Commonwealth of Massachusetts
Office of the State Auditor
Suzanne M. Bump
Making government work better

Official Audit Report – Issued March 21, 2019

Office of Medicaid (MassHealth)—Review of Counseling Provided to MassHealth Members Receiving Medication-Assisted Treatment for Opioid Use Disorders

For the period January 1, 2011 through December 31, 2015

Commonwealth of Massachusetts
Office of the State Auditor
Suzanne M. Bump
Making government work better

March 21, 2019

Ms. Marylou Sudders, Secretary
Executive Office of Health and Human Services
1 Ashburton Place, 11th Floor
Boston, MA 02108

Dear Secretary Sudders:

I am pleased to provide this performance audit of the Office of Medicaid, which examined counseling provided to MassHealth members receiving medication-assisted treatment for opioid use disorders. This report details the audit objective, scope, methodology, findings, and recommendations for the audit period, January 1, 2011 through December 31, 2015. It includes the results of interviews with sampled member prescribers that were conducted between February 6, 2017 and August 16, 2017. My audit staff discussed the contents of this report with management of the agency, whose comments are reflected in this report.

I would also like to express my appreciation to MassHealth for the cooperation and assistance provided to my staff during the audit.

Sincerely,

Suzanne M. Bump
Auditor of the Commonwealth

cc: Daniel Tsai, Assistant Secretary and Director, Office of Medicaid
Alda Rego, Assistant Secretary for Administration and Finance, Executive Office of Health and Human Services
Susan Harrison, Director of Program Integrity, Office of Medicaid
Joan Senatore, Director of MassHealth Compliance, Office of Medicaid
Teresa Reynolds, Executive Assistant to Secretary Sudders

TABLE OF CONTENTS

LIST OF ABBREVIATIONS

ASAM	American Society of Addiction Medicine
CMR	Code of Massachusetts Regulations
DPH	Department of Public Health
MAT	medication-assisted treatment
MCO	managed-care organization
MMIS	Medicaid Management Information System
OSA	Office of the State Auditor
SAMHSA	Substance Abuse and Mental Health Services Administration

EXECUTIVE SUMMARY

The Office of the State Auditor (OSA) receives an annual appropriation for the operation of a Medicaid Audit Unit to help prevent and identify fraud, waste, and abuse in the state's Medicaid program, known as MassHealth. Medicaid is a joint federal-state program created by Congress in 1965 as Title XIX of the Social Security Act. At the federal level, the Centers for Medicare & Medicaid Services, within the federal Department of Health and Human Services, administer the Medicare program and work with state governments to administer state Medicaid programs.

Under Chapter 118E of the Massachusetts General Laws, the Executive Office of Health and Human Services, through the Division of Medical Assistance, administers MassHealth. MassHealth provides access to healthcare for approximately 1.8 million eligible low- and moderate-income children, families, seniors, and people with disabilities annually. In fiscal year 2017, MassHealth paid healthcare providers more than $15.3 billion, of which approximately 50% was funded by the Commonwealth. Medicaid expenditures represent approximately 39% of the Commonwealth's total annual budget.

OSA has conducted an audit of opioid use disorder counseling provided to MassHealth members who received buprenorphine under any brand or generic name as part of their medication-assisted treatment (MAT) for opioid use disorders for the period January 1, 2011 through December 31, 2015. Our audit sample was based on buprenorphine prescriptions for calendar years 2011 through 2015. Our interviews with sampled members' prescribers occurred between February 6, 2017 and August 16, 2017.

In August 2018, Governor Baker signed into law Chapter 208 of the Acts of 2018, An Act for Prevention and Access to Appropriate Care and Treatment of Addiction. This law established a commission on community behavioral health promotion, made up of 21 appointees, to "work to promote positive mental, emotional and behavioral health and early intervention for persons with a mental illness, and to prevent opioid use disorders among residents of the commonwealth." The law also, among other things, expands access to naloxone[1] and MAT, such as treatments using buprenorphine, and provides for additional services to help residents of the Commonwealth overcome opioid use disorders. Services include recovery coaching; support for families and children; and training and supervision for medical professionals to test for, detect, and treat early signs of opioid use disorders.

1. Naloxone is the drug used to reverse the effects of opioid overdoses to save lives.

The purpose of this audit was to determine whether MassHealth members received and/or had access to appropriate and necessary counseling to aid in their recovery from opioid use disorders.

Finding 1 **Page 11**	Some MassHealth members who were treated for opioid use disorders did not receive, and/or may not have had access to, recommended counseling.
Recommendations **Page 13**	1. MassHealth should take additional measures to better ensure that prescribers effectively facilitate member participation in opioid use disorder counseling. 2. MassHealth should further investigate the reasons that were provided to OSA during this audit for members' not having access to counseling and take whatever measures it can to minimize these barriers to access.
Finding 2 **Page 17**	Some MassHealth members are not receiving opioid use disorder counseling from healthcare professionals who either are certified or specialize in addiction treatment.
Recommendation **Page 18**	MassHealth should collaborate with the Department of Public Health to ensure that opioid use disorder counselors have the proper training, skills, and knowledge to provide effective opioid use disorder counseling.
Finding 3 **Page 20**	Prescribers did not always maintain documentation supporting medical visits where prescriptions were given to MassHealth members.
Recommendation **Page 20**	MassHealth should conduct a review of these prescribers' medical documentation and recover any payments for services that were not properly documented.

OVERVIEW OF AUDITED ENTITY

Under Chapter 118E of the Massachusetts General Laws, the Executive Office of Health and Human Services is responsible for administering the state's Medicaid program, known as MassHealth. Through its behavioral health programs, MassHealth provides treatment and medications to help members recover from opioid use disorders. The services provided include, among other things, coverage for medications; inpatient and outpatient treatment programs; and opioid use disorder counseling in individual, group, and family/couple settings.

The table below provides details of all buprenorphine prescriptions provided to MassHealth members from January 1, 2011 through August 16, 2017.

Buprenorphine Prescriptions Provided to MassHealth Members

Year	Number of Prescription Claims Paid	Total Amount Paid
2011	110,404	$ 25,411,932
2012	141,941	35,105,389
2013	217,581	45,602,509
2014	315,870	59,196,643
2015	353,270	58,687,386
2016	444,046	67,796,944
January 1, 2017–August 16, 2017	318,662	49,682,140
Total	1,901,774	$ 341,482,943

Opioids and Opioid Use Disorders

The term "opioid" refers to a family of natural and synthetic substances that includes heroin, morphine, codeine, fentanyl, and oxycodone. Many opioids are prescribed for legitimate medical uses, such as relieving pain, but they are also misused for recreation. The mass.gov webpage "The Massachusetts Opioid Epidemic: A Data Visualization of Findings from the Chapter 55 Report"[2] states that ingesting opioids, for legitimate reasons or recreationally, can lead to opioid use disorders. It also states,

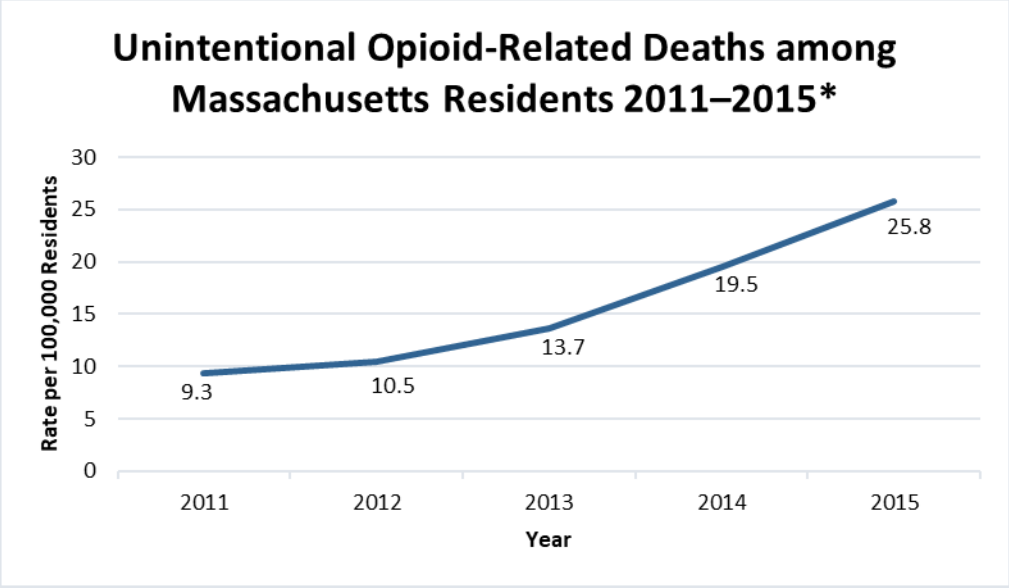
> *Addiction to opioids can put people at greater risk for infectious diseases like HIV or hepatitis, deteriorating conditions like cirrhosis or cognitive decline, family disruption like domestic violence or child abuse, job loss, exposure to criminal behavior, overdose, and death.*

2. Chapter 55 of the Acts of 2015 was passed by the Legislature and signed into law in August 2015. This law permits the use of data to perform trend analysis and issue a report, referred to as the Chapter 55 report, on opioid use in the Commonwealth. The report is a compilation of information provided by 29 Massachusetts entities, including academic institutions, private institutions, and governmental units, providing information on trends and issues related to the opioid epidemic in the Commonwealth.

According to some medical professionals, society also stigmatizes opioid use disorders. For example, the 2016 report *Facing Addiction in America: The [US] Surgeon General's Report on Alcohol, Drugs, and Health* states,

> *We also need a cultural shift in how we think about addiction. For far too long, too many in our country have viewed addiction as a moral failing. This unfortunate stigma has created an added burden of shame that has made people with substance use disorders less likely to come forward and seek help. It has also made it more challenging to marshal the necessary investments in prevention and treatment.*

Opioid use disorders are a significant problem in Massachusetts. The Chapter 55 report estimated that approximately 4.4% of Massachusetts residents over age 11 use opioids. In addition, according to the Health Policy Commission[3] report *Opioid Use Disorder in Massachusetts*, issued in September 2016, hospital inpatient stays related to opioid use in Massachusetts increased by 84% from 2007 through 2014. Further, a 2016 Department of Public Health (DPH) publication titled *Data Brief: Opioid-Related Overdose Deaths among Massachusetts Residents* reported that the rate of unintentional opioid-related deaths of Massachusetts residents[4] rose from 9.3 to 25.8 deaths per 100,000 residents from 2011 through 2015, as shown below.



* Figures include deaths, excluding suicides, that are confirmed or suspected to be related to opioids. Source: DPH data brief *Opioid-Related Overdose Deaths among Massachusetts Residents.*

3. Massachusetts established the Health Policy Commission as part of Chapter 224 of the Acts of 2012. The commission is responsible for monitoring healthcare spending growth of both public and private insurers and healthcare organizations in Massachusetts and for promoting transparency, accountability, and ways to control increases in healthcare costs.
4. Figures include deaths that are confirmed or suspected to be related to opioids.

Medication-Assisted Treatment

According to the federal Substance Abuse and Mental Health Services Administration (SAMHSA), medication-assisted treatment (MAT) for opioid use disorders consists of a combination of prescription medication and outpatient opioid use disorder counseling to provide patients with behavioral coping skills to treat their disorders. Treatment strategies can vary widely depending on the patient. According to SAMHSA's website, programs, and campaigns, as well as the Chapter 55 report, some patients require long-term monitoring and intervention in a formal healthcare setting, and others may be able to achieve stability on their own or through self-help groups.

According to SAMHSA, the American Society of Addiction Medicine (ASAM), the National Institute of Drug Addiction, and healthcare professionals with whom we spoke who have been trained in treating opioid use disorders, patients who require medication to treat such disorders usually receive either buprenorphine or methadone. Patients who receive methadone typically obtain daily doses along with mandatory counseling on site at a federally regulated opioid treatment program, frequently referred to as a methadone clinic. Patients receiving buprenorphine obtain a prescription for buprenorphine and ingest the medication at home. New patients visit buprenorphine prescribers frequently, but visits become less frequent (typically once per month) as the patients stabilize. Buprenorphine patients can receive prescriptions from a variety of healthcare providers, ranging from individual family practitioners to healthcare providers in clinics or large academic hospitals who have been specifically trained in treating opioid use disorders. SAMHSA encourages buprenorphine prescribers to ensure that patients also receive opioid use disorder counseling as a best practice.

The primary goal of opioid use disorder treatment is to counteract the disruptive effects of these disorders. Successful treatment enables patients to reestablish productive living situations in their families, workplaces, and communities.

Opioid Use Disorder Counseling

MassHealth covers medically necessary opioid use disorder counseling for all members. However, there are no regulations that require members who are prescribed buprenorphine to obtain counseling to overcome opioid use disorders. Additionally, MassHealth does not require providers who prescribe buprenorphine to ensure that members receive opioid use disorder counseling. Rather, providers who treat members for opioid use disorders make their own determinations of the quantity and frequency of

counseling depending on each member's individual needs and/or a treatment program's policies and procedures. Nonetheless, opioid use disorder counseling is an essential component of MAT.

Two major authorities on treating opioid use disorders, ASAM and SAMHSA, recommend counseling in conjunction with any pharmacological treatment of opioid use disorders and believe that the combination of medication and counseling is the most effective approach to treating patients. Additionally, various SAMHSA Treatment Improvement Protocols[5] and a study by the US Surgeon General have reported the effectiveness of individual opioid use disorder counseling and generally support its use as an effective intervention for patients with such disorders. In fact, Section 823 of Title 21 of the US Code requires physicians to be able to refer patients to appropriate counseling before they are allowed to prescribe buprenorphine.

Opioid use disorder counseling may be delivered in many different forms depending on a person's needs. For example, it may consist of individual or group sessions, self-help programs, or meetings with peer recovery coaches. Opioid use disorder counseling is delivered by a wide range of professionals, including physicians, clinical psychologists, clinical social workers, nurse practitioners, clinical nurse specialists, and physician assistants. It may include cognitive behavioral therapy, motivational enhancement therapy, patient education, and/or prevention education.

Buprenorphine

Approved by the federal Food and Drug Administration in 2002 for opioid use disorder treatment, buprenorphine is a partial opioid agonist that can activate the various opioid receptors in the brain to allow for some opioid effect, but less of an effect than a full agonist, such as heroin, has. This helps reduce symptoms of opioid withdrawal and cravings. Sometimes buprenorphine is combined with naloxone, which binds to opioid receptors and can fully block the effect of other opioids, to prevent misuse of buprenorphine. Buprenorphine is available in both tablet and sublingual (under the tongue) film form.

Practitioners must be certified by the federal Drug Enforcement Agency before they can prescribe buprenorphine to MassHealth members.

5. Specifically, SAMHSA Treatment Improvement Protocols 40 and 43 address this issue.

Medication and counseling are important factors in opioid use disorder treatment; however, patients who receive buprenorphine to treat opioid use disorders are not required to obtain counseling. Some addiction medicine professionals told us that some buprenorphine patients are unwilling to obtain counseling; the providers believe it is better to continue treating the patients without counseling than to stop treatment.

AUDIT OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with Section 12 of Chapter 11 of the Massachusetts General Laws, the Office of the State Auditor (OSA) has conducted a performance audit of opioid use disorder counseling provided to MassHealth members who received buprenorphine as part of their medication-assisted opioid use disorder treatment for the period January 1, 2011 through December 31, 2015. The audit included interviews with sampled member prescribers that were conducted between February 6, 2017 and August 16, 2017.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Below is our audit objective, indicating the question we intended our audit to answer, the conclusion we reached regarding the objective, and where the objective is discussed in the audit findings.

Objective	Conclusion
1. Do MassHealth members who are treated with buprenorphine for opioid use disorders receive, or have access to, appropriate and necessary counseling?	**No; see Findings 1 and 2**

To achieve our audit objective, we reviewed and analyzed medical claim data from the state's Medicaid Management Information System (MMIS) and used the data when selecting our sample population for testing. We relied on the work performed by OSA in a separate project that tested certain information system controls in MMIS, which is maintained by the Executive Office of Health and Human Services. As part of the work performed, OSA reviewed existing information, tested selected system controls, and interviewed knowledgeable agency officials about the data. Additionally, we performed validity and integrity tests on all claim data related to our audit objective, including (1) testing for missing data, (2) scanning for duplicate records, (3) testing for values outside a designated range, (4) looking for dates outside specific time periods, and (5) tracing a sample of claims queried to source documents. We identified an issue (Finding 3) when tracing a sample of claims to source documentation maintained by prescribers. Specifically, prescribers for six of the sampled members tested did not maintain any

documentation for services provided. Based on our procedures, despite the issue discussed in Finding 3, we determined that the data obtained were sufficiently reliable for the purposes of this report.

From discussions with MassHealth officials, we gained an understanding of internal controls over MassHealth's process for ensuring that members have access to opioid use disorder counseling.

We conducted 12 informational interviews with healthcare professionals and personnel at healthcare programs, such as Duffy Health Center, who specialize in treating opioid use disorders. We also met with behavioral health professionals at the six managed-care organizations MassHealth had under contract at the time of our audit (Health New England, Boston Medical Center HealthNet, Fallon, Tufts Health Plan, Neighborhood Health, and Celticare) to provide care for some of its members. Finally, we met with representatives from the Massachusetts Association for Behavioral Healthcare. This research gave us an understanding of current practices for the treatment of MassHealth members with opioid use disorders, the various healthcare settings in which members can be treated, and the other issues associated with members accessing counseling.

Given the sensitivity and confidentiality of the information we used in selecting a sample of members for testing, we will not disclose specific members' personal information in this report.

We selected a statistical sample of 103 MassHealth members who were given at least one prescription for buprenorphine between January 1, 2011 and December 31, 2015. We identified a prescribing physician for each of the 103 sampled members and conducted interviews to determine whether each member had access to necessary counseling. We shared our sample and test plans with MassHealth officials at the audit entrance conference and in meetings during audit fieldwork. We did not extrapolate the results of our findings to the population of members because 20 of the sampled prescribers did not respond to our requests for interviews.

When determining whether members had access to counseling for opioid use disorders, we reviewed claim data from January 1, 2011 through December 31, 2015 for all members who had obtained at least one prescription for the following drug names, to which we will refer as buprenorphine:

- Buprenorphine
- Suboxone
- Zubsolv

- Bunavail

When determining whether members received any services associated with counseling for their opioid use disorders, we considered the following procedure codes, many of which are not specifically for counseling and therapy, but are sometimes used by providers when treating members for opioid use disorders: 99201–99205, 99211–99215, 99408, 99409, H0001, H0004, H0005, T1006, 90882, 90486, 90791, 90792, 90832–90834, 90836–90840, 90863, 90887, 90889, S9485, 90847, 90853, H2015, H2019, H2027, H0038, 90806, H2018, and G0463. For 83 sampled members, we interviewed the prescribers and reviewed the medical files for evidence of medical services provided, such as individualized treatment plans. If a member had more than one prescriber during the audit period, we selected the one who made the highest number of prescriptions, prescribed the highest number of units, or made prescriptions that resulted in the highest amount paid to the pharmacy that filled the prescriptions.

Additionally, for the 103 sampled members, we reviewed fee-for-service and encounter claim data in MMIS and from Member All Service Reports (reports listing all medical services provided to a member within a certain time period) to determine whether the members received counseling while they were prescribed buprenorphine. We also performed data analytics on the prescriptions and counseling that all members received during the audit period to determine whether any members received prescriptions without counseling.

To determine whether members had access to appropriate counseling, we researched each prescriber for our audit sample to verify that they obtained certifications and/or medical specialties in addiction medicine, using physician locator search tools on the websites of the American Society of Addiction Medicine, the Substance Abuse and Mental Health Services Administration, the American Board of Preventive Medicine, the American Board of Addiction Medicine, and the American Board of Psychiatry and Neurology.

DETAILED AUDIT FINDINGS WITH AUDITEE'S RESPONSE

1. Twenty-seven percent of MassHealth members who were treated for opioid use disorders did not receive, and/or may not have had access to, recommended counseling.

Although it is widely recognized that effective treatment for opioid use disorders using medication-assisted treatment (MAT) includes both medication and counseling, we found that for various reasons, MassHealth and its prescribers did not effectively facilitate member participation in, and access to, necessary counseling. As a result, these members may not have received the most effective treatment to combat their opioid use disorders.

Using data analytics, we found that approximately 7,000, or 27%, of the MassHealth members treated with buprenorphine from January 1, 2011 through December 31, 2015 did not receive any type of opioid use disorder counseling. We found several issues with the administration of counseling related to the members in our sample:

Type of Problem	Number of Sampled Members
Prescribers did not know whether the members they were treating for opioid use disorders actually received their prescribed counseling.	11
Prescribers did not enforce consequences (e.g., directing members to other types of treatment) for members who did not attend their prescribed counseling, even though their treatment policies required members to participate in counseling.	33
Prescribers stated that members experienced wait times to obtain counseling. Wait times ranged from a few days to 12 months.	23

Although it was not possible to determine from the data exactly why this occurred for all 7,000 members, our interviews with prescribers for 83 of 103 sampled members revealed a number of possible reasons, described in the "Reasons for Issues" section below.

Authoritative Guidance and Best Practices

Section 823(2)(B)(ii) of Title 21 of the US Code imposes the following requirements as a condition of dispensing controlled substances, such as buprenorphine:

> *With respect to patients to whom the practitioner will provide such drugs [as buprenorphine] or combinations of drugs [i.e., any controlled substances listed by the Drug Enforcement*

Administration as schedule III, IV, or V controlled substances], the practitioner has the capacity to refer the patients for appropriate counseling and other appropriate ancillary services.

Providing opioid use disorder counseling as part of MAT for people who have opioid use disorders is widely accepted as a best practice, as evidenced by the following examples:

- The federal Substance Abuse and Mental Health Services Administration's (SAMHSA's) *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction: Treatment Improvement Protocol (TIP) Series 40* states that opioid use disorder treatment with buprenorphine is most effective in combination with opioid use disorder counseling.

- The American Society of Addiction Medicine's (ASAM's) *Opioid Addiction Treatment Guide* states that opioid use disorder counseling is essential in conjunction with any pharmacological treatment, including buprenorphine.

- Several MassHealth opioid use disorder treatment professionals and personnel at opioid use disorder treatment programs we interviewed indicated that counseling is highly recommended to all patients. In fact, personnel at one large Boston-based opioid use disorder program told us they required all opioid use disorder patients to participate in counseling as a condition of treatment.

- The chief executive officer of the Association for Behavioral Healthcare[6] told us in interviews that the association's members who are also behavioral healthcare providers believe strongly in opioid use disorder counseling for patients who are treated with medication. The association is currently working with Congress and state officials to enhance health systems to enable high-quality opioid use disorder counseling.

Reasons for Issues

Interviews with prescribers, and reviews of their medical records, indicated that some MassHealth members encountered three main types of obstacle in obtaining opioid use disorder counseling—programmatic limitations, limited counseling options, and lack of understanding of available services and/or treatment protocols—as detailed below.

Reported programmatic limitations include the following:

- Many prescribers stated that there were not enough counselors available for patients with opioid use disorders.

- Prescribers reported a lack of consistency regarding MAT covered by MassHealth's managed-care organizations (MCOs):[7] some MCOs require prior authorization for services, and others do

6. According to its website, the Association for Behavioral Healthcare "represents the community-based mental health and addiction treatment organizations of Massachusetts."
7. Effective March 2018, MassHealth started delivering health services through 17 accountable care organizations instead of through MCOs.

not. In addition, some MCOs limit how many counselors can cover a specific geographic area, causing shortages of counseling in some areas.

- Some prescribers indicated that there is not enough support (for example, case managers) to, among other things, manage members' transition from inpatient detoxification programs to outpatient programs or connect them with MAT prescribers and opioid use disorder counselors.

Reported issues with limited counseling options include the following:

- Many counseling providers do not take walk-in appointments, nor do they provide services on evenings and weekends.
- MassHealth reimbursement rates for opioid use disorder counselors are too low, and there are no additional financial incentives.
- There are few bilingual or multilingual counselors.

Reported issues with a lack of understanding of available services and/or treatment protocols (on the part of both prescribers and members) include the following:

- MassHealth does not have a specific policy requiring prescribers to ensure that members have access to, and receive, opioid use disorder counseling.
- There is limited formal advanced addiction medicine education at medical schools, in residency training, and in continuing education; therefore, many prescribers have not had the opportunity to learn about the importance of counseling in conjunction with MAT.
- MassHealth's website does not provide links (like those it provides for dental services, for instance) that members and their families can use to educate themselves and advocate for counseling during opioid use disorder treatment.

Finally, according to our discussions with some of the prescribers, there are few training opportunities sponsored by the Massachusetts Department of Public Health (DPH), or in the United States as a whole, for addiction medicine.

Recommendations

1. MassHealth should take additional measures to better ensure that prescribers effectively facilitate member participation in opioid use disorder counseling.
2. MassHealth should further investigate the reasons that were provided to the Office of the State Auditor (OSA) during this audit for members' not having access to counseling and take whatever measures it can to minimize these barriers to access.

Auditee's Response

MassHealth agrees with OSA about the importance of best practices and the need to ensure that members with [opioid use disorder, or OUD] receive quality, comprehensive care. However, MassHealth does not agree with OSA's interpretation of the national guidelines or its resulting conclusions. Specifically, OSA's analysis focused exclusively on only certain billed counseling services but did not account for other relevant treatment and services, including, for example, other outpatient behavioral health services, and nurse care management provided through the office based opioid treatment (OBOT) program. In addition, both the American Society for Addiction Medicine (ASAM) and the Substance Abuse and Mental Health Services Administration (SAMHSA) highlight the need for shared decision-making and patient choice in determining appropriate treatments; SAMHSA guidelines explicitly discuss instances in which individuals choose to not engage in counseling services.

To advance best practices and ensure members with OUD receive quality care, MassHealth, in partnership with the Department of Public Health (DPH), secured [federal approval] for expanding Substance Use Disorder services to combat the opioid epidemic. Over the five year period of the [federal approval] commencing in 2017, MassHealth will increase expenditures on [substance use disorder] and co-occurring disorder treatment services by more than $200 million, including expansion of co-occurring enhanced Residential Rehabilitation Services; supporting expansion of MAT; adding Recovery Coaches and Recovery Support Navigators services as a benefit; and implementing a standardized assessment tool based on the ASAM criteria.

MassHealth has also undertaken an analysis of claims data, the findings of which demonstrate the positive effects of MAT. MassHealth's analysis reviewed FY17 claims for approximately 68,000 members, comprising the entire population of MassHealth managed care enrolled . . . individuals with at least one claim for any service where an opioid use disorder diagnosis was included on the claim. Of these approximately 68,000 MassHealth members, 67% (approx. 46,000) received MAT at some point during the year and of those members, 54% (approx. 25,000) were adherent to MAT, meaning that they received MAT for at least 80% of the year. The data showed that individuals on MAT, regardless of utilization of any other service, cost approximately $4,000 (15%) less per year than the cohort of members with OUD who did not receive MAT. This cost reduction was driven by declines in 24-hour and acute levels of care. Members who were adherent to MAT experienced the greatest reductions in 24-hour levels of care. Finally, members who were on MAT had fewer fatal and/or non-fatal overdoses (7% v. 13%).

Based on the demonstrated efficacy of MAT alone, MassHealth disagrees that the OSA finding of [27%] of sampled MassHealth members on buprenorphine not receiving counseling is necessarily demonstrative of negative care outcomes or a lack of adherence to best practices. OSA's audit does not include an analysis of outcomes for members who did not receive counseling. Furthermore, the OSA analyzed the incidence of certain types of counseling services among the members who received a buprenorphine prescription, but the analysis of MassHealth's claims data described above shows that 95% of MassHealth managed care members with OUD who utilized buprenorphine in FY17 also received at least one outpatient behavioral health service. Additionally, services funded by other state agencies, such as the OBOT nurse care management services would not be identifiable in an analysis of medical claims. The OSA audit does not

account for these services in their analysis of the counseling and behavioral health supports provided to individuals receiving buprenorphine. . . .

The Baker Administration has made an unprecedented commitment to improving behavioral health services—the total investment to date and through FY22 (as a result of the Medicaid waiver) is $1.96 billion. These investments include $68 million in outpatient rate increases; $18 million in inpatient rate increases; an additional $14 million specifically with regard to child specific codes (bringing that investment since FY16 to over $42m); $83 million at [the Department of Mental Health] for adult services, with a very clear expectation that they have the capability to serve individuals with dual disorders; and a $50 million commitment to Community Health Centers (including to raise the rates for adult and child psychiatry) over the next five years. These investments are critical elements in supporting individuals with opioid use disorder with the full continuum of care and supports—not only enhanced MAT, but also strengthened outpatient behavioral health services and recovery coach supports. . . .

MassHealth will continue to invest in behavioral health services, including support for best practices for individuals with OUD and efforts to ensure access to all medically necessary behavioral health services. Furthermore, MassHealth agrees prescribers should offer referrals and follow-up to appropriate behavioral health outpatient counseling services for members who receive MAT services. However, MassHealth disagrees that members should be required to obtain counseling as a condition of obtaining MAT. MassHealth disagrees that specific measures to address rates of engagement in counseling, as defined by OSA, for members with OUD who are prescribed buprenorphine are necessary for the reasons state above.

Auditor's Reply

MassHealth asserts that OSA did not consider other relevant treatment and services, such as other behavioral health services administered by the Massachusetts Behavioral Health Partnership (a MassHealth contractor) and office-based opioid treatment, when conducting our analysis; however, this is not the case. In determining which procedure codes to include in our analysis, OSA conducted interviews with MassHealth, the Massachusetts Behavioral Health Partnership, and various medical professionals who administered office-based opioid use disorder treatment to obtain an understanding of all relevant procedure codes for opioid use disorder counseling. OSA ultimately included, among others, all procedure codes that are billed for behavioral health outpatient treatment paid for by the Massachusetts Behavioral Health Partnership and all outpatient office-based opioid treatment. It was during these interviews that some prescribers called our attention to the fact that not all members had access to appropriate counseling and others had to wait to obtain their counseling, which is why these issues are presented in our report.

Although we do not dispute that it is sometimes appropriate to let members with opioid use disorders choose not to engage in counseling, MAT by definition includes a combination of medication and other

behavioral treatment, which studies have shown is the most effective treatment model. Federal regulations recognize the importance of providing counseling to treat opioid use disorders by requiring doctors to acknowledge, as a condition of dispensing controlled substances such as buprenorphine, that they have the capacity to refer patients to appropriate counseling and other ancillary services. Further, our report does not conclude that members' being on buprenorphine and not receiving counseling always indicates negative care outcomes or a lack of adherence to best practices. Rather, our report presents our concern that MassHealth members who want, and might benefit from, counseling appear not to be receiving it for a variety of reasons and therefore may not have received the most effective treatment to combat their disorders. A number of authoritative sources, including SAMHSA and ASAM, state that the most effective treatment for patients recovering from opioid use disorders is to engage them in counseling while they undergo MAT. This type of treatment protocol is important because, according to the healthcare professionals with whom we spoke, many people with opioid use disorders have additional behavioral health issues (referred to as co-occurring disorders) that may have led to the opioid use. For this reason, many addiction treatment professionals we spoke with during this audit stated that it is important to provide patients with counseling, as it not only helps them recover from opioid use disorders but also helps treat co-occurring disorders.

In its response, MassHealth states that it performed its own analysis of fiscal year 2017 claim data and found many positive results from its administration of MAT to its members during this period. Because OSA was not given any information about this analysis during our audit and therefore did not have the opportunity to review it, and because MassHealth's analysis covered a different time period from ours, we cannot comment on MassHealth's analysis. It should be noted that MassHealth's analysis was based on a different approach; it looked at members with diagnoses of opioid use disorders, whereas OSA's analysis was based on members who were prescribed buprenorphine.

MassHealth is correct in stating that our report does not analyze the outcomes of members who did receive counseling versus those who did not. This is because, given that providing opioid use disorder counseling in conjunction with MAT is widely accepted as a best practice, OSA decided to focus the audit work on determining the extent to which members who had opioid use disorders received and/or had access to appropriate counseling and, if not, why.

MassHealth states that our data analysis of medical claims would not have identified office-based opioid treatment nurse care management services. However, this is not the case. While interviewing

prescribers, some of whom participate in the Boston Medical Center's Office-Based Opioid Treatment Program, we asked what procedure codes were used to bill MassHealth for services rendered. We did include these codes (99201–99205 and 99211–99215) in our analysis. We found that during our audit period, approximately 7,000, or 27%, of the MassHealth members treated with buprenorphine did not receive any type of opioid use disorder counseling and therefore may not have received the most effective MAT treatment to combat such disorders. As stated in our report, providing opioid use disorder counseling as a part of MAT for people who have opioid use disorders is widely accepted as a best practice by organizations like SAMHSA and ASAM.

Contrary to MassHealth's statements, OSA did not recommend that MassHealth require all members receiving buprenorphine to obtain counseling. Rather, OSA recommended that MassHealth work with its prescribers to ensure that to the extent practical, they facilitate member engagement in counseling, since it is recognized that counseling in conjunction with medication is the most effective treatment for people with opioid use disorders. To this end, we again recommend that MassHealth further investigate the reasons we were given during this audit for members' not having access to counseling and take whatever measures it can to minimize these barriers to access.

2. Some MassHealth members are not receiving opioid use disorder counseling from healthcare professionals who either are certified or specialize in addiction treatment.

When we interviewed 83 prescribers for 103 sampled members, 49 prescribers responded that they personally gave the sampled members opioid use disorder counseling. Of these 49 prescribers, 11 may not have the qualifications necessary to provide effective counseling for members being treated for opioid use disorders. Specifically, the physicians specialized in internal medicine, family medicine, or psychiatry, not addiction medicine. None of them had addiction medicine certifications from the American Board of Preventive Medicine, American Board of Psychiatry and Neurology, or American Board of Addiction Medicine. As a result, some members may not have received comprehensive counseling when undergoing treatment for opioid use disorders.

Best Practices

According to an ASAM article titled "How to Identify a Physician Recognized for Expertness in the Diagnosis and Treatment of Addiction and Related Health Conditions," a qualified substance abuse counselor should possess expert knowledge, training, and education in the field of addiction medicine.

ASAM recommends that healthcare professionals complete an accredited residency or fellowship in addiction medicine or addiction psychiatry or obtain a certification or subspecialty in addiction medicine from one of the following boards:

- ASAM or the American Board of Addiction Medicine
- the American Board of Preventive Medicine
- the American Board of Psychiatry and Neurology
- the American Osteopathic Association

Reasons for Issue

MassHealth does not specifically identify what type of education or certification counselors should obtain to provide counseling to members recovering from opioid use disorders. According to physicians we interviewed as part of this audit, there is a lack of training opportunities sponsored by DPH, and in the United States as a whole, for counseling in the field of addiction medicine.

Recommendation

MassHealth should collaborate with DPH to ensure that opioid use disorder counselors have the proper training, skills, and knowledge to provide effective opioid use disorder counseling.

Auditee's Response

MassHealth agrees that practitioners providing counseling, and other services, to members with OUD should be qualified and well trained, but disagrees with this OSA finding. The OSA audit bases its finding on ASAM's public policy statement "How to Identify a Physician Recognized for Expertness in the Diagnosis and Treatment of Addiction and Related Health Conditions." The scope of this ASAM public policy statement is specific to recognizing whether a physician has expertise in addiction. . . . The OSA finding extrapolates from this publication that all counselors must have the qualifications outlined in the publication, including having completed a residency or fellowship in addiction medicine or addiction psychiatry or obtained a certification or subspecialty in addiction medicine from a medical board. There is no indication that any practitioners treating MassHealth members with OUD are operating outside of their scope of practice or licensure. In fact, many different practitioner types can appropriately provide treatment, including counseling, to members with OUD. The ASAM guidelines recommend a broad range of practitioners according to individual patient need. An overview of the ASAM guidelines published by the Medicaid Innovation Accelerator Program states that providers eligible to provide treatment in an outpatient setting may include "appropriately credentialed

and/or licensed treatment professionals including counselors, social workers, psychologists, and physicians (whether addiction-credentialed or generalist)." . . .

Furthermore, best practices for the treatment of OUD must also include treatment for co-occurring disorders, as appropriate. MassHealth members with OUD have a high prevalence of co-occurring disorders and integrated treatment planning and delivery for co-occurring disorders involves a range of healthcare professionals. Such healthcare professionals must necessarily have a broader range of expertise than those recommended within this audit finding.

Auditor's Reply

In its response, MassHealth points out that according to Medicaid Innovation Accelerator Program guidelines, a broad range of appropriately credentialed and/or licensed treatment professionals, including counselors, social workers, psychologists, and physicians, are eligible to provide opioid use disorder treatment in outpatient settings. We do not dispute this fact, but as noted above, MassHealth does not specifically identify what type of education or certification counselors should obtain to provide counseling to members recovering from opioid use disorders. OSA acknowledges that there are various appropriately trained and/or credentialed healthcare professionals who could effectively provide these services. However, during our audit, we looked at whether the physicians providing the counseling to the members in question had any specialized training in this area. As noted above, we found that 11 might not have the qualifications necessary to provide effective counseling for members they were treating for opioid use disorders. They specialized in internal medicine, family medicine, or psychiatry, not addiction medicine; none of them had addiction medicine certifications. OSA is not asserting that all counselors who provide services to members must have this specialized training, but that members may have better outcomes if they receive counseling from healthcare professionals who have had such training. In support of this, as noted above, ASAM has stated that a qualified substance abuse counselor should possess expert knowledge, training, and education in the field of addiction medicine.

Further, OSA does not state or suggest that the MassHealth providers in question are working outside the scope of their practice or licensure. Rather, our concern is that MassHealth does not currently have any policies or regulations that specifically identify the standards, including the types of education and certification, its counselors should obtain to provide counseling to members recovering from opioid use disorders. We encourage MassHealth to work with DPH to develop and document such standards.

In its response, MassHealth states that appropriate treatment for opioid use disorders must also include treatment for co-occurring disorders, as appropriate. Although we do not dispute this assertion, OSA

believes that in addition to receiving counseling for their co-occurring disorders, members might benefit from counseling by a healthcare professional with a certification or specialties in addiction medicine.

3. Prescribers did not always maintain documentation supporting medical visits where prescriptions were given to MassHealth members.

Prescribers from our sample did not always maintain documentation for medical visits in which they gave buprenorphine prescriptions to MassHealth members. Specifically, five prescribers wrote a total of 72 prescriptions for 6 members (for a total of $22,733 paid to pharmacies by MassHealth) but did not keep any kind of documentation, such as prescriptions issued or medical services provided. The lack of documentation that buprenorphine, a highly addictive controlled substance, was prescribed to the members in question creates a risk of their misusing the substance.

Authoritative Guidance

According to Section 433.409(D)(1) of Title 130 of the Code of Massachusetts Regulations (CMR), a physician must maintain documentation of all medications prescribed to members, and this documentation must include dosage and strength:

> *Medical records corresponding to office, home, nursing facility, hospital outpatient department, and emergency department services provided to members must include the reason for the visit and the data upon which the diagnostic impression or statement of the member's problem is based, and must be sufficient to justify any further diagnostic procedures, treatments, and recommendations for return visits or referrals. Specifically, these medical records must include, but may not be limited to, the following . . .*
>
> *(g) any medications administered or prescribed, including strength, dosage, and regimen.*

In addition, according to 130 CMR 450.205(A), MassHealth will not pay a provider for services if the provider does not have adequate documentation of the services.

Reasons for Issues

None of the five prescribers provided a reason for not maintaining documentation.

Recommendation

MassHealth should conduct a review of these prescribers' medical documentation and recover any payments for services that were not properly documented.

Auditee's Response

MassHealth agrees with OSA's recommendation that an additional review of these five prescribers is warranted based on the apparent lack of medical documentation. Once the final draft of the audit is issued and the five prescribers are identified, MassHealth intends to conduct an audit to further investigate the lack of documentation for these providers. If MassHealth determines that these prescribers systematically lack documentation in their practice, MassHealth will take appropriate actions, which may include recovery of payments.