Fighting Back: Massachusetts Health Care Providers and the Opioid Crisis

Prepared by the
Office of Senator Elizabeth Warren
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1. Executive Summary

Communities across the country are struggling to respond to an opioid epidemic that continues to grow in scope and impact. In Massachusetts, more than five people die from opioid overdoses every day.[1] This public health crisis has devastated families across the state and placed significant demands on health care providers working to prevent, diagnose, and treat those suffering from the addiction.

Innovative policies at the federal, state, and local levels have helped Massachusetts make substantial progress in expanding access to quality, affordable behavioral health care. However, the state's mental health and addiction treatment facilities continue to face significant challenges. To better understand the policy decisions that contribute to this progress – and shed light on remaining challenges – the Office of Senator Elizabeth Warren sent the Massachusetts Substance Use Disorder Treatment and Recovery Services Survey to more than 80 behavioral health organizations and community health centers across the state.[2] This report summarizes the feedback from 51 organizations who responded to the survey and highlights the essential role that behavioral health care providers and their allies play in treating individuals with addiction. This report finds that:

- **Massachusetts facilities that offer behavioral health services deliver affordable, high-quality care made possible by high rates of insurance coverage and access to treatment.** Almost 75 percent of the facilities reported that they were able to provide effective mental health and addiction treatment. Few reported that lack of insurance coverage was a barrier to treatment, and the vast majority indicated that additional coverage provided by the *Patient Protection and Affordable Care Act (ACA)* has helped them provide a wide-range of critical services.

- **Massachusetts addiction treatment centers continue to face challenges in providing care, including long waiting lists, offering adequate referral services, hiring and retaining staff, and parity in behavioral health coverage.** In particular, more than half of respondent facilities providing beds for detox or rehabilitation services reported having a waiting list – some as long as three weeks. Patients waiting for admission to a residential recovery home could wait as long as three months. Many facilities reported difficulty in providing referral services, such as housing or career counseling, hindering patients' chances of full recovery. Facilities also reported substantial challenges in hiring or retaining staff. Finally, some facilities indicated that insurance reimbursement policies and lack of behavioral health parity in insurance coverage can create barriers to care for people seeking treatment.

- **Many Massachusetts facilities rely on federal financial support to carry out their critical work.** The majority of providers responding to the survey reported that they receive federal dollars made available through grants from the Department of Health and Human Services (HHS), the Department of Housing and Urban Development (HUD), the Department of Justice (DOJ), and other agencies. Over 60 percent of responding facilities reported receiving such funding in 2016.

Additional federal support would expand the ability of Massachusetts health care providers to improve services and continue to provide access to addiction treatment for those in need. However, slashing funding for Medicaid and other federal programs supporting behavioral health providers would devastate the ability of Massachusetts treatment facilities to carry out their work. Despite increased demand for addiction prevention and treatment services, President Trump and Republicans in Congress have proposed to eliminate resources needed to combat the opioid epidemic – cuts that would only deepen this public health crisis.

The impact of the opioid epidemic in Massachusetts

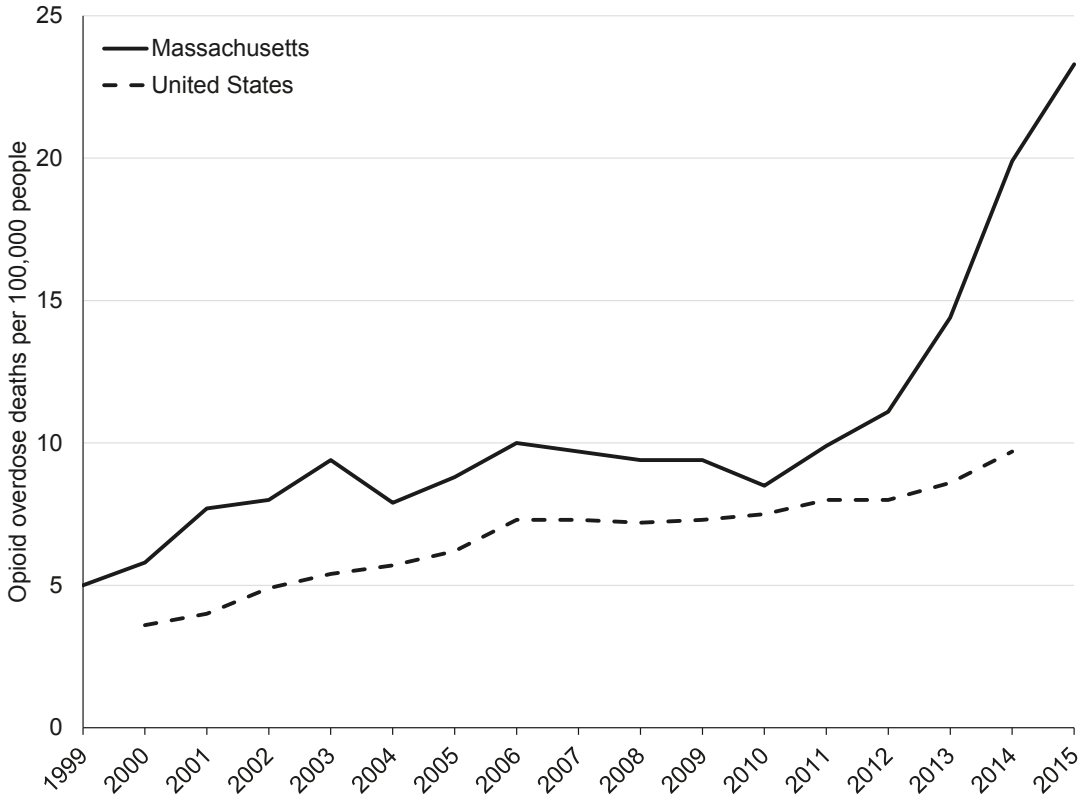
Despite ongoing efforts by the state to dedicate critical public health and safety resources, the effects of this crisis have rippled across the state's family and social services, health care, and education systems. Between 1999 and 2014, the opioid-related drug overdose fatality rate in Massachusetts more than tripled. And between 2010 and 2014, the overdose fatality rate increased faster than the national average, despite steps taken by the state to dramatically increase access to prevention, intervention, treatment, and recovery services (Figure 1).[3] In just one year, between 2015 and 2016, the number of estimated opioid-related fatalities in Massachusetts increased by a stunning 17 percent.[4]

In 2016, approximately 2,000 people in Massachusetts died of opioid overdose.[5] Massachusetts Department of Public Health (DPH) Bureau of Substance Abuse Services (BSAS) data show that opioid-related admissions to addiction treatment centers and programs rose from one-third of all admissions in 2000 to more than half of admissions by 2015. During that same period, the Massachusetts Health Policy Commission (HPC) reported comparable findings for emergency room visits and hospitalizations.[6]

While deaths from prescription opioid and heroin use have increased dramatically over the past two decades,[7] in recent years, the synthetic opioid fentanyl has contributed significantly to skyrocketing overdose rates due to its extreme potency. From 2013-2014, heroin, fentanyl, or both were found in the blood of 85 percent of opioid-overdose patient deaths in Massachusetts,[8] and fentanyl has overtaken heroin as the leading cause of fatal opioid overdoses (Figure 2)[9].

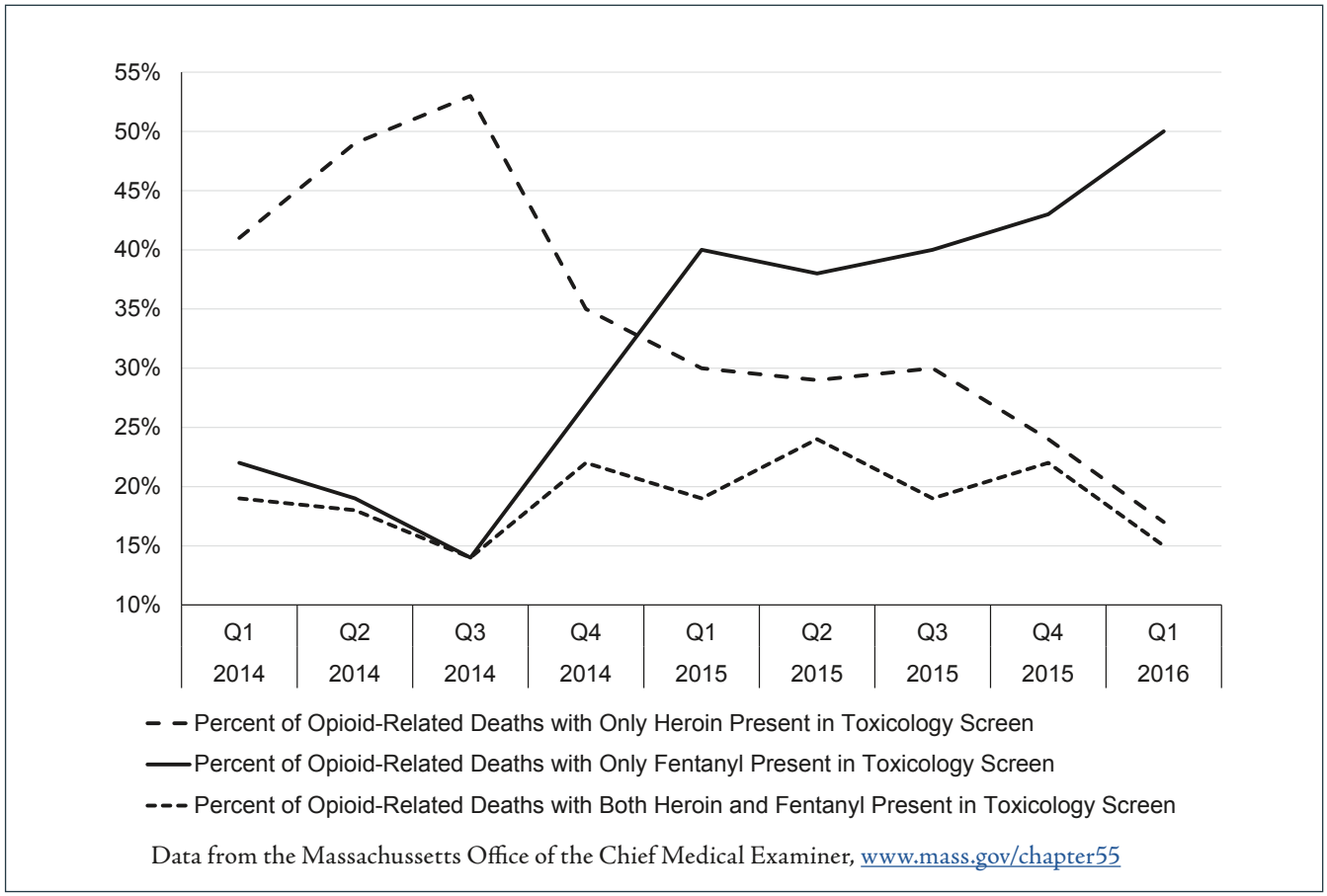
Massachusetts residents under the age of 45 are especially at risk for fatal opioid overdose. In 2016, about two-thirds of people in Massachusetts who died from an opioid overdose were in this age group.[10]

Figure 1: Rate of opioid overdose deaths in Massachusetts outpaces national rate



Data from the Massachussetts Department of Public Health, www.mass.gov/chapter55

Figure 2: Fentanyl is the leading cause of opioid overdose death in Massachusetts



Data from the Massachussetts Office of the Chief Medical Examiner, www.mass.gov/chapter55

Residents from all racial and ethnic backgrounds are impacted by the epidemic as well. Opioid-related deaths among white, non-Hispanic people in the state rose from 23.9 deaths per 100,000 (age-adjusted) in 2014 to 32.5 in 2016. For black, non-Hispanics, the opioid-related death rate rose from 11.1 to 16.4, and for Hispanics this rate almost doubled from 15.8 in 2014 to 30.2 in 2016.[11]

The opioid epidemic has devastated families and communities across the state. The Massachusetts Department of Children and Families (DCF) has indicated that substance disorder (SUD) is a contributor to child neglect and abuse cases in the state and a major factor driving Massachusetts children into the foster care system.[12] Further, the number of infants born with Neonatal Abstinence Syndrome (NAS) – meaning they were exposed to opioids while in the womb – increased by 29 percent between 2011 and 2013.[13] Children who have experienced these adverse life events are more likely to develop SUD and abuse their own children.[14]

Massachusetts addiction treatment facilities provide a range of important services

Behavioral health facilities in Massachusetts provide a range of addiction treatment and recovery services that are closely coordinated to offer a continuum of care. These services include: acute treatment services (ATS/detox), clinical stabilization services (CSS/post-detox/step-down), transitional support services (TSS), residential recovery homes, Structured Outpatient Addiction Programs (SOAP), and medication-assisted treatment (MAT) offered in both inpatient and outpatient settings. All of these services are essential for patients with SUD and other co-morbid conditions. This continuum of care helps patients remain sober and healthy as they build relationships with their health care providers.[15]

MAT is an essential component of addiction treatment and recovery. According to the federal Substance Abuse and Mental Health Services Administration (SAMHSA), "MAT is the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders."[16] SAMHSA's website on MAT further states: "A combination of medication and behavioral therapies is effective in the treatment of substance use disorders, and can help some people to sustain recovery."[17] MAT has been shown to be effective in increasing retention in treatment and reducing the risk of relapse, as well prevent transmission of HIV and viral hepatitis through intravenous drug use.[18] MAT medications include methadone, buprenorphine, and naltrexone. In particular, buprenorphine is used by behavioral health providers as a long-term MAT, and federal regulations recently expanded the number of patients that qualified physicians and nurse practitioners are able to treat with the drug.[19]

Community health centers (CHCs) in Massachusetts also play a crucial role in efforts to tackle the opioid epidemic. Nationwide, more than 1,200 CHCs provide care to over 20 million medically underserved individuals, providing services such as preventative care, family medicine, optometry and dentistry, and behavioral health services.[20] There are more than 50 CHC organizations in Massachusetts, operating at more than 300 sites across the state and serving about 1 in 7 residents.[21]

Behavioral health care providers are primarily funded through reimbursement by private insurers or public insurance programs (Medicare, Medicaid, or Tricare, the Department of Defense's health insurance program). This reimbursement may occur either on a fee-for-service basis or through a managed care organization and is essential to supporting provider staff and operations. Insurer and federal reimbursement rates therefore have an immense impact on the capacity at which addiction treatment centers and organizations can offer care.

3. Methodology

The Office of Senator Elizabeth Warren developed the Massachusetts Substance Use Disorder Treatment and Recovery Services Survey in order to improve our understanding of the needs of Massachusetts addiction treatment facilities and to help inform federal policymakers of those needs. The survey was sent to more than 80 organizations across Massachusetts that provide a variety of prevention, treatment, and recovery services for patients and families experiencing mental health and addiction. The survey asked 33 questions about patient access, types of services, insurance coverage, federal funding, and existing challenges. A complete copy of the survey is included in Appendix B.

The findings in this report are based on 54 responses from 51 provider organizations and facilities, including 17 CHCs, who submitted survey data.[22] While the survey was not designed to provide a statistically representative survey of all facilities in the state, those facilities that responded to the survey offer services across the continuum of care and provide insight into the challenges facing each provider type. The majority of respondents provide outpatient counseling and MAT. Most respondents provide services to adults, while fewer than half of survey respondents provide services for people under 18 years of age.

Respondents identified by name in the report gave their permission to be listed and quoted, when applicable. Where necessary, minor edits to responses have been made for style and consistency.

A. High rates of insurance coverage support Massachusetts addiction treatment facilities' ability to provide high-quality care

Behavioral health care providers in Massachusetts responding to the survey reported high levels of ability to offer addiction treatment and recovery services. When asked about their "ability to provide sufficient treatment services for individuals with substance use disorder," 75 percent of respondents ranked their ability as excellent or above average (a response of 4 or 5 on a scale of 1 to 5).[23] Similarly, 67 percent ranked their ability to "provide adequate access to medication-assisted treatment (MAT)" as excellent or above average,[24] and 68 percent ranked their ability to "provide access or referrals to mental health care" as excellent or above average (Figure 3).[25]

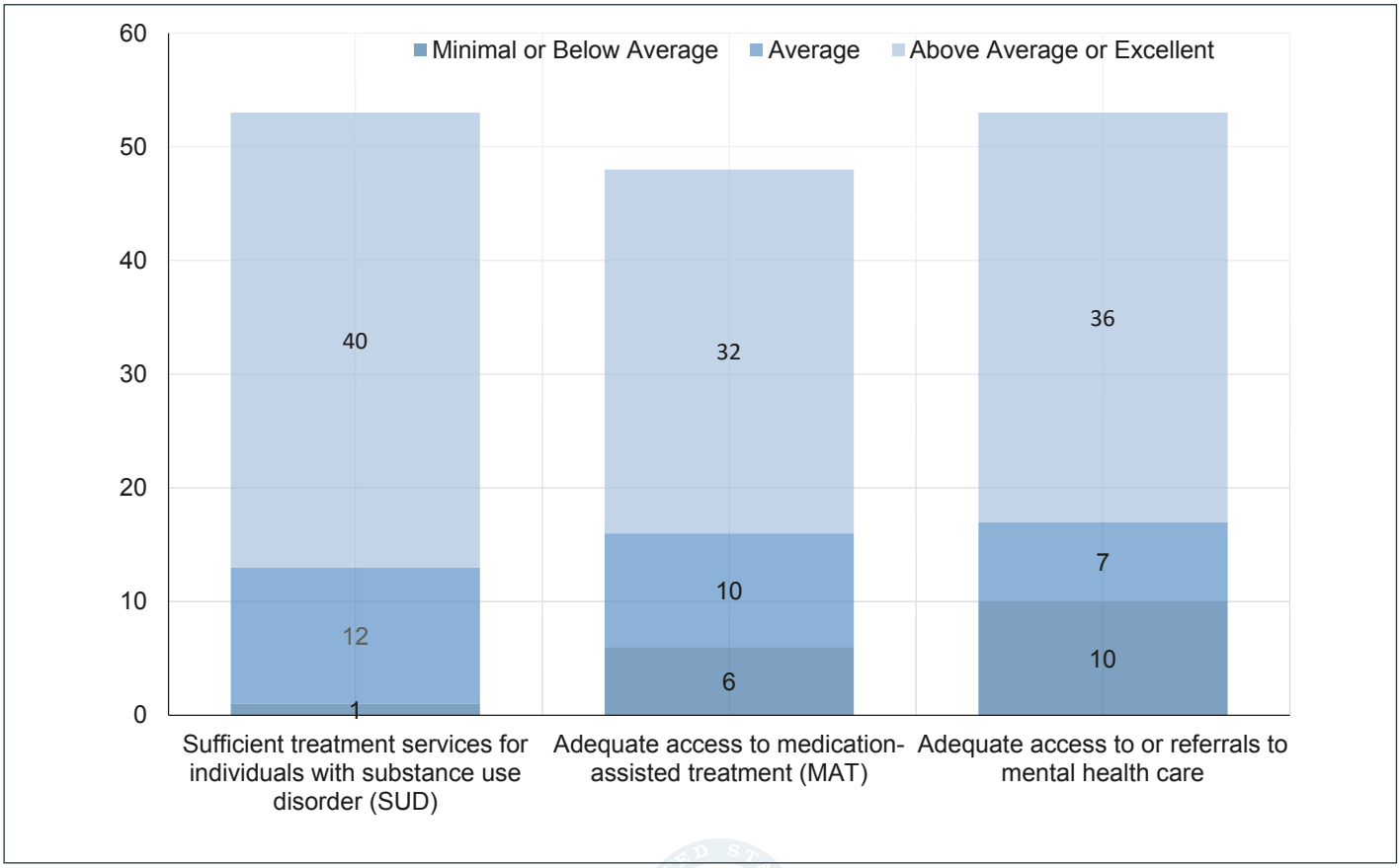
> *"We feel grateful to be located in Massachusetts, with its generally good insurance coverage due to health reform."* – Fenway Health, Boston

Facilities responding to the survey reported that the overwhelming majority of patients seeking addiction treatment and other services have some type of insurance coverage. Only two respondents reported that over 30 percent of their patients did not have insurance.[26] Providers are also able to offer enrollment services to most uninsured patients to help them gain coverage, such as through MassHealth (the state's Medicaid program), prior to or after admission. For example, 35 of 51 providers disclosed that over 70 percent of their patients were enrolled in MassHealth.[27]

> *"MassHealth has allowed us to work with all [patients] to make sure they have insurance coverage. We're lucky to live in a state where getting on MassHealth is a simple process."* – ServiceNet, Inc., Northampton

These findings underscore the importance of high health insurance coverage rates in Massachusetts

Figure 3: Behavioral health organizations feel able to provide SUD treatment and mental health services



for health care providers' ability to help combat the opioid epidemic. The state's own health reforms, coupled with the ACA, have allowed for near-universal coverage that includes behavioral health services. For example, Cambridge Health Alliance reported that, prior to Massachusetts health reform becoming law in 2006, one-third of its patient care was for the uninsured. Now, due to the Medicaid and other coverage expansions supported under the ACA, that fraction has dropped such that only about 10 percent of its patient care is for the uninsured.[28] Massachusetts enacted state-level health reform that created standards of coverage, expanded preventive care and public programs for those without employer-based care, implemented incentives to make commercial insurance more affordable, and established a state insurance exchange, the Massachusetts Health Connector. This state-level law was made possible, and continues to function, largely due to federal Medicaid dollars and served as the model on which the ACA – signed into law four years later – was based.[29]

The ACA enabled better integration and coordination of care for individuals with SUD, reduced the need for referrals, and increased data sharing across providers. Further, the ACA's Medicaid expansion has immensely improved and expanded behavioral health coverage by providing access to care for vulnerable populations. Almost 1.3 million people nationwide now receive behavioral health treatment through the Medicaid expansion.[30] Because of the expansion, nearly 400,000 individuals in Massachusetts obtained more affordable, robust coverage through MassHealth.[31] The Medicaid expansion has also increased access to MAT, with Medicaid in general supporting 35-50 percent of MAT nationwide.[32]

B. Behavioral health care facilities in Massachusetts also face challenges

Wait times for addiction treatment and recovery services

Despite Massachusetts' near-universal insurance coverage and the presence of high-quality health care providers, access to inpatient addiction treatment – particularly beds for detox and rehabilitation – remain a challenge for many. More than half of facilities responding to the survey offering inpatient detox and rehabilitation services (e.g., ATS, CSS, TSS) also report having waiting lists, with patients waiting up to three weeks to receive treatment.[33] Additionally, 90 percent of residential recovery homes responding to the survey have waiting lists, with one provider's list having over 100 waiting patients.[34] Further, patients wishing to enter a residential recovery home could wait up to 90 days for a bed. Survey respondents indicated that residential recovery home stays can vary from two weeks to a year.

Respondents identified two primary causes of this problem. First, some respondents cited the need for additional beds to provide timely access to inpatient detox and rehabilitation services, noting wait times can arise when facilities do not have enough capacity to serve everyone in need of treatment. In addition, respondents pointed to the need for long-term recovery strategies, including access to MAT and counseling services, which could prevent individuals with SUD from relapsing and requiring admittance to detox and rehabilitation services.[35] For example, according to Gosnold on Cape Cod:

> *"We are not paying enough attention to readmission reduction strategies. [L]ook at the detox and rehab readmission rates."*
> – Gosnold on Cape Cod, Falmouth

The Massachusetts Special Commission to Investigate and Study State Licensed Addiction Treatment Centers found that about 30 to 40 percent of patients entering state-licensed inpatient treatment facilities (e.g., ATS, CSS, TSS) do not complete treatment, while 1 in 8 receiving adult residential treatment are readmitted within a month of being discharged.[36] Further, a 2015 report on addiction and recovery services in Boston by the Blue Cross Blue Shield of Massachusetts Foundation recommended improving access to information on available beds and increasing coordination along the continuum of care as strategies for preventing and reducing relapses.[37]

Providing referral services is difficult

Referral services can include additional non-clinical services to support patients' and families' transportation, employment, childcare, housing, and legal and financial counseling needs, among others.[38] These services are critical to ensuring that patients in need of treatment have the best chance at achieving

and sustaining a full, healthy recovery. The 2016 U.S. Surgeon General's report, *Facing Addiction in America*, reported that, among homeless veterans with co-occurring SUD and mental health disorders, providing non-clinical "wrap-around" interventions improved behavioral health outcomes up to a year later.[39]

A large number of Massachusetts addiction treatment facilities reported difficulties in providing adequate housing referral services following inpatient treatment. Almost half of survey respondents – 43 percent – assigned a relatively low ranking to their ability to refer patients to any housing aside from residential recovery homes.[40] Among the addiction treatment providers that responded to the survey, approximately two-thirds ranked their ability to effectively refer patients to career counseling services as relatively low (Figure 4).[41]

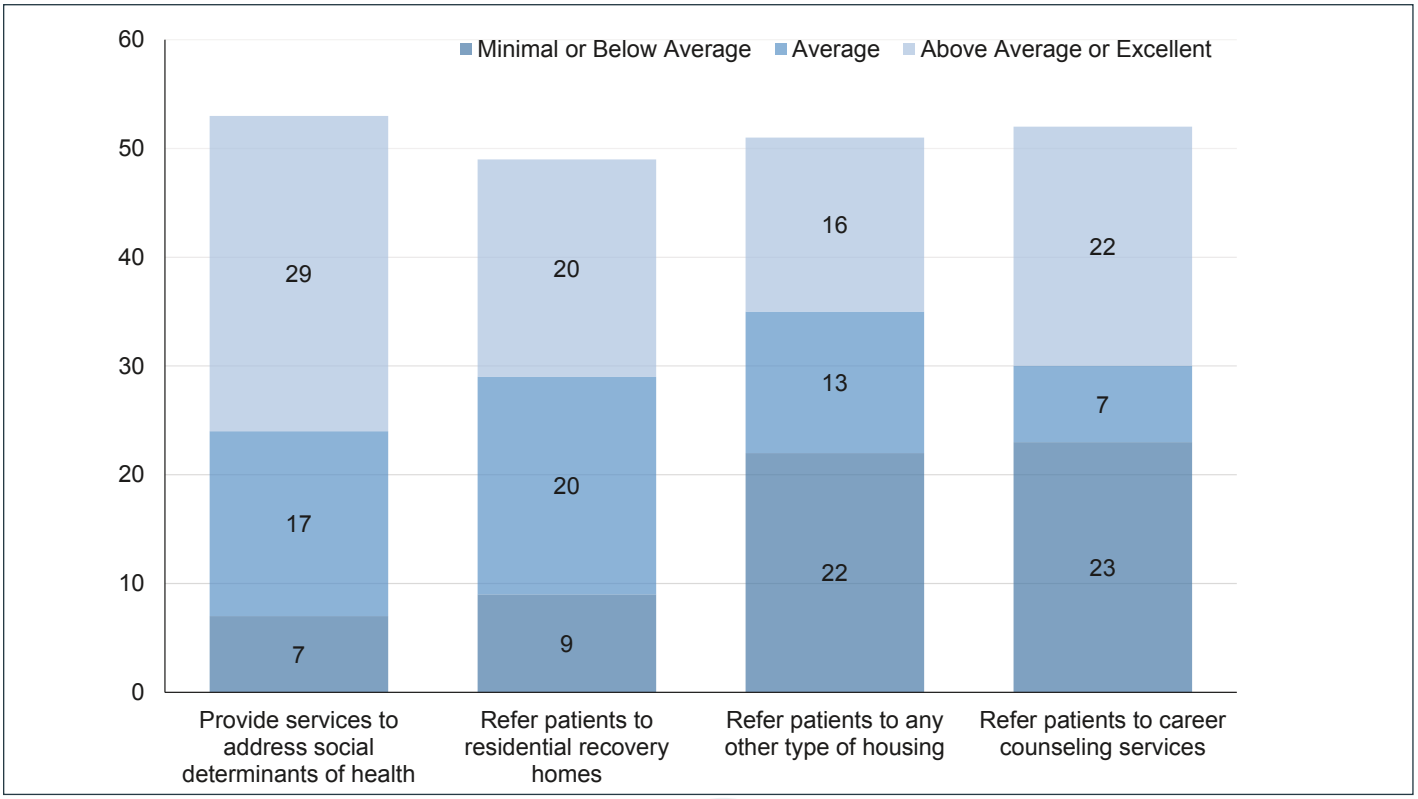
> *"The inability to refer patients to halfway houses or residential treatment facilities is an unnecessary burden that can cause loss to treatment follow up."* – Codman Square Health Center, Dorchester

> *"If [housing] vouchers were available while [patients] remained in treatment, the treatment program could assist the individual/family to locate housing, and they could be discharged to a stable living environment. Many people relapse[,] given the stress of homelessness[. T]his is a vicious circle that does not make public policy sense."* – Lahey Health Behavioral Services, Danvers

> *"Safe, sober housing[,] together with access to community-based services[,] is the best option for patients that are ready to reintegrate back into their home communities after medical detoxification. But right now, community-based options are limited due to a tight housing market and gaps in coverage for continuing care and support."* – Volunteers of America, Massachusetts, Jamaica Plain

When asked to provide additional comments on the survey, respondents highlighted the particular challenge of referring patients to transportation services. Lack of transportation to an outpatient appointment can be extremely problematic for patients, even for those eligible for medical transportation through MassHealth. As a result, patients rely on public transportation, which takes much longer and

Figure 4: Behavioral health organizations struggle to provide referral services for housing and career counseling



can impact their ability to receive consistent treatment, as well support themselves and their families. Further, lack of transportation services is an even greater obstacle for patients living in rural areas, where public transportation may not be available at all.

> *"Transportation is a major impediment to [patients] needing access to treatment, as well as having the ability to attend health care appointments in the community while in residential care."* – Veterans, Inc., Shrewsbury

> *"We need more resources – transportation, housing, after care for men and women who have children and need a safe place to live, job opportunities, training programs, more services for women with histories of prostitution and sexual assault."* – Advocates, Framingham

Behavioral health care workforce needs

The opioid epidemic has also taken a toll on the health care workforce. Across Massachusetts and the country, organizations offering addiction treatment and recovery services rely on high quality staff – from social workers to physicians – to help patients along the entire continuum of care. But these providers are grappling with a growing demand for behavioral health services, even as they struggle to recruit specialized staff, such as psychiatrists and counselors.[42] For example, without doctors, nurse practitioners, and physician assistants, patients are not able to receive MAT in order to remain in recovery.

Unfortunately, addiction treatment providers have been experiencing a workforce shortage for decades,[43] and it is expected to grow over the next ten years.[44] According to 2010 data available from SAMHSA, for every 1,000 people in Massachusetts suffering from SUD, there were fewer than 50 psychiatrists, psychologists, counselors, and social workers available to provide care.[45] Each year, about 1 in 4 addiction treatment clinicians leave their job – and often the field – citing exhaustion and low pay.[46] According to the U.S. Bureau of Labor Statistics (BLS), the median wage for behavioral health disorder counselors in May 2016 was $41,070 per year, with the lowest 10 percent earning less than $26,210.[47] Mental health and addiction social workers make only slightly more, with a median annual salary of $42,700.[48] These relatively low salaries stem from low reimbursements by public and commercial insurers, leading some providers to take only those patients who can pay out-of-pocket, which further increases the gap between those who can access behavioral health services and those who cannot.[49] Further, the declining number of psychiatrists choosing to participate in insurance networks can lead to longer wait times for patients, forcing those who can afford it to seek out-of-network care and paying higher out-of-pocket costs.[50]

The survey results support these broad findings. Nearly half of survey respondents, 24 out of 54, assigned a relatively low ranking to their ability to "hire and train behavioral health staff."[51] Forty percent (21 of 53) reported difficulty retaining "adequately trained behavioral health staff" (Figure 5).

> *"Our sector is in a serious workforce crisis (both recruiting and retention) at every level - Psychiatrists, nurses, clinical staff, outreach and direct care."* – Vinfen, Cambridge

> *"Hiring and retaining quality staff to provide the valuable work we do is one of the ongoing challenges in providing quality service with as little wait as possible. If the mental health and substance use treatment fields received the level of funding and compensation commensurate with the importance of the work and the need that exists for the work, then perhaps there would be more people entering the field."* – LUK, Inc., Fitchburg

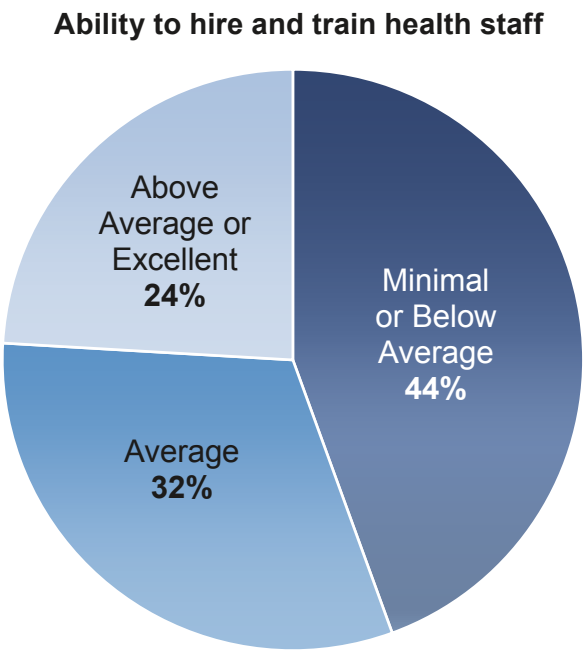
> *"Fees paid for our services (set by the insurers and the [s]tate) are not adequate to hire, retain and train quality staff. Staff turnover rates are high."* – Behavioral Health Network, Inc., Springfield

> *"Our clinic does an excellent job helping our patients get insured. However, we need another insurance coordinator to meet the demand."* – South End Community Health Center, Boston

Reimbursement and coverage concerns

Near-universal coverage in Massachusetts does not mean that addiction treatment facilities experience a seamless insurance system. Some providers reported difficulty obtaining reimbursement for their services. For instance, respondents that offer SOAP cited

Figure 5: Hiring, training, and retaining behavioral staff is a substantial challenge



difficulty in obtaining reimbursement from federal payers for intensive outpatient treatment and other services. According to respondents, reimbursement for certain types of services can be particularly problematic for people enrolled in Medicaid fee-for-service, Medicare, or Tricare. Insurers' prior authorization policies may also contribute to delays in treatment, such as administering buprenorphine.

> *"Medicaid [fee-for-service] and Medicare and Tricare plans do not cover SOAP or [intensive outpatient] programs, which is often the cheapest level of care and necessary for so many. While we served 250, we had to turn away twice that many who could not access the services because of Medicaid and Medicare not paying for this service type. [Our] CSP (Community Support Program) is also highly successful in providing case management and community[-]based supports for these individuals, including housing and employment supports, and is also not covered by Medicaid [fee-for-service] (non-[managed care] plans), Medicare[,] or Tricare."* – Clinical and Support Options, Inc., Northampton

> *"[We have d]ifficulty trying to get patients' [primary care physicians] switched with their MassHealth plan[, and we have] delays on [prescriptions] because of prior authorization issues."* – North End Waterfront Health, Boston

Massachusetts addiction treatment facilities also identified low reimbursement rates and lack of coverage parity as barriers to care. Employer-sponsored health insurance plans offering behavioral health coverage are required by law to do so at parity with medical and surgical benefits. The ACA extended parity requirements to individual and small group plans and made behavioral health services an Essential Health Benefit (EHB), which all plans sold on the state exchanges are required to cover.[52] Some Medicaid plans also cover these EHBs.[53]

Despite the progress made since behavioral health parity reforms and the ACA became law, challenges in achieving full parity remain. According to a recent survey by the National Alliance on Mental Illness (NAMI), almost half of individuals and family respondents said they had been denied coverage for mental or behavioral health care, while only 14 percent had been denied coverage for physical health care.[54] Lack of access to care is exacerbated by the fact that psychiatrists may not participate in insurance plans due to low reimbursement rates or heavy administrative burdens. Awareness of existing law and insurance coverage requirements and access to up-to-date information on providers accepting insurance are also major obstacles for those seeking behavioral health services.[55]

> *"Parity is not in accordance with the law. It's not being enforced. Insurance rates for outpatient services are not even close to reality."* – Gosnold on Cape Cod, Falmouth

> *"In general, reimbursement for behavioral health services is poor and usually does not cover the full cost of providing the service. Inadequate reimbursement for behavioral health services is a major impediment to achieving mental health and substance use parity. This is a major factor limiting patient access to necessary services along the continuum of care and to the sustainability of services."* – Cambridge Health Alliance, Cambridge

C. Massachusetts facilities rely on federal funding

The federal government plays a critical role in providing funding for states to address the opioid epidemic – through reimbursement for services covered by Medicare, Medicaid, and Tricare and via federal grants. HHS, which includes the Centers for Medicare and Medicaid Services (CMS), SAMHSA, and the Health Resources and Services Administration (HRSA), oversees the majority of these programs. Funding through grants and demonstration projects is also awarded by the DOJ, the Department of Veterans Affairs (VA), and other departments and agencies.

In Massachusetts, BSAS administers the state's Substance Abuse Prevention and Treatment Block Grants (SABG), which supports "the planning, implementation and evaluation of substance use disorder prevention, intervention, treatment and recovery oriented activities in the Commonwealth."[56] SAMHSA also provides states with funding through the Community Mental Health Services Block Grant (MHBG), administered by the Massachusetts Department of Mental Health.[57] The purpose of the MHBG is to "help build and support the community-based public mental health system for adults with serious mental illness (SMI) and children with severe emotional disturbance (SED)."[58]

The *21st Century Cures Act* re-authorized funding for the SABG program and authorized funding for State Targeted Response to the Opioid Crisis Grants (Opioid STR). The new law authorized $500 million each for fiscal years (FY) 2017 and 2018, subject to Congressional appropriation.[59] HHS will administer $485 million in grants to all 50 states based on "rates of overdose deaths and unmet need for opioid addiction treatment."[60] To date, Massachusetts has received almost $12 million of these funds to bolster its public health response. These funds will be used to focus on outpatient opioid treatment and recovery services, as well as community-based prevention efforts and addiction treatment in state prisons.[61]

Federal grants provide a significant amount of support for mental health and addiction treatment in Massachusetts. The survey revealed that over 60 percent (32 of 52) of participants received federal grants in FY 2016, with SAMHSA, HRSA, HUD, and DOJ among the most common sources. Of those who received federal funds, about 70 percent reported using them to expand existing programs, and 73 percent reported using them to implement new programs.[62]

Massachusetts behavioral health care providers are making the most of these grants, increasing capacity, creating innovative programs, and enhancing existing ones. Respondents also indicated that federal funding is necessary to fill in gaps not reimbursed by the government or insurers, such as casework and referral services.

> *"[Veterans Affairs] funds created a … program that provides transitional housing for homeless veterans. We bring clinical staff from our outpatient treatment and recovery program … to provide needed services and supports on-site, when the veteran [patient] is in early recovery. We take a similar approach with housing search, employment services, and re-entry services, providing wrap-around services where appropriate for veterans or offenders reintegrating back into society after stays in jail or in shelter."* – **Volunteers of America, Massachusetts, Jamaica Plain**

> *"[Greater Lawrence Family Health Center] … received funding in [FY 2016] to support new initiatives, specifically work focused on Health Information Technology."* – **Greater Lawrence Family Health Center, Lawrence**

> *"Federal HRSA substance use expansion funds supported the addition of new office based treatments[,] such as naltrexone and behavioral health addiction-focused counseling."* – **Family Health Center of Worcester, Inc., Worcester**

> *"[T]he grant allowed [for] more providers [and hiring of] additional nurses, counselors, and community health workers."* – **Brockton Neighborhood Health Center, Brockton**

> *"We hope to continue to grow [our MAT/Office-Based Opioid Treatment] program[,] as we believe this work is best and [safest] and delivered with the highest quality when integrated with primary care. This said, additional support is needed for integrated care…At Manet, we are committed to providing this[. Yet it] can pose resource challenges, and workforce remains a top*

vulnerability in our collective abilities to serve." – Manet Community Health Center, Quincy

"[The Boston Health Care for the Homeless Program] is working very hard to identify innovative practices to increase access and appropriate allocation of grant funding, but the needs are enormous in comparison to what we can accommodate right now." – Boston Health Care for the Homeless Program, Boston

"We feel sincerely grateful to be a federally qualified health center and HRSA 330 grant recipient.[63] *Without these factors we would not be able to provide our current level of excellent care in a sustainable way."* – Fenway Health, Boston

"The assistance of HRSA and our representatives in [C]ongress is absolutely critical to South Cove's ability to provide high quality[,] low[-]cost care in a culturally competent fashion[,] regardless of ability to pay. State and [f]ederal financing for addictions treatment does not cover the cost of treatment." – South Cove Community Health Center, Boston

"State and [f]ederal financing for addictions treatment does not cover the cost of treatment. Therefore[,] we must provide services to those that can either self-pay or that have commercial insurance so that we may cost shift to cover the cost of those with government sponsored insurance." – Spectrum Health Systems, Inc., Worcester

"Insurance companies typically do not cover services[,] such as case management and peer support services[,] that are essential to assuring early intervention to prevent relapse and increase adherence to treatment programs." – Cambridge Health Alliance, Cambridge

No matter how they are using these grants, the vast majority of respondents stated they could not do their work without federal support. In response to the question, "Would you have been able to offer or enhance the program or service without such grants?" all but three respondents answered "no" to the question.

5. Conclusion

The opioid epidemic in Massachusetts has had an enormous impact on individuals and their families. It has overwhelmed communities and strained the health care, social welfare, and justice systems across the Commonwealth. But Massachusetts has also been at the center of innovations and advances in health insurance reform and policies to address the opioid crisis. The increasing demand for addiction treatment and recovery services in Massachusetts means providers need more resources to continue to serve all patients and communities in need, alleviate behavioral health workforce shortages, and provide quality referral services for patients trying to support themselves and their families.

Behavioral health parity reforms, the ACA and its expansion of Medicaid, state health reforms, and federal and state funding have all played an important role in expanding access to affordable, quality behavioral health coverage, but more needs to be done. Repeal of the ACA or steep cuts to Medicaid and other federal programs that provide support for behavioral health would be devastating to the millions of Americans suffering from SUD, as well as to their loved ones. For example, Medicaid is the primary insurer for most patients receiving services from the treatment facilities responding to this survey.

President Trump's FY 2018 budget proposal also threatens other health care programs essential to helping communitites fight the opiod epidemic. The President proposes hundreds of billions of dollars in cuts to Medicaid, shifting these health care costs to state governments and stifling their ability to address the opioid epidemic. Finally, President Trump has also proposed cutting the budget of SAMHSA and HRSA, two of the main providers of federal grants to Massachusetts behavioral health organizations, and decreasing funding for behavioral health research and development at the National Institute of Health by 20 percent.[64] Fortunately, Congress has boosted funding for NIH by $2 billion and provided over $100 million to combat the opioid crisis through September 2017. [65]

Addressing this public health crisis in Massachusetts and across the country will require significant, sustained investment to equip health care providers and communities with the resources they need. Improved reimbursement policies and substantial, reliable federal funding streams are required to reverse behavioral health workforce shortages, expand services, and get care to patients as quickly as possible so they can maintain long-term treatment goals and reach full recovery.

Appendix A – List of survey participants[66]

Acadia Healthcare, Inc. – Habit OPCO and Gifford Street Wellness Center

Advocates

Bay Cove Human Services, Inc.

Bay State Community Services

Behavioral Health Network, Inc.

Boston Health Care for the Homeless Program

Boston Public Health Commission

Bridgewell Counseling Services[67]

Brockton Neighborhood Health Center

Cambridge Health Alliance

Catholic Charities Family Counseling and Guidance Center

Center for Human Development

Clinical and Support Options, Inc.

Codman Square Health Center

Community Healthlink, Inc.

DotHouse Health

Family Health Center of Worcester, Inc.

Fenway Health

Gandara Center

Gosnold on Cape Cod

Greater Lawrence Family Health Center

High Point Treatment Center

Hope House

Institute for Health and Recovery

Justice Resource Institute

Lahey Health Behavioral Services

Lowell Community Health Center

LUK, Inc.

Manet Community Health Center

Mattapan Community Health Center

North Cottage Program, Inc.

North End Waterfront Health

North Suffolk Mental Health Association

Old Colony Y Mental Health Clinic

Pine Street Inn, Inc.

ServiceNet, Inc.

SMOC Behavioral Health Services

Southcoast Behavioral Health

South Cove Community Health Center

South End Community Health Center[68]

South Shore Mental Health

Spectrum Health Systems, Inc.

Stanley Street Treatment and Resources, Inc.

The Brien Center

The Dimock Center

The Home for Little Wanderers

Veterans, Inc.

Victory Programs, Inc.

Vinfen

Volunteers of America, Massachusetts, Inc.

Appendix B – Massachussetts Substance Use Disorder Treatment and Recovery Services Survey

Senator Warren is committed to ensuring that people in Massachusetts who suffer from substance use disorder are able to access the treatment and recovery services they need. Your insights are critical to ensuring stakeholder views are represented as Congress works to develop policy solutions to address this ongoing public health crisis.

If you prefer to fill this survey out online please visit https://tinyurl.com/treatment-survey. This is highly encouraged.

Contact Information (# 1 – 7)

1. Organization Name _____
2. Phone Number _____
3. Mailing Address _____
4. Who is the best point of contact within your organization? _____
5. What is the point of contact's email address? _____
6. What is the point of contact's phone number? _____
7. Does your organization offer addiction treatment services for the following populations? (Check all that apply.)

   ☐ a. Women
   ☐ b. Men
   ☐ c. Families
   ☐ d. Youth (under 18 years of age)

Patient Access and Types of Services (# 8 – 16)

Please indicate whether your organization offers any of the following service(s). If you do offer the service(s), please provide additional information. If you do not offer the service(s), please skip to the next section.

8. Acute Treatment Services (ATS-detox)
   a. How many beds do you operate? _____
   b. What is the average length of stay in this program? _____
   c. Do you currently have a wait list? ☐ Yes ☐ No
   d. If so, how many clients on average are on the wait list? _____
   e. What is the average time a client waits for an available bed? _____
   f. What percentage of clients discharged from the program are on a methadone maintenance regime or buprenorphine? _____

9. Clinical Stabilization Services (CSS/post detox step-down)
   a. How many beds do you operate? _____
   b. What is the average length of stay in this program? _____
   c. Do you currently have a wait list? ☐ Yes ☐ No
   d. If so, how many clients on average are on the wait list? _____
   e. What is the average time a client waits for an available bed? _____
   f. What percentage of clients discharged from the program are on a methadone maintenance regime, buprenorphine, or naltrexone? _____

10. Transitional Support Services (TSS)
   a. How many beds do you operate? _____
   b. What is the average length of stay in this program? _____
   c. Do you currently have a wait list? ☐ Yes ☐ No
   d. If so, how many clients on average are on the wait list? _____
   e. What is the average time a client waits for an available bed? _____

11. Residential Recovery Homes
   a. How many beds do you operate? _____
   b. What is the average length of stay in this program? _____
   c. Do you currently have a wait list? ☐ Yes ☐ No
   d. If so, how many clients on average are on the wait list? _____
   e. What is the average time a client waits for an available bed? _____

12. Opioid Treatment Program
   a. How many individuals do you serve on average daily? _____
   b. How many individuals did your organization serve in FY16? _____
   c. What is the average length of stay in this program? _____
   d. Do you currently have a wait list? ☐ Yes ☐ No
   e. If so, how many clients on average are on the wait list? _____
   f. What is the average time a client waits for admission to this program?

13. Structured Outpatient Addiction Program (SOAP)
   a. How many individuals do you serve on average daily? _____
   b. How many individuals did your organization serve in FY16? _____
   c. What is the average length of stay in this program? _____
   d. Do you currently have a wait list? ☐ Yes ☐ No
   e. If so, how many clients on average are on the wait list? _____
   f. What is the average time a client waits for admission to this program? _____

14. Outpatient Addiction Treatment (Check all that apply.)
    - ☐ a. Individual counseling
    - ☐ b. Group counseling
    - ☐ c. Family counseling
    - ☐ d. Naltrexone
    - ☐ e. Buprenorphine
    - ☐ f. Other

15. If your organization offers Outpatient Addiction Treatment:
    a. Do you currently have a wait list? ☐ Yes ☐ No

    b. If so, how many clients on average are on the wait list? _____

    c. What is the average time a client waits for an assessment/first appointment?_____

    d. Please indicate any specific services for which there is a wait list, along with the average wait time.

    _____

    _____

    _____

16. Do you have any comments or concerns regarding overall patient access and your ability to provide quality services to clients? _____

    _____

    _____

    _____

Insurance Coverage and Health Care Financing (# 17 – 27)

The next set of questions asks about potential sources of insurance coverage for your clients, including: MassHealth, Medicare, commercial insurance, and TRICARE. We understand that you may not have exact data, but please provide your closest estimation of the share of clients who fall into each category.

17. For FY16, what percentage of addiction treatment clients did not have health insurance coverage when they contacted you for treatment services? _____

18. Of those who came to you without health care coverage, what percentage of these clients are you typically able to enroll in insurance coverage as part of the services you provide? _____

19. For FY16, what percentage of addiction treatment clients were enrolled in MassHealth (including MassHealth Fee-For-Service, MassHealth Managed Care Entities, and the Primary Care Clinician Plan)?

    _____

20. For FY16, what percentage of addiction treatment clients were enrolled in Medicare or a Medicare Advantage plan only? _____

21. For FY16, what percentage of addiction treatment clients were dually eligible (i.e., enrolled in both MassHealth and Medicare, including One Care Plans)?_____

22. For FY16, what percentage of addiction treatment clients were enrolled in TRICARE, the U.S. Department of Defense's military health system? _____

23. For FY16, what percentage of addiction treatment clients were commercially insured? _____

24. Did your organization receive any federal grants in FY16? ☐ Yes ☐ No

25. If your organization received federal grants in FY16:

    a. What were the granting agencies? _____
    _____
    _____

    b. Did the grant funding supplement existing services? Please explain. _____
    _____
    _____

    c. Did the grant funding support the creation of a new program or service? Please explain. _____
    _____
    _____

    d. Would you have been able to offer or enhance the program or service without such grants? Please explain.
    _____
    _____
    _____
    _____
    _____

26. From a scale of 1 to 5, with 1 being minimal ability and 5 being excellent ability, how would you rate the following:

    a. Your ability to provide sufficient treatment services for individuals with substance use disorder

    ○1 ○2 ○3 ○4 ○5 ○N/A

    b. Your ability to provide adequate access to medication assisted treatment (MAT)

    ○1 ○2 ○3 ○4 ○5 ○N/A

    c. Your ability to provide adequate access to or referrals to mental health care

    ○1 ○2 ○3 ○4 ○5 ○N/A

    d. Your ability to provide other services to address social determinants of health

    ○1 ○2 ○3 ○4 ○5 ○N/A

    e. Your ability to successfully refer clients to residential recovery homes

    ○1 ○2 ○3 ○4 ○5 ○N/A

    f. Your ability to successfully refer clients to any other type of housing

    ○1 ○2 ○3 ○4 ○5 ○N/A

    g. Your ability to successfully refer clients to career counseling services

    ○1 ○2 ○3 ○4 ○5 ○N/A

27. Do you have any comments on overall insurance coverage and financing at your facility? _____

_____

_____

_____

_____

_____

Additional Services [# 28 – 32]

28. Does your organization offer mental health outpatient treatment services? (Check all that apply.)

- ☐ a. Individual counseling
- ☐ b. Group counseling
- ☐ c. Family counseling
- ☐ d. Medication management
- ☐ e. Other
- ☐ f. Not applicable

29. Does your organization offer referral services to address social determinants of health, in addition to addiction treatment services? (Check all that apply.)

- ☐ a. Legal services
- ☐ b. Career counseling
- ☐ c. Family counseling or services
- ☐ d. Primary health care
- ☐ e. Long-term housing assistance
- ☐ f. Referral to residential recovery homes, including sober living facilities
- ☐ g. Guidance on obtaining health insurance
- ☐ h. Other
- ☐ i. Not applicable

30. If any services are offered in house, or if you checked "Other" for #27 or #28, please specify below.

_____

_____

31. On a scale of 1 to 5, with 1 being extremely difficult and 5 being excellent, how would you rate your ability to approach the following:

a. Receive timely reimbursement for any type of treatment service
○1 ○2 ○3 ○4 ○5 ○N/A

b. Hire and train behavioral health staff
○1 ○2 ○3 ○4 ○5 ○N/A

c. Retain adequately trained behavioral health staff
○1 ○2 ○3 ○4 ○5 ○N/A

d. Collaborate with state and local officials, as well as community members, to receive entry to local sites to provide quality, accessible services
○1 ○2 ○3 ○4 ○5 ○N/A

32. Do you have any comments or concerns regarding services offered within your organization? _____

Other Comments

33. Do you have any further comments on overall needs at your facility? Are there any specific concerns that you would like to bring to Senator Warren's attention?

Endnotes

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4 Massachusetts Department of Public Health, "Data Brief: Opioid-Related Overdose Deaths among Massachusetts Residents" (May 2017) (online at: http://www.mass.gov/eohhs/docs/dph/stop-addiction/current-statistics/data-brief-overdose-deaths-may-2017.pdf).

5 *Ibid.*

6 Massachusetts Department of Public Health, "The Massachusetts Opioid Epidemic: A Data Visualization of Findings from the Chapter 55 Report" (online at: http://www.mass.gov/chapter55/). Accessed May 17, 2017.

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8 "The Massachusetts Opioid Epidemic: A Data Visualization of Findings from the Chapter 55 Report," *supra*.

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13 Massachusetts Health Policy Commission, "Health Policy Commission Investments in NAS," (March 13, 2017) (online at: http://www.mass.gov/eohhs/docs/health-policy-commission-investments-in-nas.pdf).

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17 U.S. Substance Abuse and Mental Health Services Administration, "MAT Overview: Medication Assisted Treatment (MAT)" (online at: http://www.integration.samhsa.gov/clinical-practice/mat/mat-overview). Accessed June 4, 2017.

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19 Former U.S. Surgeon General Vivek Murthy, "Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health," *U.S. Department of Health and Human Services* (2016), pp. 4-23–24 (online at: https://addiction.surgeongeneral.gov/surgeon-generals-report.pdf); U.S. Substance Abuse and Mental Health Services Administration, "Medication-Assisted Treatment for Opioid Addiction: Facts for Families and Friends" (2011) (online at: https://store.samhsa.gov/shin/content/SMA09-4443/SMA09-4443.pdf).

20 Peter Shin, Jessica Sharac, Zoe Barber, Sara Rosenbaum, Julia Paradise, "Community Health Centers: A 2013 Profile and Prospects as ACA Implementation Proceeds," *Kaiser Family Foundation* (March 17, 2017) (online at: http://kff.org/report-section/community-health-centers-a-2013-profile-and-prospects-as-aca-implementation-proceeds-issue-brief/).

21 MassLeague of Community Health Centers member list (online at: http://www.massleague.org/About/MemberList.php); MassLeague of Community Health Centers, "History of Community Health Centers," (online at: http://www.massleague.org/CHC/History.php).

22 A list of survey participants can be found in Appendix A.

23 This represents 40 of 53 respondents to the question. For all questions with ranking 1-5: 1 = minimal, 2 = below average, 3 = average, 4 = above average, 5 = excellent. Throughout the report, respondents marking "Not applicable" were not included in the count.

24 This represents 32 of 48 respondents to the question.

25 This represents 36 of 53 respondents to the question.

26 Lahey Health Behavioral Services says: "Approximately 10% in ATS [did not have coverage;] and as you move away from acute services[,] the number declines."

27 Advocates specifies that 85 percent of their patients in residential care are covered by MassHealth. Volunteers of America, Massachusetts did not include patients for whom Medicare was the primary payer. ServiceNet, Inc. said 42 percent of its outpatients, including addiction treatment patients, were covered by MassHealth.

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31 "Medicaid Expansion Enrollment," *Kaiser Family Foundation* (January-March 2016) (online at: http://kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D).

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33 Twenty survey respondents operate residential recovery homes, and 16 offer SOAP. ATS and CSS providers both operate over 500 beds in the state, while only 312 beds are available for TSS. The 20 organizations operating residential recovery homes have over 1,400 beds.

34 This represents 18 of 20 respondents to the question.

35 Data from outside studies confirm these concerns. In 2015, fewer than half of people admitted to state-licensed adult residential treatment centers completed their treatment program, with more than 12 percent relapsing in less than a month. On the other hand, treatment centers offering ATS, CSS, and TSS had completion rates of 64 percent, 68 percent, and 58 percent, respectively. Massachusetts Special Commission to Investigate and Study State Licensed Addiction Treatment Centers, "Final Report" (November 21, 2016) (online at: http://www.mass.gov/eohhs/docs/special-commission-to-investigate-and-study-state-licensed-addiction-tre-.pdf).

36 Bob Salsberg, "State Report Reveals Barriers in Opioid Addiction Treatment," *Associated Press* (December 29, 2016) (online at: https://www.boston.com/news/local-news/2016/12/29/state-report-reveals-barriers-in-opioid-addiction-treatment); Massachusetts Special Commission to Investigate and Study State Licensed Addiction Treatment Centers, *supra*.

37 "Addiction and Recovery Services in the City of Boston: A Blueprint for Building a Better System of Care," *Blue Cross Blue Shield of Massachusetts Foundation* (January 2015) (online at: http://s3.amazonaws.com/media.wbur.org/wordpress/1/files/2015/05/Boston_Addiction_report_May2015_final.pdf).

38 Former U.S. Surgeon General Vivek Murthy, *supra*.

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49 Steven Ross Johnson, *supra*.

50 Janet R. Cummings, "Declining Psychiatrist Participation in Health Insurance Networks: Where Do We Go from Here?" (2015) *JAMA* 313(2): 190-191; doi: 10.1001/jama.2014.12472.

51 "Relatively low" means a ranking of 1 to 2 on a 5-point scale.

52 "A Long Road Ahead: Achieving True Parity in Mental Health and Substance Use Care," *National Alliance on Mental Illness* (April 2015) (online at: https://www.nami.org/About-NAMI/Publications-Reports/Public-Policy-Reports/A-Long-Road-Ahead/2015-ALongRoadAhead.pdf).

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54 "A Long Road Ahead: Achieving True Parity in Mental Health and Substance Use Care," *supra*.

55 "Out-of-Network, Out-of-Pocket, Out-of-Options: The Unfulfilled Promise of Parity," *National Alliance on Mental Illness* (November 2016) (online at: https://www.nami.org/parityreport#sthash.BWgbUyqo.dpuf).

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58 "Community Mental Health Services Block Grant," *Benefits.gov* (online at: https://www.benefits.gov/benefits/benefit-details/765). Accessed May 19, 2017.

59 American Society of Addiction Medicine, "*The 21st Century Cures Act* - Highlights for ASAM Members," *ASAM Magazine* (December 7, 2016) (online at: https://www.asam.org/magazine/read/article/2016/12/07/the-21st-century-cures-act---highlights-for-asam-members).

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66 List includes only those survey respondents who have agreed to be named as having participated. Analysis and results incorporate data from all respondents who submitted responses by May 31, 2017.

67 Includes three separate submissions – One entry was system-wide, one was for the Lowell Adult Day Treatment programs, and one was for Bridgewell Counseling Services in Chelmsford, which also provides services for children and families.

68 Includes two separate submissions.