

34 Days and Counting

WAITS FOR SUD TREATMENT
LENGTHEN DUE TO
WORKFORCE CRISIS

MAY 2023

ISSUE BRIEF



ABH

ASSOCIATION
FOR BEHAVIORAL
HEALTHCARE

RESPONDENTS

55 surveys received from **25** provider organizations reporting data from **103** licensed programs across all regions of Massachusetts.

WHO WE ARE

The Association for Behavioral Healthcare (ABH) is a statewide association of 80 community-based mental health and substance use disorder treatment provider organizations. Our member organizations are the Commonwealth's safety net for behavioral healthcare services. ABH members operate Department of Public Health-licensed substance use treatment programs and deliver services at 171 licensed sites across the state.

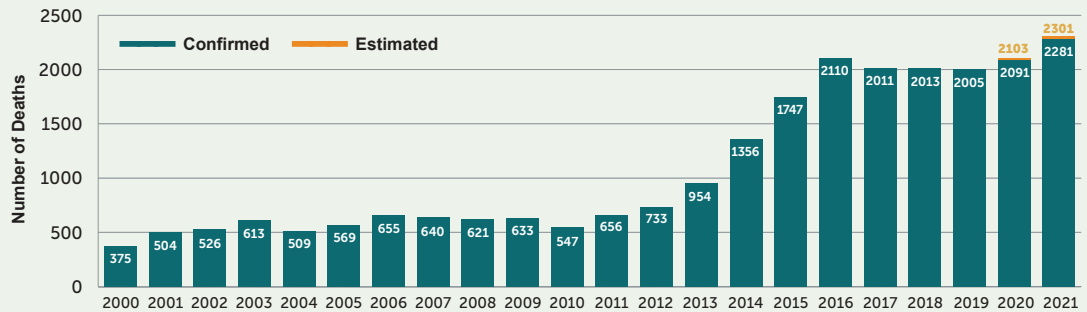
1. Current Opioid Statistics, Massachusetts Department of Public Health. December 2022.

Introduction

Substance use disorders (SUDs) are both preventable and treatable, and there is a range of evidence-based and effective treatment options available. Access to appropriate SUD treatment and care has taken on additional urgency, as Massachusetts continues to experience unprecedented fatal overdose rates. In 2021, an estimated 2,301 Commonwealth residents died due to an opioid-related overdose, the highest level ever recorded and a 9% increase from 2020 (Figure 1).¹

Fast, easy, and ongoing access to harm reduction, substance use disorder treatment, and recovery supports keeps people alive and decreases fatal overdoses. Engagement in services can help people avoid costlier, higher levels of care, including inpatient stays and Emergency Department visits. More importantly, it helps people return to their homes, support systems, and employment. The type and frequency of care is determined by the nature and severity of a person's condition.

FIGURE 1
Opioid-Related Overdose Deaths, All Intent
MASSACHUSETTS RESIDENTS: 2000 - 2021



SURVEY BACKGROUND

Staffing challenges make it more difficult for individuals to access the care they need, when they need it. ABH surveyed our members to learn about the depth of their workforce challenges in April 2022. Information from respondents was supplemented and updated with publicly available data to give additional context to the issues facing the substance use disorder treatment care continuum.

SUMMARY

Our members organizations report difficulty recruiting and retaining staff due to inadequate compensation and benefits, resulting in large numbers of safety net treatment beds being unavailable to individual's seeking treatment and significant access challenges for Opioid Treatment Program (OTP) services.

ABH survey respondents reported a 24% total position vacancy rate across the substance use disorder treatment system. Master's-level clinicians and counselors experienced the highest turnover rate, for every 9.2 clinicians hired, 10 leave.

Staffing challenges permeate every level of substance use treatment care. In Acute Treatment Service (ATS) settings, almost half (46%) of staff have left over the 12 months preceding the survey. Clinical Stabilization Services (CSS) are experiencing a counselor vacancy rate of 33%, impacting the delivery of daily clinical programming. Residential Rehabilitation Services (RRS) have an average wait time of 34 days, with a quarter of respondents reporting that clients wait for 60 days or more for recovery services. In outpatient Opioid Treatment Programs (OTPs), 81% of nurses left their positions over 12 months, a critical workforce shortage that impacts OTP operations and the ability to dose methadone.

Overview of the Care Continuum

Massachusetts is home to a robust continuum of treatment and recovery services, although not everyone has access to the full continuum of care. This brief focuses on the following key components of the care continuum:

- » **LEVEL 3.7** **LEVEL 3.5** 24/7 substance use treatment in inpatient settings for withdrawal management;
- » **LEVEL 3.1** 24/7 substance use treatment in the community for rehabilitation; and
- » **LEVEL 1** Medications for Opioid Use Disorder delivered in outpatient settings via Opioid Treatment Programs.

Appropriate treatment for a substance use disorder (SUD) varies depending on the substance(s) used and the characteristics and preferences of an individual. There is no one treatment and recovery pathway appropriate for all individuals. It is important to note that individuals with moderate to severe substance use disorders often require ongoing care for effective treatment and may benefit from different levels of care at different points in their lives. Treatment decisions should be determined by the individual and their treating provider.



Substance Use Disorder Continuum of Care²

| | | |
|------------------|--|---|
| LEVEL 0.5 | PREVENTION/EARLY INTERVENTION SERVICES | |
| LEVEL 1 | OUTPATIENT SERVICES Includes methadone delivered in Opioid Treatment Programs (OTPs) | Covered by: MassHealth; Commercial payers; Medicare; Bureau of Substance Addiction Services (for uninsured and under-insured individuals) |
| LEVEL 2 | INTENSIVE OUTPATIENT AND PARTIAL HOSPITALIZATION SERVICES | |
| | Outpatient services provided at greater intensity/frequency than traditional counseling | Covered by: MassHealth; Commercial payers; Medicare; Bureau of Substance Addiction Services (for uninsured and under-insured individuals) |
| LEVEL 3.1 | RESIDENTIAL REHABILITATION SERVICES | |
| | 24/7 community-based, clinically-managed residential services | Covered by: MassHealth; Bureau of Substance Addiction Services (for uninsured and under-insured individuals) |
| LEVEL 3.3 | POPULATION SPECIFIC HIGH INTENSITY RESIDENTIAL SERVICES | |
| | This level of care does not currently exist in Massachusetts | |
| LEVEL 3.5 | CLINICAL STABILIZATION SERVICES | |
| | 24/7 care for post-acute withdrawal | Covered by: MassHealth; Commercial payers; Bureau of Substance Addiction Services (for uninsured and under-insured individuals) |
| LEVEL 3.7 | ACUTE TREATMENT SERVICES | |
| | 24/7 care including withdrawal management and stabilization | Covered by: MassHealth; Commercial payers; Bureau of Substance Addiction Services (for uninsured and under-insured individuals) |
| LEVEL 4.0 | LEVEL 4.0: INTENSIVE INPATIENT SERVICES | |
| | 24/7 care including withdrawal management and stabilization provided in a hospital setting | Covered by: MassHealth; Commercial payers; Medicare; Bureau of Substance Addiction Services (for uninsured and under-insured individuals) |

For individuals with SUD, Massachusetts is fortunate in that there is a robust treatment and recovery service system that generally coincides with the American Society of Addiction Medicine's (ASAM) continuum of care. ASAM utilizes numeric representations to demonstrate levels of care, from outpatient to intensive inpatient.

2. American Society of Addiction Medicine; The ASAM Criteria Third Edition; 2013.

GLOSSARY

SUD Substance Use Disorder.

OD Opioid Use Disorder.

MAT (Medication for Addiction Treatment): medications that are used to treat people with a substance use disorder.

MOUD (Medication for Opioid Use Disorder): a subset of MAT specifically to treat people with OUD, currently methadone, buprenorphine and naltrexone.

ASAM (American Society of Addiction Medicine): group of addiction treatment professionals who created the naming conventions for the levels of care available in MA and the criteria to determine what type(s) of treatment would meet a person's individual treatment needs.

BSAS (Bureau of Substance Addiction Services) MA State Authority responsible for licensing SUD treatment providers.

FDA (Food and Drug Administration): federal agency that approves medications for public use.

For Massachusetts residents, SUD treatment is paid for by private health care plans, Medicaid plans (MassHealth and its contracted managed care organizations), the Bureau of Substance Addiction Services (BSAS), and out of pocket, depending on the service. Due to the passage of Chapter 258 of the Acts of 2014, many Massachusetts health plans are required to cover up to 14 days of inpatient treatment.³

However, access to certain programs and services still varies depending on an individual's insurance coverage (Table 1). This includes access to medications, which are usually dispensed in combination with some form of behavioral therapy. Medications are a well-researched and highly effective treatment for substance use disorder. Medications are not available for all substance use disorders, such as stimulant use disorders. When medication is not available, treatment often consists of behavioral therapies tailored to the individual.

Access to medications for opioid use disorder (MOUD) varies based on type of medication and setting:



TABLE 1

Access to MOUD in Clinical Settings

| Medication | Dispensing/ Prescribing Requirements | Available in intensive inpatient settings? (Levels 4.0 and 3.7) | Available in other 24/7 programs? (Level 3.1-3.5) | Available in outpatient settings (physician's office, clinic, etc)? |
|----------------------|---|--|--|---|
| METHADONE | Can only be dispensed at a federally-approved and regulated location, referred to as an Opioid Treatment Program (OTP). | Can be used to manage withdrawal and to start maintenance. | Can be continued when they are already prescribed to an individual through take-homes and guest dosing arrangements with OTPs. | Only in federally-approved and regulated locations. |
| BUPRENORPHINE | Can be prescribed by a licensed prescriber. | Can be used to manage withdrawal and to start maintenance. | Can be continued when they are already prescribed to an individual. | Yes, can be prescribed. |
| NALTREXONE | Can be prescribed by a licensed prescriber to individuals who have completed detox. | Not usually; patient needs to be off all opioids for a period of time prior to receiving the medication. | Yes, can be prescribed. | Yes, can be prescribed. |

Adherence to any of the three FDA-approved medications for opioid use disorder (MOUD) – methadone, buprenorphine, and naltrexone – has been shown to be effective in reducing illicit opioid use, retaining individuals in treatment and reducing the risk of overdose death. It has also been demonstrated that MassHealth members receiving MOUD have lower cost of care and have lower rates of overdose as compared to individuals with an opioid use disorder who are not receiving medication.⁴ Yet, pervasive stigmatization of individuals with a substance use disorder and of MOUD as a treatment option have impacted prescribing and access to this life-saving intervention.

3. Ch. 258 of the Acts of 2014

4. <https://www.mass.gov/doc/medication-assisted-treatment-commission-report-10119/download>

Substance Use Disorder Treatment Safety Net

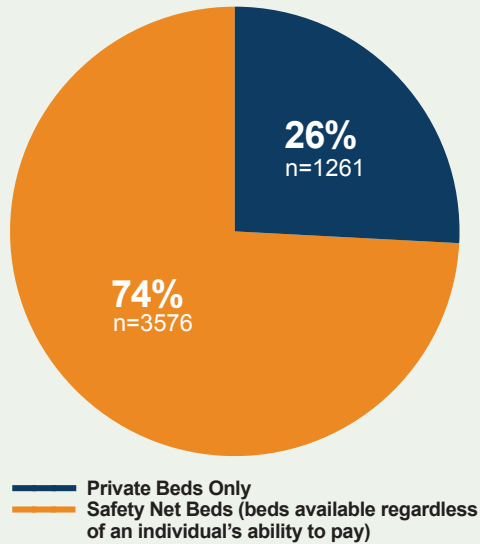


PATIENT PROFILE

Clients accessing safety net programs are often over the age of 30 (78%) with multiple prior admissions into treatment (59%), employment challenges (92%), and polysubstance use. The most common primary drugs of choice reported upon enrollment are heroin/fentanyl (64%) and alcohol (56%). The most common form of insurance coverage is Medicaid (85%).⁵

FIGURE 2

Treatment Beds Available by Insurance Type



The substance use disorder treatment safety net serves individuals regardless of their ability to pay. This includes individuals with MassHealth and those who are uninsured or underinsured.

For the purposes of this brief, ABH limited our scope to surveying members who deliver Level 3.1 (Residential Rehabilitation), 3.5 (Clinical Stabilization), 3.7 (Acute Treatment) services and who operate Opioid Treatment Programs.

Figure 2 shows the percent of treatment beds that are available in the safety net bedded system as compared to beds available to individuals with private insurance or who can pay out-of-pocket. ABH survey respondents represent 53% (2,276/4,319) of total Acute Treatment Services (3.7) and Clinical Stabilization Services (3.5) beds in the safety net.⁶

Substance Use Disorder Treatment Workforce

Our member organizations report large numbers of treatment beds offline and significant access challenges for Opioid Treatment Program (OTP) services. They also report that there is a disproportionate impact on services available to publicly insured individuals in contrast to individuals with commercial insurance or those who can afford to privately pay for care. This treatment access reduction is primarily due to a crisis in the ability to attract and retain prescribers, nurses, and counselors and is happening while fatal overdoses are at unprecedented levels.

For every **9.2** master's-level clinicians or counselors hired, **10** leave.



5. Bureau of Substance Addiction Services Provider Profile Reports Fiscal Year 2021.

6. Respondents of the survey represent 62% (412/665) of total ATS beds available in the safety net; 56% (388/691) of total CSS beds available in the safety net; and 53% (2,276/4,319) of total beds available in the safety net, at the time of the survey.

24% total position vacancy rate across the substance use disorder treatment system.

Across all client-facing positions that ABH surveyed, respondents reported a 24% total position vacancy rate across the substance use disorder treatment system (418 positions out of 1,713). Vacancies are experienced by nearly all programs, with 96% (53/55 respondents) reporting one or more client-facing staff vacancies. Providers additionally reported that it is taking longer to hire and fill vacancies than it has in the past; 44% of the time it took respondents more than six months to fill any vacant position.

The need for higher compensation and benefits was the most frequently cited reason for staff departures, and every respondent agreed or strongly agreed that additional reimbursement would help retain staff. Master’s-level clinicians and counselors experienced the highest turnover rate. For every 9.2 master’s-level clinicians or counselors hired, 10 leave (164 hired and 177 departed).

Hidden Safety Net Access Crisis for 24/7 Care

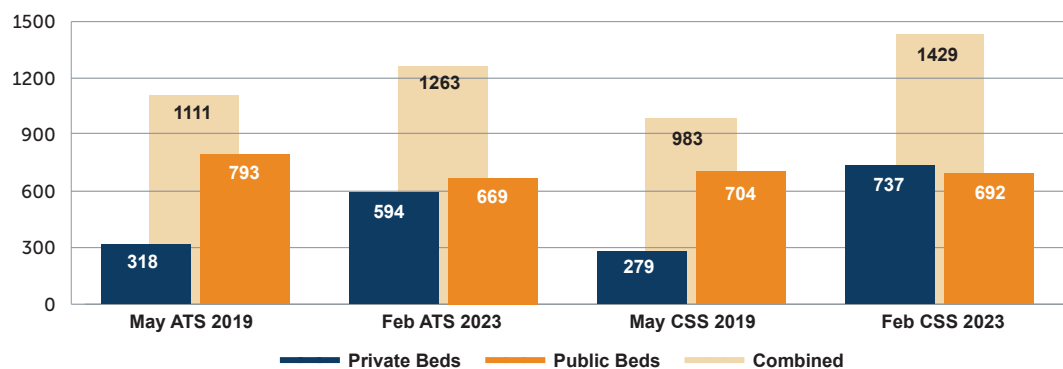
The Department of Public Health’s Bureau of Substance Addiction Services licenses substance use treatment programs, including 24/7 treatment services. The number of licensed beds is one indication of system capacity. Since 2019, 598 new Acute Treatment Services (Level 3.7) and Clinical Stabilization Services (Level 3.5) beds have opened.⁷

Since 2019, the number of licensed Acute Treatment Services beds have increased by 14%. However, in that time, the number of beds available to low-income or uninsured individuals has decreased by 15% (Figure 3). The growth in beds for individuals who are commercially insured or who can pay privately is obscuring the loss of beds for individuals covered by the safety net.

The number of Clinical Stabilization Services beds have expanded by 45% since 2019. However, the number of beds for individuals with commercial insurance or who can pay privately increased by 164%, while the number of beds available for individuals covered by the safety net decreased by 1.7% (Figure 3). This is worrisome given people covered by the safety net have more complex needs.

The number of (ATS) beds available to low-income or uninsured individuals has decreased by **15%**.

FIGURE 3
Public Bed Capacity Over Time



7. Licensing Data for programs from the Bureau of Substance Addiction Services

Substance Use Disorder Treatment Utilization

Licensed bed capacity (Figure 3) is only part of the picture, as operational capacity represents the actual number of beds that are available to an individual needing care. Available data from Feb 2023 shows that more than 140 licensed beds in Acute Treatment Services (ATS) and Crisis Stabilization Services (CSS) are temporarily unavailable, largely due to staffing issues (Figure 4). From February-May 2023 alone, an additional 189 ATS and CSS beds have closed either temporarily or permanently.⁸

FIGURE 4
Licensed vs Operational Capacity Per Respondents

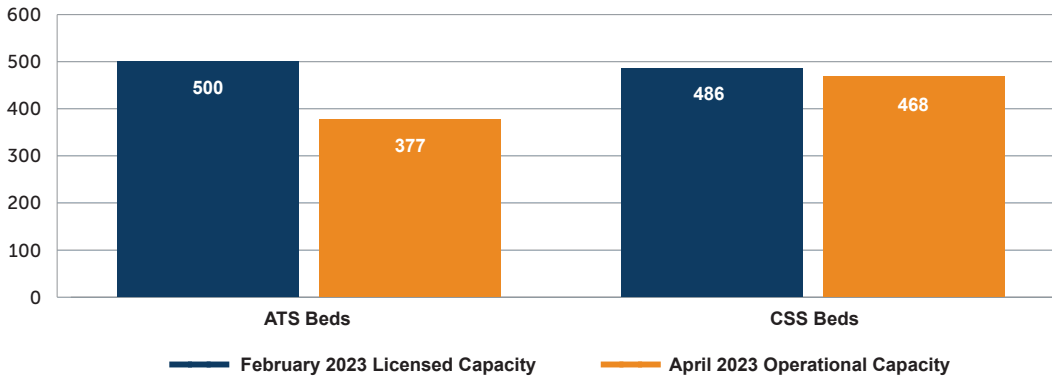
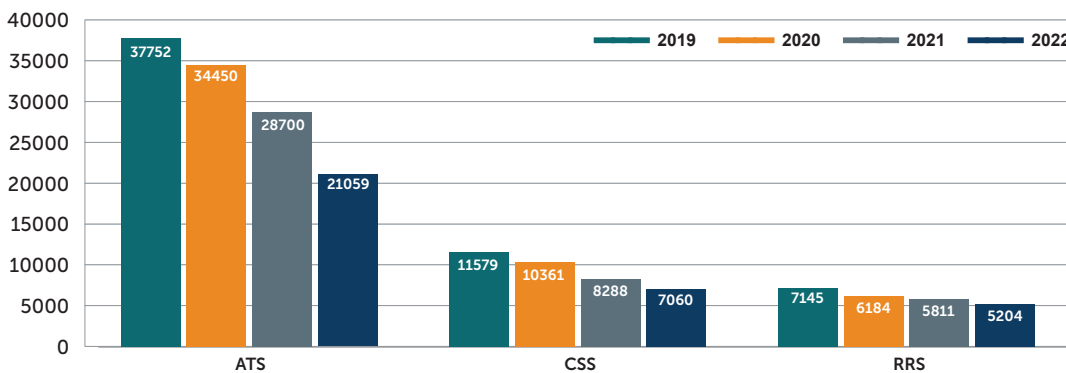


Figure 4. Operating capacity is based on the number of beds that are available to an individual needing care.

As capacity in the entire SUD safety net system has declined, so has utilization of ATS, CSS, and Residential Rehabilitation Service (RRS) beds (Figure 5). Since the onset of the public health emergency, the number of enrollments in ATS, CSS, and RRS beds have steadily declined.

FIGURE 5
Admissions to ATS, CSS, and RRS



From 2019 to 2022, there were 44% fewer ATS admissions (16,693 fewer admissions), 39% fewer CSS admissions (4519 fewer admissions), and 27% fewer RRS admissions (1941 fewer admissions) than prior to the public health emergency.

8. Licensing Data for programs from the Bureau of Substance Addiction Services; The TSS level of care is not included in these analyses. In 2019, there were 10 licensed TSS programs with 382 beds. As of August 1, 2022, there were only 7 programs with 243 beds – a loss of 3 programs and 139 beds.

LEVEL 3.7

Acute Treatment Services (ATS)

SURVEY RESPONDENTS: 6 providers completed surveys representing **10/26** licensed program locations

“The need for individual observation with patient care has increased due to their symptoms presented. We do not have enough staff to provide this. We do not have treatment centers that we can refer them to for appropriate care. ATS has turned into a triage center, which is great, if we have the staff to function in that manner.”

“We need more candidates qualified to address and work in this level of care that are paid appropriately. Expectations from the state need to be more realistic so we can actually provide care.”

BACKGROUND

Many, but not all, individuals who are seeking to recover begin treatment in an Acute Treatment Services program, commonly referred to as “Detox”. ATS is a 24/7, medically-focused treatment model that is designed to safely manage and stabilize symptoms related to acute withdrawal from substances, and offer psychotherapeutic interventions and comprehensive discharge planning. Acute Treatment Services can start individuals onto medications for opioid use disorder (MOUD). The average length of stay in ATS is five days.⁹

WORKFORCE CHALLENGES IN ACUTE TREATMENT SERVICES

Acute Treatment Service programs report significant staff vacancy rates. The overall position vacancy rate is 35% (98 vacant/283 required staff). Almost as many staff left ATS as were hired over the course of 12 months, with 139 staff hired but 129 staff departing. Across 12 months, 46% of all ATS staff have (129 staff departed/283 required).

NURSING

Acute Treatment Services rely extensively on nurses. Registered nurses (RNs) conduct admission assessments, physicals, approve discharges, monitor withdrawal symptoms, conduct medication reconciliations, and supervise Licensed Practical Nurses (LPNs). Under the direction of an RN or physician, an LPN can monitor vital signs, dispense medications, execute the nursing care plan, monitor patient progress and assist with admissions and discharges.

ATS providers report difficulty in retaining and recruiting nursing staff:

- » RN position **vacancy rate is 34%** (20.2 vacant/59.2 required);
- » LPN position **vacancy rate is 74%** (23 vacant/31 required);
- » Combined RN/LPN position **vacancy rate is 48%** (43 vacant/90 required); and
- » **58% of RN/LPNs have left their positions** across 12 months (52 RN/LPNs left their positions/90 required).

With nearly half of all nursing positions vacant, programs are forced to admit fewer patients, and when they do admit patients, those admissions may take additional time to complete. As providers turn to temporary nursing services, nurses may be less familiar with withdrawal management protocols and need additional supervision.

RECOVERY SPECIALISTS

Recovery Specialists are the front-line caregivers in ATS programs and provide critical support to the nursing staff. They work to ensure that the treatment environment is safe and responsive to patients' needs and conduct routine health and safety checks. They are available 24/7 and are often the first staff on scene in the event of a behavioral or medical crisis in the program.

ATS programs are also struggling to hire and retain Recovery Specialists.

- » Recovery Specialist position **vacancy rate is 32%** (30.4 vacant/95.6 required); and
- » **49% of Recovery Specialists** have left over 12 months (47 departed/95.6 required).

9. Bureau of Substance Addiction Services Provider Profile Reports Fiscal Year 2021.

SURVEY RESPONDENTS: 6 completed surveys representative of **10/37** licensed program locations

BACKGROUND

After acute withdrawal in Acute Treatment Services (ATS), many individuals step down to Clinical Stabilization Services for further care. Some individuals begin their recovery here. This 24/7 treatment service is designed to manage post-acute withdrawal symptoms. This service provides individual and group counseling; psychoeducational groups regarding addiction; case management and aftercare planning. Individuals here are also introduced to community-based recovery supports. The average length of stay in Clinical Stabilization Services is 13 days.¹⁰

WORKFORCE CHALLENGES IN CLINICAL STABILIZATION SERVICES

- » Overall position **vacancy rate is 23%** (58 vacant/254 required); and
- » **34% of all staff** left over 12 months (87 departed/254 required).

COUNSELING

The intensive treatment program provided at the CSS incorporates a robust educational and therapeutic group schedule facilitated by counseling staff that focuses on helping the patient develop and apply recovery skills; learn about available treatment options; and develop coping skills and relapse prevention strategies. Counselor vacancies impact the delivery of daily clinical programming by skilled group facilitators.

CSS programs are experiencing vacancies among counselor positions:

- » Counselor position **vacancy rate is 33%** (19 vacant/57 required).

“

Clients have increased medical and psychiatric conditions.

”

“

Agency staff is being used to fill gaps causing the program to not run as it should [“agency staff” refers to temporary and relief staff provided through an external employment agency].

”

“

Staff leaving has created additional hours and duties for other staff.

”

10. Bureau of Substance Addiction Services Provider Profile Reports Fiscal Year 2021.

LEVEL

3.1 Residential Rehabilitation Services

SURVEY RESPONDENTS: 31 completed surveys Representative of **59/120** licensed program locations

“Staff turnover results in loss of organization knowledge, increased training costs, overtime and temporary staffing agency cost to cover shifts to meet requires ratios, and increased cost of administrative oversight. More effort and resources are required to meet the basic which diverts time and other resources from actives that improve services such as implementing new techniques and quality assurance activities.”

“It has been very difficult with staff turnover, at one point there was more vacancies than staff in the program.”

BACKGROUND

Residential Rehabilitation Services (RRS) are clinically-managed residential services that provide a supervised environment to assist patients to fully stabilize in recovery by helping individuals practice recovery skills, relapse prevention and emotional coping strategies in a homelike community-based living environment to promote personal responsibility and reintegration into work, education and family life.

The average length of stay in Residential Rehabilitation Services is 98 days, but varies based on individual need.¹¹ The RRS level of care is also the service that is most frequently provided in a “recovery home”. RRS is a MassHealth/Medicaid benefit, but is not generally covered by private health insurance.

WORKFORCE CHALLENGES IN RESIDENTIAL RECOVERY SERVICES

- » For All Level 3.1 (TSS/RRS/COERRS)¹² - **68% of respondents** reported maintaining a waitlist for admission (21 out of 31);
- » A total of **266 clients were waiting** for services at the time of the survey;
- » Respondents with a waitlist reported that the average wait for admission was 34 days. A quarter report that clients **wait for 60 days or more**, with some waiting **as long as 135 days** ;
- » Total staff vacancies **across all positions is 24%** (187 vacant/776 required); and
- » **39% of all staff left** over 12 months (301 departed/776 required).

CLINICAL DIRECTOR

The Clinical Director is an experienced clinician with expertise in the treatment of people in early recovery from substance use disorders who is responsible for the oversight of all clinical programming and interventions in the RRS program. The Clinical Director plays a critical role in the training and supervision of all front-line staff, including counselors, case managers and recovery specialists.

- » Clinical Director position **vacancy rate is 39%** (24 vacant/61 required);
- » **43% of Clinical Directors** left over 12 months (26 departed/61 required); and
- » Over the course of 12 months, more Clinical Directors left their positions than were hired **(26 departed/20 hired)** .

RECOVERY SPECIALISTS

Recovery Specialists are the front-line caregivers in RRS programs. They work to ensure that the treatment environment is safe and responsive to clients’ needs. They provide guidance and direction to residents and oversee resident activities in conformance with program policies. They are available 24/7 and are often the first responders in the event of a behavioral or medical crisis in the program.

- » Recovery Specialist position **vacancy rate is 28%** (126 vacant/454 required); and
- » **44% of Recovery Specialists** left over 12 months (201 departed/454 required).

11. Bureau of Substance Addiction Services Provider Profile Reports Fiscal Year 2021.

12. Transitional Support Services (TSS) and Co-Occurring Enhanced Residential Recovery Services (COERRS) are Level 3.1 Residential Rehabilitation Services for specialized populations.

LEVEL 1

Opioid Treatment Programs (OTPs) (Level 1)

SURVEY RESPONDENTS: 7 completed surveys Representative of **24/53** total sites

The U.S. FDA has approved several different medications to treat opioid use disorders. MOUD relieve the withdrawal symptoms and psychological cravings that cause chemical imbalances in the body. There are three FDA-approved medications used to treat opioid use disorders: methadone, buprenorphine and naltrexone. These are evidence-based treatment options and one cannot be substituted for another, a common misperception. MOUDs are safe to use for months, years, or even a lifetime depending on the individual.

OTP services consist of medical and pharmacological interventions with administration of MOUD, counseling, psychoeducation, and recovery support in a clinic setting. Methadone for the treatment of opioid use disorder may only be dispensed in an OTP.

OTPs play a critical role in the SUD treatment delivery system as a specialty provider with the expertise to manage the complex needs of clients when they are experiencing acute symptoms that require the intervention of a specialist. At the time of initial diagnosis or during an exacerbation of symptoms, it may be necessary to refer to a specialty provider with additional expertise to provide the necessary treatment and stabilization services until the crisis resolves. For people with Opioid Use Disorders, OTPs provide a place where those specialized services can be rapidly obtained and, for some people, methadone is the treatment of choice to attain and maintain stability.

WORKFORCE CHALLENGES IN OTPS

- » Opioid Treatment Program total position **vacancy rate is 23%** (101/448.8); and
- » **56% of OTP staff** left over 12 months (251 departed/448 required).

NURSES

Nurses are critical to an OTP's operations, as they are responsible for dispensing methadone and monitoring individuals post-dosing. A lack of nursing can increase wait times for dosing, decrease satisfaction, and ultimately may lead programs to temporarily close and for individuals to "guest dose" at an alternative location.

- » Nurse positions are experiencing a **vacancy rate of 28%** (28 vacant/101 required);
- » **81% of nurses left** over 12 months (82 departed/101 required); and
- » Almost as many nurses departed as were hired (**86 hired/82 departed**).

MASTERS-LEVEL CLINICIANS, COUNSELORS AND CASE MANAGERS

Clinicians, counselors and case managers provide all of the clinical and support programming to clients including: individual counseling, referrals to community-based supports, group counseling, and psychoeducation.

- » Masters-level clinician position **vacancy rate is 29%** (59 vacant/206 required);
- » **56% of masters-level clinicians left** over 12 months (115 departed/205.5 required);
- » Over the course of 12 months, **more clinicians have departed** than have been hired (95 hired/115 departed); and
- » The average **caseload for a clinician is 62** clients, with a range of 27 to 97.

“Staff turn over impacts the program for opening dosing hours for reception, nursing coverage and expanded growth with clinical caseloads.”

“The areas that we are short-staffed in that impact the daily functions of the program the most are Clinicians and Nursing. Due to nursing shortage, our Nurse Manager is tasked with dosing patients daily (including some weekends). Additionally we have recruited our Nurse Manager in the OBOT program to dose in the OTP when needed. Due to Clinician shortages we have transitioned from a predominant 1:1 clinical service model to a group model. Additionally wait times for our same-day admissions has increased due to Clinician availability.”

1



Decrease Stigma and Achieve Parity Among Payers

Access to care is impacted by insurance coverage, and more work is needed to hold public and private payers accountable to ensure that behavioral health treatment parity is a reality. The substance use treatment continuum has been impeded by different rules for different payers.

ENFORCE STATE AND FEDERAL PARITY REQUIREMENTS

While recently passed legislation¹³ will require ongoing assessments of parity compliance, Massachusetts may consider implementing additional measures to enforce state and federal parity requirements, including:

- » Promptly begin parity market conduct exams of substance use treatment provider reimbursement rates;
- » Assess rates of payment for substance use treatment through public plans as compared to rates paid by commercial plans and rates paid by other state Medicaid plans for the same services;
- » Where possible, adopt Medicare codes and rates;
- » Publicly post parity data for public and commercial plans; and
- » Issue guidance that publicly invites behavioral health providers to help identify possible parity violations.

STANDARDIZE AND INVEST IN OPIOID TREATMENT PROGRAMS ACROSS INSURANCE SYSTEM

Opioid treatment programs (OTPs) are currently paid via a bundled rate and code (“G codes”) for services provided to Medicare and MassHealth clients. ABH endorses the care model that the bundle represents as the standard of care for clients receiving treatment through an OTP. In order to ensure standardization and adequate reimbursement for services, **ABH recommends that the Health Connector, GIC and commercial carriers adopt the OTP G-Code and direct plans to cover services at least at the rate that MassHealth has adopted, and with minimal cost sharing.** This would continue the movement away from fee-for-service and towards payment strategies that promote understood standards of care.

13. Chapter 177 of the Acts of 2022

2



Improve Workforce Recruitment and Retention

As detailed in this report, maintenance and expansion of existing substance use disorder services, and development of new SUD services is impossible without the corresponding workforce to support it. Investments in student loan repayment programs (MA Repay) are an encouraging step toward improved retention of the workforce, but more can be done to retain staff and enhance the workforce pipeline so that more individuals choose to work in the safety-net behavioral healthcare field.^{14,15}

ENHANCE RATES OF PAYMENT FOR SUBSTANCE USE DISORDER SERVICES

Providers’ ability to provide effective, high quality behavioral health care is directly related to the Commonwealth setting and paying appropriate rates for these essential services. Historically low rates and the difficulty filling jobs serving complex populations has resulted in high vacancy rates, frequent turnover, long waitlists and the permanent closure of certain programs.

14. <https://mass-league-loan-repayment-program.netlify.app/about>

15. Behavioral Health Trust Fund Advisory Commission. Final Report: Findings and Recommendations. May 3, 2023.

Currently, inadequate rates set by public payers prevent employers from paying fair and competitive salaries in safety-net settings. This is due to the state utilizing median Bureau of Labor Statistics (BLS) benchmarks for direct care, clinical and nursing salaries instead of a more accurate measure. In fact, a recent report conducted on behalf of the Department of Public Health found that “Massachusetts ranked 31st in adjusted hourly wage out of 34 states for which we had data” in wages for human services direct care staff. That report recommends that the Commonwealth adopt “policies—such as using the 75th percentile of BLS wage data instead of the 50th to calculate remuneration paid to contracted service providers for direct care labor.”¹⁶

At a minimum, ABH urges the Commonwealth to benchmark substance use disorder services rates to at least the 75th percentile of BLS salaries. The 75th percentile is closer to what providers are already paying staff and since rates are prospective, they must also account for salaries for the next two years. We fear that without significantly deepened investment, access to addiction treatment services for individuals in the safety net will only diminish.

UTILIZE STUDENT LOAN REPAYMENT PROGRAMS TO RECRUIT STAFF

The MA Repay program is an effective retention tool, as it will be accessed by individuals who are already employed by an organization. ABH additionally urges the Commonwealth to **invest in recruitment strategies, particularly for clinicians, prescribers/psychiatrists, and other providers with specialized training and/or linguistic competency.** There is precedent to enabling both retention and recruitment in student loan repayment programs, as the state’s prior Section 1115 Demonstration included a recruitment component for prescribers.

CREATE A BEHAVIORAL HEALTH WORKFORCE CENTER OF EXCELLENCE

Currently, no single entity at the state level is charged with addressing behavioral health workforce issues. **An ongoing center of excellence, staffed by experts and embedded in the field of higher education, would exist over multiple years and could conduct long-term planning, including establishing baseline needs and developing recommendations and strategies to meet these needs.**¹⁷

A Behavioral Health Workforce Center of Excellence would ensure that appropriate resources and time are spent on the complex issues affecting the behavioral health workforce. The idea was also included in a set of recommendations from a recent Blue Cross Blue Shield Massachusetts Foundation report, *Creating a Robust, Diverse, and Resilient Behavioral Health Workforce in Massachusetts*.¹⁸ Similar efforts are already underway in Nebraska through the Behavioral Health Education Center of Nebraska.^{19,20}

16. Eastern Research Group, Inc. Analysis of the Medication Administration Program (MAP) and Current Practices in Community Settings. September 30, 2022. <https://www.mass.gov/doc/map-evaluation-report-2022-pdf/download>

17. H.1275,S.829 - An Act establishing a behavioral health workforce center of excellence.

18. <https://www.bluecrossmafoundation.org/publication/creating-robust-diverse-and-resilient-behavioral-health-workforce-massachusetts>

19. <https://www.unmc.edu/bhec/>

20. Behavioral Health Education Center of Nebraska. Legislative Report FY2020 & FY2021. https://www.unmc.edu/bhec/_documents/bhec_legislative_report_fy20-21_final.pdf

3



Increase Access

REMOVE CO-PAYMENTS AND OTHER COST-SHARING

As reported by the Health Policy Commission in their 2022 Cost Trends Report, the presence of high-deductible health plans and cost-sharing increases challenges to affordability, access, and experience of care, particularly among individuals that are low-income.²¹ ABH appreciates the waiving of some co-pays for medications for opioid use disorder among commercial carriers, an evidence-based approach that improves substance use disorder outcomes. **However, waiving co-payments or deductibles for all substance use disorder interventions, including zero-dollar cost-sharing for naloxone, should be considered as part of a strategy to improve health equity.**

21. Massachusetts Health Policy Commission. 2022 Health Care Cost Trends Report and Policy Recommendations. September 2022. <https://www.mass.gov/service-details/annual-cost-trends-report>

EXPAND ACCESS TO HARM REDUCTION SERVICES, INCLUDING OVERDOSE PREVENTION CENTERS

In 2021, 2,301 people fatally overdosed, an 9% increase over the state's previous peak in 2016. As fatal overdoses remain at unprecedented levels, there is an urgent need to implement evidence-based and efficacious interventions, like overdose prevention centers, that keep people alive and that can serve as a linkage to further treatment and care. **ABH supports recently filed legislation, *An Act relative to preventing overdose deaths and increasing access to treatment*, that would authorize an overdose prevention center to be established in an interested community.**²²

INCREASE CULTURAL, ETHNIC, AND LINGUISTIC COMPETENCY OF SERVICES

In order to improve access to services for individuals and populations disproportionately impacted by overdoses and substance use disorders, the Commonwealth should fund and develop programming that is culturally, ethnically, and linguistically diverse. This includes **paying a rate differential for services offered in a language other than English.**

ADDRESS SOCIAL DETERMINANTS OF HEALTH

Where people live and work impacts their wellbeing. Increased investment in a Housing First model enables individuals who may have challenges with remaining in housing, or might otherwise not qualify for support, to access and retain stable housing. **ABH encourages the continued funding and procurement of low-threshold congregate care and individual housing units** that do not require sobriety for placement and provide individual case management services.

COMMERCIAL PLAN REIMBURSEMENT FOR SUPERVISED MASTERS PREPARED CLINICIANS

ABH urges the Commonwealth to promptly implement and enforce supervisory protocols, as mandated by Chapter 177 of the Act of 2022.²³ The care delivery system has been impeded by different rules for different payers, and a number of individuals are waiting for services due to insurance coverage restrictions on the type of clinician they can see. MassHealth and certain commercial plans have already recognized the value of allowing for Masters-prepared clinicians, under the supervision of a licensed clinician, to provide services. Requiring standardization across payers for clinician's eligibility to provide services would help ensure that individuals can access timely services, regardless of their health plan.

22. S1242, H1981 - An Act relative to preventing overdose deaths and increasing access to treatment.

23. <https://www.mass.gov/doc/bulletin-2023-03-clinicians-working-toward-licensure-and-practicing-under-supervision-of-licensed-professional-issued-january-4-2023/download>

4



Improve Service Delivery

There is no one treatment and recovery pathway appropriate for all individuals with a substance use disorder, and our care continuum should reflect this by offering a flexible service delivery model that can meet people's different needs.

INTEGRATION OF PRIMARY CARE IN BEHAVIORAL HEALTH SETTINGS

Many of our provider groups deliver specialty behavioral health services, including services that provide longitudinal treatment and diversionary services for individuals with mild to serious disorders. Many of these services are not well suited to primary care offices. Efforts must be made to coordinate and link these behavioral health services with primary care so that an individual can access specialty, patient-centered care when clinically appropriate. This includes the **promotion of payment methodologies that support specialty behavioral health partners.** In many collaborative care models, the specialty system partnering with primary care is not adequately resourced. In addition, payment methodologies and regulatory strategies should support bidirectional integration, as many individuals with moderate to serious behavioral health disorders prefer to access their care through specialty behavioral health providers that are skilled in meeting their unique needs.