM Criteria, Level 3.*
- <sup>111</sup> Within Level 3, Residential/Inpatient (Non-acute care hospital) Services. *Op. cit. ASAM Criteria, Level 3.*
- <sup>112</sup> *Op. cit. ASAM Criteria, Level 3.*
- <sup>113</sup> *Op. cit. ASAM Criteria, Level 3.1.*
- <sup>114</sup> *Op. cit. ASAM Criteria, Level of Care Placement.*
- <sup>115</sup> *Op. cit. ASAM Criteria, Level of Care Placement.*
- <sup>116</sup> *Op. cit. ASAM Criteria, Level of Care Placement.*
- <sup>117</sup> Guidelines further state that although treatment is focused on re-integration into the community and a transition to a lower level of care, “[i]n some situations, there may initially be no effective substitute for residential secure placement and support as reliable protection from the toxic influences of substance exposure, problematic or substance-infested environments, or the cultures of substance-involved and antisocial behaviors.” *Op. cit. ASAM Criteria, Level 3.1.*
- <sup>118</sup> *Op. cit. MA-DPH BSAS: Substance Abuse Transitional Support Services (ASAM Level III.3). RFR 300221.*
- <sup>119</sup> *Op. cit. MA-DPH BSAS: Substance Abuse Transitional Support Services (ASAM Level III.3). RFR 300221.*
- <sup>120</sup> Milieu-Therapy Learning Center. What is Milieu-Therapy? Accessed 11 August 2015: <http://www.milieu-therapy.com/CommonQuestions.en.html>.

Milieu Therapy is a planned treatment environment in which everyday events and interactions are therapeutically designed for the purpose of enhancing social skills and building confidence. Academics are woven into the daily routine using an integrative and interactive approach that incorporates learning styles and areas of interest. The milieu, or “life space,” provides a safe environment that is rich with social opportunities and immediate feedback from...staff. The milieu is not static but, flexible and features normalizing and developmental perspectives that use common structures intended to be familiar to all...

- <sup>121</sup> *Op. cit. MA-DPH BSAS: Substance Abuse Transitional Support Services (ASAM Level III.3). RFR 300221.*  
 Transportation services are provided to “aftercare interviews, placements, resource visits, community-based self-help meetings, medical and psychiatric appointments, methadone dosing appointments and required court appearances.”
- <sup>122</sup> *Op. cit. 105 CMR 164.432(B): Program Components, Transitional Support Services.*
- <sup>123</sup> *Op. cit. MA-DPH BSAS: Substance Abuse Transitional Support Services (ASAM Level III.3). RFR 300221.*  
 Recommended topics include, but are not limited to: relapse prevention, health education (including HIV, STDs, Hep C and TB), medication assisted treatment options, housing and employment search, introduction to and understanding self-help programs, and staff or peer led discussion groups within the TSS program.
- <sup>124</sup> *Op. cit. MA-DPH BSAS: Substance Abuse Transitional Support Services (ASAM Level III.3). RFR 300221.*
- <sup>125</sup> *Op. cit. MA-DPH BSAS: Substance Abuse Transitional Support Services (ASAM Level III.3). RFR 300221.*
- <sup>126</sup> *Op. cit. The ASAM Criteria. Dimensions 4-6.*
- <sup>127</sup> *Op. cit. MA-DPH BSAS: Substance Abuse Transitional Support Services (ASAM Level III.3). RFR 300221.*
- <sup>128</sup> *Op. cit. MA-DPH BSAS: Clinical Stabilization Services – Franklin County. RFR 501123.*
- <sup>129</sup> *Op. cit. 105 CMR 164.133(A)(1)(c): Clinically Monitored Detoxification.*
- <sup>130</sup> Email correspondence, 8 July 2015, Quality Assurance and Licensing, Bureau of Substance Abuse Services, Massachusetts Department of Public Health (QAL, BSAS, MA-DPH). Bed counts as of July 2015.
- <sup>131</sup> *Op. cit. The ASAM Criteria, Level 3.5.*
- <sup>132</sup> *Op. cit. ASAM Criteria, Level of Care Placement.*
- <sup>133</sup> *Op. cit. ASAM Criteria, Level of Care Placement.*
- <sup>134</sup> *Op. cit. ASAM Criteria, Level of Care Placement.*
- <sup>135</sup> *Op. cit. The ASAM Criteria, Level 3.5.*
- <sup>136</sup> *Op. cit. The ASAM Criteria, Level 3.5.*
- <sup>137</sup> *Op. cit. The ASAM Criteria, Level 3.5.*
- <sup>138</sup> *Op. cit. The ASAM Criteria, Level 3.5.*
- <sup>139</sup> *Op. cit. The ASAM Criteria, Level 3.5.*
- <sup>140</sup> Phone interviews by Compass staff conducted July and August 2014 with Massachusetts provider staff from: AdCare, High Point Treatment Centers, Spectrum Health Systems.
- <sup>141</sup> *Op. cit. 105 CMR 164.133(A)(1)(b)1: Medically Monitored Inpatient Detoxification Services.*
- <sup>142</sup> *Op. cit. 105 CMR 164.133(A)(1)(b)2.*
- <sup>143</sup> *Op. cit. Email correspondence, 8 July 2015, QAL, BSAS, MA-DPH. Bed counts as of July 2015.*
- <sup>144</sup> *Op. cit. The ASAM Criteria, Level 3.7.*
- <sup>145</sup> *Op. cit. The ASAM Criteria, Level 3.7.*
- <sup>146</sup> *Op. cit. ASAM Criteria, Level of Care Placement.*
- <sup>147</sup> *Op. cit. 105 CMR 164.133(A)(1)(a)1: Medically Managed Intensive Inpatient Detoxification Services.*
- <sup>148</sup> *Op. cit. 105 CMR 164.133(A)(1)(a)2.*
- <sup>149</sup> *Op. cit. Email correspondence, 22 August 2014, QAL, BSAS, MA-DPH.*
- <sup>150</sup> ATS and CSS licensed beds are combined for adolescents in the state. Currently 2 providers manage 48 licensed beds. *Op. cit. Email correspondence, 22 August 2014, QAL, BSAS, MA-DPH.*
- <sup>151</sup> *Op. cit. The ASAM Criteria, Level 4.*
- <sup>152</sup> *Op. cit. The ASAM Criteria, Level 4.*







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**Actuarial Assessment of House Bill 3264  
Submitted to the 189<sup>th</sup> General Court:  
An Act relative to rehabilitation periods  
for substance abusers**

Prepared for  
Commonwealth of Massachusetts  
Center for Health Information and Analysis

March 2016

Prepared by  
Compass Health Analytics, Inc.



# Actuarial Assessment of House Bill 3264: “An Act relative to rehabilitation periods for substance abusers”

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# Actuarial Assessment of House Bill 3264: “An Act relative to rehabilitation periods for substance abusers”

## Executive Summary

Massachusetts House Bill 3264 (H.B. 3264), as drafted for the 189<sup>th</sup> General Court, would require commercial health insurance plans to cover medically-necessary acute treatment services (ATS) and clinical stabilization services (CSS) for up to a total of 30 days and prohibit plans from requiring preauthorization prior to obtaining such services.<sup>1</sup> This bill amends specified sections of Chapter 258 of the Acts of 2014, “An Act to increase opportunities for long-term substance abuse recovery.”<sup>2</sup>

Massachusetts General Laws (M.G.L.) c. 3 § 38C charges the Massachusetts Center for Health Information and Analysis (CHIA) with reviewing the potential impact of proposed mandated health care insurance benefits on premiums paid by businesses and consumers. CHIA has engaged Compass Health Analytics, Inc. to provide an actuarial estimate of the effect the proposed mandate would have on the cost of health care insurance in Massachusetts.

Assessing the impact of this bill on premiums entails analyzing its incremental effect on spending by insurance plans. This in turn requires comparing estimated spending under the provisions of the bill to spending for the relevant services under current statutes – particularly Chapter 258 – and current benefit plans.

### Background

H.B. 3264 amends selected sections of Chapter 258, effective October 1, 2015. Table ES1 summarizes the relevant provisions of Chapter 258 and the incremental effect of H.B. 3264.

**Table ES1:  
Chapter 258 Provisions and H.B. 3264 Proposed Incremental Changes**

<b>Chapter 258 Provisions</b>	<b>H.B. 3264 Incremental Changes</b>
Creates mandatory minimum coverage for 14 days for medically-necessary acute treatment and clinical stabilization services (ATS and CSS).	Increases minimum coverage for medically-necessary ATS and CSS to a total of 30 days.
Eliminates an insurer’s ability to terminate authorization through utilization review for the first 14 days of an ATS/CSS treatment episode.	Eliminates an insurer’s ability to terminate authorization through utilization review for the first 30 days of an ATS/CSS treatment episode.
Shifts the determination of medical necessity for ATS and CSS from the carrier to the provider.	No change.
Forbids carriers from requiring prior authorization for substance abuse treatment in general, including ATS, and CSS. <sup>3</sup>	No change.

### *Coverage before implementation of Chapter 258*

Until implementation of the relevant provisions of Chapter 258 in October 2015, commercial insurers in Massachusetts could require prior authorization for substance use disorder treatment services.<sup>4</sup> For patients who received prior authorization for treatment, insurers most often provided preliminary approval for a set number of treatment days. If a provider determined that treatment needed to extend beyond this initially-approved timeframe, the insurer could conduct a utilization review (UR) to determine if additional treatment was medically necessary. The insurer both defined the medical necessity criteria used and determined whether a patient met the criteria outlined for treatment.

### *Coverage under Chapter 258*

Chapter 258 shifts the balance of decision-making about treatment for various levels of substance abuse services from the insurer to the provider; under the new law, the provider determines into which level of service a patient is admitted without need for prior authorization from the insurer. For ATS and CSS specifically, the law goes further and transfers to the provider the ability to both define and determine the medical necessity of treatment for the first 14 days of a treatment episode.<sup>5</sup> This is a significant change, as the respective definitions of medical or treatment necessity held by commercial insurers and substance abuse treatment providers often differ. Note that because the relevant provisions of Chapter 258 were not effective until October 15, 2015, insufficient time has passed to gather data on their effects.

### Analysis

Analyzing the bill's impact on commercial fully-insured premiums requires isolating its effects from those of Chapter 258, the relevant provisions of which became effective October 1, 2015. H.B. 3264 will increase premiums if it increases carrier net reimbursements for ATS and CSS bed-days and related substance abuse services.

The actuarial assessment of Chapter 258 published by CHIA estimated the effect on premiums of the 14-day minimum coverage requirement for ATS and CSS.<sup>6</sup> It stated that CSS utilization is constrained by projected bed capacity throughout the five-year projection period of the analysis. With CSS beds expected to be at capacity through the period even with planned bed expansions, any increase in average length of stay per patient would be offset by fewer patients being served,<sup>i</sup> with no net increase in total bed-days provided. Therefore the proposed mandate would generate no increase in insurer medical expense beyond those generated by Chapter 258.

For H.B. 3264 to result in significant cost, assuming utilization levels in the scenarios of the Chapter 258 study, CSS bed capacity would have to increase by 170 percent over the estimate in the Chapter 258 analysis, which was already set at levels higher than BSAS has indicated they expect to increase bed capacity. With this far larger increase, capacity would meet demand, and only with additional increases beyond that level could longer lengths of stay increase costs (as long as demand exceeds

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<sup>i</sup> ATS programs are not assumed to be constrained in the Chapter 258 analysis, but lengths of ATS stays do not contribute significantly to this analysis.

supply longer lengths of stay result in fewer admissions with no change in bed days). At the time of the Chapter 258 analysis, CSS bed capacity was 297; BSAS currently reports that an additional 32 beds have come on line and it anticipates up to 250 more, resulting in an expected increase of 282 beds. In the Chapter 258 study, an increase of 384 beds was assumed by 2019, the end of the projection period. At that level, capacity would not meet demand, and so H.B. 3264's requirements would not have an incremental effect on utilization, and wouldn't until about 637 beds were added. Chart 1 illustrates the comparison of actual historical CSS bed capacity, BSAS's anticipated expanded bed capacity, CSS projected expanded capacity at the end of the 5-year projection period in the Chapter 258 analysis, and estimated capacity at which supply meets demand. For H.B. 3264 to result in any cost, the number of CSS beds would need to grow by more than 637. Even if this analysis assumed very large capacity increases, an unrealistic scenario, the potential increase in premiums would be small, under 0.1 percent.

### Summary results

The estimate of the incremental effect of H.B. 3264 on average commercial fully-insured premiums over the time period 2016 to 2020 is insignificant and assumed to be zero.

## Executive Summary Endnotes

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<sup>1</sup> The 189<sup>th</sup> General Court of the Commonwealth of Massachusetts, House Bill 3264, “An Act relative to rehabilitation periods for substance abusers”. Accessed 16 July 2015: <https://malegislature.gov/Bills/189/House/H3264>.

<sup>2</sup> Chapter 258 of the Acts of 2014, “An Act to Increase Opportunities for Long-Term Substance Abuse Recovery.” Accessed 16 July 2015: <https://malegislature.gov/Laws/SessionLaws/Acts/2014/Chapter258>. Specific amendments to Sections 9, 19, 21, 23, 25 and 27.

<sup>3</sup> *Op. cit.* Chapter 258 of the Acts of 2014; Sections 9, 19, 21, 23, 25 and 27.

<sup>4</sup> Phone interviews by Compass staff conducted July and August 2014 with Massachusetts provider staff from: AdCare, High Point Treatment Centers, Spectrum Health Systems.

<sup>5</sup> Preliminary interpretation of the law might suggest that provider-defined criteria will be used for determining medical necessity of stays for ATS and/or CSS through the first 14 days of treatment, presuming that the criteria have been formally published and/or adopted by a relevant professional organization such as ASAM. After 14 days of treatment, insurers may define and determine the medical necessity of a continuing stay. Moreover, for levels of service other than ATS or CSS, the definition and determination of the medical necessity of substance abuse treatment remains with the insurer (as defined by contract/policy terms).

<sup>6</sup> Massachusetts Center for Health Information and Analysis. “Mandated Benefit Review of Chapter 258 of the Acts of 2014: An Act to increase opportunities for long-term substance abuse recovery. Actuarial Assessment: ATS/CSS/SAT.” Published December 2014: <http://www.chiamass.gov/assets/Uploads/Substance-Abuse-Mandates-Chapter-258-of-the-Acts-of-2014.pdf>: 13.

# Actuarial Assessment of House 3264: “An Act relative to rehabilitation periods for substance abusers”

## 1. Introduction

Massachusetts House Bill 3264 (H.B. 3264),<sup>1</sup> as drafted for the 189<sup>th</sup> General Court, would require commercial health insurance plans to cover medically-necessary acute treatment services (ATS) and clinical stabilization services (CSS) for up to a total of 30 days and prohibits plans from requiring preauthorization prior to obtaining such services. This bill amends specified sections of Chapter 258 of the Acts of 2014, “An Act to increase opportunities for long-term substance abuse recovery.”<sup>2</sup>

Massachusetts General Laws (M.G.L.) c. 3 § 38C charges the Massachusetts Center for Health Information and Analysis (CHIA) with reviewing the potential impact of proposed mandated health care insurance benefits on premiums paid by businesses and consumers. CHIA has engaged Compass Health Analytics, Inc. to provide an actuarial estimate of the effect the proposed law would have on the cost of health care insurance in Massachusetts.

Assessing the impact of this proposed mandate on premiums entails analyzing its incremental effect on spending by insurance plans. This in turn requires comparing spending under the provisions of the bill to spending for the relevant services under current statutes – particularly Chapter 258 – and current benefit plans.

Section 2 of this analysis outlines the provisions of the bill. Section 3 summarizes the analysis and discusses important considerations in translating the bill’s language into its incremental impact on health care costs. Section 4 summarizes the results.

## 2. Interpretation of House Bill 3264

The following subsections describe the provisions of H.B. 3264.

### 2.1. Plans affected by the proposed mandate

H.B. 3264 would amend Chapter 258 which addresses the following types of health insurance plans:

- Insurance for persons in service of the Commonwealth (amending M.G.L. c. 32A, § 17N, as established by Chapter 258 of the Acts of 2014)
- Accident and sickness insurance policies (amending M.G.L. c. 175, § 47GG, as established by Chapter 258)
- Contracts with non-profit hospital service corporations (amending M.G.L. c. 176A, § 8II, as established by Chapter 258)

- Certificates under medical service agreements (amending M.G.L. c. 176B, § 4II, as established by Chapter 258)
- Health maintenance contracts (amending M.G.L. 176G, § 4AA, as established by Chapter 258)

The bill requires coverage for members under the relevant plans, regardless of whether they reside within the Commonwealth or merely have their principal place of employment in the Commonwealth.

Self-insured plans, except for those managed by the Group Insurance Commission (GIC), are not subject to state-level health insurance benefit mandates. State mandates do not apply to Medicare or Medicare Advantage plans, the benefits of which are qualified by Medicare. This analysis assumes that this mandate does not affect Medicare extension/supplement plans even to the extent they are regulated by state law. Finally, this analysis does not apply to Medicaid/MassHealth.

The proposed mandate applies to fully-insured commercial insurance policies and self-insured plans operated for state and local employees by the GIC. The relevant provisions of H.B. 3264 are assumed to be effective for policies issued or renewed on or after January 1, 2016.

## 2.2. Covered services

H.B. 3264 amends selected sections of Chapter 258, effective October 1, 2015. Table 1 summarizes the relevant provisions of Chapter 258 and the incremental effect of H.B. 3264.

**Table 1:  
Chapter 258 Provisions and H.B. 3264 Proposed Incremental Changes**

<b>Chapter 258 Provisions</b>	<b>H.B. 3264 Incremental Changes</b>
Creates mandatory minimum coverage for 14 days for medically-necessary acute treatment and clinical stabilization services (ATS and CSS).	Increases minimum coverage for medically-necessary ATS and CSS to a total of 30 days.
Eliminates an insurer’s ability to terminate authorization through utilization review for the first 14 days of an ATS/CSS treatment episode.	Eliminates an insurer’s ability to terminate authorization through utilization review for the first 30 days of an ATS/CSS treatment episode.
Shifts the determination of medical necessity for ATS and CSS from the carrier to the provider.	No change.
Forbids carriers from requiring prior authorization for substance abuse treatment in general, including ATS, and CSS. <sup>3</sup>	No change.

## 2.3. Carrier coverage

### Coverage requirements introduced by Chapter 258

Before implementation of Chapter 258 in October 2015, private insurers in Massachusetts could require prior authorization for substance abuse services, including ATS and CSS, under most circumstances.<sup>4</sup> Chapter 258 requires mandatory minimum coverage for 14 days for medically-necessary ATS and CSS, and eliminates an insurer's ability to terminate authorization through utilization review for the first 14 days of an ATS/CSS treatment episode. It enables providers to control initial access to specified substance abuse services and limits the ability of insurers to impose prior authorization requirements or medical necessity criteria.

Until implementation of Chapter 258, for patients who receive prior authorization for treatment or admission, insurers most often provided preliminary approval for a set number of treatment days. If a provider determined that treatment needed to extend beyond this initially-approved timeframe, the insurer could conduct a utilization review (UR) to determine if a longer stay or additional treatment was medically necessary. The insurer both defined the medical necessity criteria used and determined whether a patient met the criteria outlined for a longer stay or treatment.

Chapter 258 shifts the balance of decision-making about approval for various levels of substance abuse services from the insurer to the provider; under the new law, the provider determines into which level of service a patient is admitted without need for prior authorization from the insurer. For ATS/CSS services specifically, the law goes further and transfers to the provider the ability to both define and determine the medical necessity of treatment for the first 14 days of a patient's treatment episode.<sup>5</sup> This is a significant change, as the respective definitions of medical or treatment necessity held by commercial insurers and substance abuse treatment providers are generally different. Note that because the relevant provisions of Chapter 258 were not effective until October 15, 2015, insufficient time has passed to gather data on their effects.

A more detailed explanation of the relevant provisions of Chapter 258 can be found in CHIA's "Mandated Benefit Review of Chapter 258 of the Acts of 2014: An Act to increase opportunities for long-term substance abuse recovery."<sup>6</sup>

### Coverage requirements in H.B. 3264

H.B. 3264's provisions would modify commercial health insurance coverage by expanding the number of days for which commercial plans must cover medically-necessary ATS and CSS from a total of 14 days to a total of 30 days. Note this analysis assumes the insurer is prohibited from applying its medical necessity determination for 30 days, but after that it may do so. Chapter 258 and H.B. 3264 also allow the insurer to initiate utilization review after seven days, which presumably allows the insurer to review the patient's progress in treatment.

## 2.4. Existing laws affecting the cost of H.B. 3264

To the extent existing laws require insurers to cover the services required by H.B. 3264, the incremental cost of the bill is reduced, since insurers would have to cover the services anyway. This analysis has uncovered no current Massachusetts or federal insurance mandates specifically addressing minimum coverage requirements for ATS and/or CSS.

The Massachusetts mental health parity statutes<sup>7</sup> require insurers to cover biologically-based mental disorders, including substance abuse disorders, on a “non-discriminatory basis,” meaning a benefit plan may not impose any annual or lifetime dollar or unit of service limitation (cap) on coverage for diagnosis and treatment of mental disorders which is less than any cap on coverage for the diagnosis and treatment of physical conditions. These statutes would, therefore, prohibit caps on coverage for ATS and or CSS, but do not require, as would H.B. 3264, minimum coverage.

## 3. Analysis

### 3.1. Effect of minimum coverage on average length of stay

As described above, H.B. 3264 increases from 14 to 30 the number of days for which carriers must cover medically-necessary ATS and CSS and prohibits them from denying authorization for those services based on utilization review.<sup>i</sup> Analyzing the bill’s impact on commercial fully-insured premiums requires isolating its effects from those of Chapter 258, the relevant provisions of which became effective October 1, 2015. H.B. 3264 will increase premiums if it increases carrier net reimbursements for ATS and CSS bed-days and related substance abuse services.

The actuarial assessment of Chapter 258 published by CHIA estimated the effect on premiums of the 14-day minimum coverage requirement for ATS and CSS.<sup>8</sup> It stated that CSS utilization is constrained by projected bed capacity throughout the five-year projection period of the analysis, even at the assumed growth levels for CSS capacity. With CSS beds expected to be at capacity through the period, any increase in average length of stay per patient (ALOS) would be offset by fewer patients being served.<sup>ii</sup> That is, when all available beds are in use, an increase in ALOS will necessarily result in fewer patients being served, with no net increase in total bed-days provided. Therefore the proposed mandate would generate no increase in insurer medical expense beyond those generated by Chapter 258.

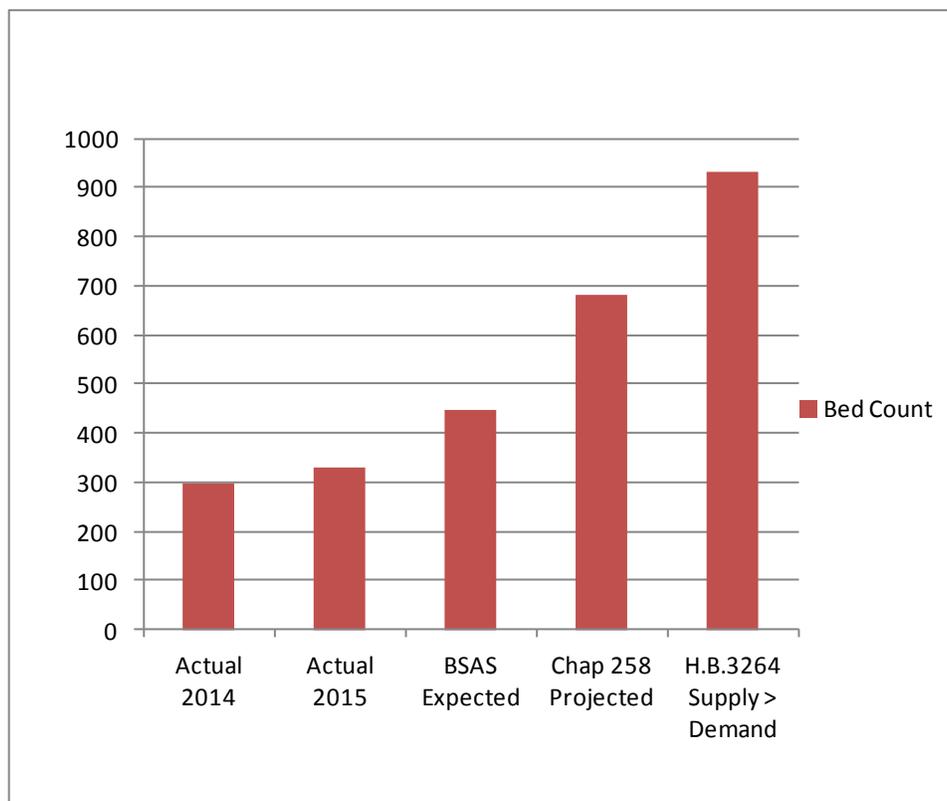
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<sup>i</sup> Concurrent review by the carrier of a case can begin after day 7, but no denial of authorization can occur until after 30 days.

<sup>ii</sup> ATS programs are not assumed to be constrained in the Chapter 258 analysis. However, given the typical length of stay for an ATS episode (four days, according to BSAS) and its clinical content, a reasonable projected increase in ALOS for ATS would not impinge upon the Chapter 258 14-day minimum coverage requirement, and thus would not be an incremental impact of H.B. 3264.

For H.B. 3264 to result in significant cost, assuming utilization levels in the scenarios of the Chapter 258 study, CSS bed capacity would have to increase by 170 percent over the estimate in the Chapter 258 study, CSS bed capacity would have to increase by 170 percent over the estimate in the Chapter 258 analysis, which was already set at levels higher than BSAS has indicated they expect to increase bed capacity. With this far larger increase, capacity would meet demand, and only with additional increases beyond that level could longer lengths of stay increase costs (as long as demand exceeds supply longer lengths of stay result in fewer admissions with no change in bed days). At the time of the Chapter 258 analysis, CSS bed capacity was 297; BSAS currently reports that an additional 32 beds have come on line and it anticipates up to 250 more, resulting in an expected increase of 282 beds. In the Chapter 258 study, an increase of 384 beds was assumed by 2019, the end of the projection period. At that level, capacity would not meet demand, and so H.B. 3264’s requirements would not have an incremental effect on utilization, and wouldn’t until about 637 beds were added. Chart 1 illustrates the comparison of actual historical CSS bed capacity, BSAS’s anticipated expanded bed capacity, CSS projected expanded capacity at the end of the 5-year projection period in the Chapter 258 analysis, and estimated capacity at which supply meets demand. For H.B. 3264 to result in any cost, the number of CSS beds would need to grow by more than 637. Even if this analysis assumed very large capacity increases, an unrealistic scenario, the potential increase in premiums would be small, under 0.1 percent.

**Chart 1:  
CSS Bed Capacity**



### 3.2. Data sources

The primary data sources used in the analysis were:

- Information from clinical providers and billing staff
- Information from a survey of private health insurance carriers in Massachusetts
- Utilization information for BSAS-licensed ATS and CSS providers including the number of admissions and the average length of stay, and other information provided by BSAS
- Academic literature, published reports, and population data cited as appropriate
- Massachusetts insurer claim data from CHIA's Massachusetts APCD for calendar year 2012, for plans covering the under-65 fully-insured and self-insured populations

## 4. Results

Based on the foregoing analysis, the incremental effect of H.B. 3264 on average commercial fully-insured medical expense and premiums over the time period 2016 to 2020 is estimated to be insignificant and assumed to be zero.

Note that while the effect on the average fully-insured member is immaterial, the impact of the proposed legislation on any one carrier may be sufficiently large as a proportion of that carrier's premiums to be noticeable, depending on its current benefit offering and the health characteristics of its insured membership.

The proposed mandate would apply to fully-insured and self-insured plans operated for state and local employees by the Group Insurance Commission (GIC). Because the benefit offerings of GIC plans are similar to most other commercial plans in Massachusetts, the effect of the proposed mandate on GIC medical expense is estimated to be insignificant.

## Endnotes

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<sup>1</sup> The 189<sup>th</sup> General Court of the Commonwealth of Massachusetts, House Bill 3264, “An Act relative to rehabilitation periods for substance abusers”. Accessed 16 July 2015: <https://malegislature.gov/Bills/189/House/H3264>.

<sup>2</sup> Chapter 258 of the Acts of 2014, “An Act to Increase Opportunities for Long-Term Substance Abuse Recovery.” Accessed 16 July 2015: <https://malegislature.gov/Laws/SessionLaws/Acts/2014/Chapter258>. Specific amendments to Sections 9, 19, 21, 23, 25 and 27.

<sup>3</sup> *Op. cit.* Chapter 258 of the Acts of 2014; Sections 9, 19, 21, 23, 25 and 27.

<sup>4</sup> Phone interviews by Compass staff conducted July and August 2014 with Massachusetts provider staff from: AdCare, High Point Treatment Centers, Spectrum Health Systems.

<sup>5</sup> Preliminary interpretation of the law might suggest that provider-defined criteria will be used for determining medical necessity of stays for ATS and/or CSS through the first 14 days of treatment, presuming that the criteria have been formally published and/or adopted by a relevant professional organization such as ASAM. After 14 days of treatment, insurers may define and determine the medical necessity of a continuing stay. Moreover, for levels of service other than ATS or CSS, the definition and determination of the medical necessity of substance abuse treatment remains with the insurer (as defined by contract/policy terms).

<sup>6</sup> Massachusetts Center for Health Information and Analysis. “Mandated Benefit Review of Chapter 258 of the Acts of 2014: An Act to increase opportunities for long-term substance abuse recovery.” Published December 2014: <http://www.chiamass.gov/assets/Uploads/Substance-Abuse-Mandates-Chapter-258-of-the-Acts-of-2014.pdf>.

<sup>7</sup> M.G.L. c.32A §22, c.175 §47B, c.176A §8A, c.176B §4A, c.176G §4M.

<sup>8</sup> Massachusetts Center for Health Information and Analysis. “Mandated Benefit Review of Chapter 258 of the Acts of 2014: An Act to increase opportunities for long-term substance abuse recovery. Actuarial Assessment: ATS/CSS/SAT.” Published December 2014: <http://www.chiamass.gov/assets/Uploads/Substance-Abuse-Mandates-Chapter-258-of-the-Acts-of-2014.pdf>: 13.