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Massachusetts Substance Use Disorder Treatment Organizations' Perspectives on the Affordable Care Act: Changes in Payment, Services, and System Design

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Abstract

The Affordable Care Act (ACA) expanded insurance benefits and coverage for substance use disorder (SUD) treatment and encouraged delivery and payment reforms. Massachusetts passed a similar reform in 2006. This study aims to assess Massachusetts SUD treatment organizations' responses to the ACA.

Organizational interviews addressing challenges of and responses to the ACA were conducted in-person June–December 2014 with 31 leaders at 12 treatment organizations across Massachusetts. Many organizations were affiliated with medical or social services and offered a range of SUD services. Sampling was based on services offered (detoxification only, detoxification and outpatient, outpatient only). Framework analysis was used.

Challenges identified were considered similar to ongoing challenges, not unique to the ACA. Organizations experienced insurance expansions in 2006 and faced new challenges, including insurance coverage, payment arrangements, expansion of services, and system design. System design efforts included care coordination/integration, workforce development, and health information technology. Differences in responses related to connections with medical and social service organizations.

Many organizations engaged in efforts to respond to changing policies by expanding capacity and services. Offering a range of SUD treatment (e.g., detoxification and outpatient) and affiliating with a medical organization could enable organizations to respond to new insurance, delivery, and payment reforms.

Keywords

Affordable Care Act; Insurance; Substance use disorder treatment; Organizational networks

Introduction

The Affordable Care Act (ACA) presented an enormous opportunity for individuals with substance use disorders (SUDs) to access health insurance that covers SUD treatment and for SUD treatment system innovations (McLellan & Woodworth, 2014). SUD treatment has historically been separated from the general health care system clinically, organizationally and financially. The ACA has the potential to bring these long-separated systems together through policies that expand insurance coverage options to populations that disproportionately include individuals with SUDs, expand the scope of SUD treatment services covered by insurance, align SUD and general health financing and organization, expand the locations in which SUD treatment are encouraged (e.g. primary care offices), and facilitate implementation of evidence-based practices and quality improvement (Buck, 2011; McCrady, 2013; McLellan & Woodworth, 2014).

The ACA was expected to expand coverage of mental health and SUD care to over 60 million Americans due both to expansion of insurance benefits and of insurance coverage (Beronio, Glied, & Frank, 2014), posing the question of what will happen to SUD treatment access and utilization across the country. Specialty SUD treatment specifically was expected to increase 36% (Ali, Teich, Woodward, & Han, 2016). Results of studies on the effect of the ACA on SUD treatment to date have found insurance coverage rates of those with SUDs have increased, but treatment rates have not (Creedon & Cook, 2016; Saloner, Antwi, Maclean, & Lê Cook, 2014; Saloner, Bandara, McGinty, & Barry, 2016) despite significant unmet need (Busch, Meara, Huskamp, & Barry, 2013).

Because of these insurance expansions, the ACA was expected to shift SUD treatment funding toward Medicaid and, to a lesser extent, private insurance and away from the state general revenue and block grant spending. This shift is expected to lead to a variety of changes for the public SUD treatment system, including the organization of SUD treatment, the type of workforce needed, and services offered (Buck, 2011). Federal experts anticipate consolidation of smaller organizations that may not be able to adapt as well to the changing environment as larger organizations (Buck, 2011), integration of SUD and medical services (Buck, 2011), utilization of a chronic care model (Betty Tai & Volkow, 2013), partnership with health care systems (Tai & Volkow, 2013), and an expanded use of health information technology (Tai, Wu, & Clark, 2012). Massachusetts provides a unique setting to examine responses to the ACA. The state implemented a health reform in 2006 that was similar to the ACA. The 2006 Massachusetts reform, like the ACA, focused on expanding insurance coverage and improving access to care. The reform included an individual mandate to purchase affordable coverage, development of a health insurance exchange (or marketplace), expansion of employer-based and publicly subsidized coverage, and insurance market reforms, including a requirement to offer substance use disorder treatment benefits (Capoccia, Grazier, Toal, Ford, & Gustafson, 2012; Long, Stockley, & Nordahl, 2012). It has led to increases in insurance coverage and access and improvements in physical and mental health status and affordability, particularly for the most economically disadvantaged (Long et al., 2012; Pande, Ross-Degnan, Zaslavsky, & Salomon; van der Wees, Zaslavsky, & Ayanian, 2013).

In response to the 2006 Massachusetts reform, SUD treatment providers increased admissions, number of services offered, use of pharmacotherapy, and acceptance of private insurance (Maclean & Saloner, 2015). At the same time, programs for special populations (e.g., seniors, LGBTQ, criminal justice involved) decreased (Maclean & Saloner, 2015). Decreases in inpatient hospital admission for SUD due to the reform were observed (Meara et al., 2014) along with increased ancillary SUD service use (Maclean & Saloner, 2015), which would be expected following an insurance expansion as people with SUDs then would have access to treatment outside of the inpatient setting. However, another study found the reform did not increase utilization, the percentage of uninsured patients with SUDs remains high, and copays for those with insurance were barriers to treatment (Capoccia et al., 2012). Capoccia and colleagues concluded that changes in eligibility, services, financing, system design, and policy may be required in addition to expanded coverage to increase utilization.

In Massachusetts, implementation of the ACA led to additional changes in the insurance market. The ACA altered eligibility for Medicaid and subsidized private coverage. These changes resulted in both the enhancement and reduction of benefits, including shifting residents from subsidized coverage to Medicaid, expansion of subsidy eligibility, and, in some cases, increases in premiums for subsidized care (Kaiser Family Foundation, 2012).

Changes to the SUD treatment system are needed to increase treatment access (Padwa et al., 2016). Yet, many SUD treatment facilities do not have the administrative and infrastructure support, including billing and clinical data systems, to meet demands of general health care financing and managed care as the ACA is implemented (Buck, 2011). Moreover, a national survey of Single State Agencies (SSAs) for addiction treatment, fewer than half reported providing technical assistance for modernizing systems to support insurance participation (Andrews et al., 2015).

The structure of organizations' networks can influence how they respond to health care reform. Robinson and Casalino (1996) suggest provider organizations that own various services (e.g., detox and outpatient) have greater potential for coordinated responses to delivery and payment reforms than those that own one service or are in contractual relationships with organizations that offer different services. Organizations that only own one service (e.g., detox) can be affiliated with organizations that own a different service (e.g., outpatient) through contracts rather than through unified ownership. The greatest advantage of this type of network is their potential for autonomous adaptation to a changing managed care environment. SSAs reported that they are helping SUD treatment programs develop collaborations with other health service programs (Andrews et al., 2015), which seems critical in light of the need to improve access and anticipated increases in coordinated and integrated care under the ACA (Buck, 2011; McLellan & Woodworth, 2014).

This study aimed to assess challenges the ACA presented to SUD treatment organizations in Massachusetts and how organizations responded to the ACA. Specifically, the interviews discussed challenges encountered by each organization, reform efforts in which they took part, and changes each organization made in response to the ACA and the resulting impact on the organization. Organizations were sampled based on the range of services provided to

examine potential differences by organizational networks. Because this study is set in Massachusetts, it has the potential to examine SUD treatment organizations' responses to the ACA in an environment where insurance expansions occurred in 2007. We expected organization's responses to the ACA to vary based on the range of services provided and for some organizations to be involved in delivery and payment innovations because of Massachusetts' leading role in health care reform.

Methods

Sample and recruitment

A sample frame was developed from a list of SUD treatment organizations that receive payments from Medicaid for three reasons: (1) this was part of a larger mixed methods study on SUD delivery and payment reform in Massachusetts using Medicaid data, (2) Medicaid expansion under the ACA was anticipated to significantly expand coverage and access for individuals with SUDs, and (3) Medicaid is one of the largest payers of SUD treatment services in Massachusetts. Organizations were categorized as Detox, Outpatient, or Detox + Outpatient if they offered residential medically monitored detoxification (i.e., withdrawal management), outpatient services, or both, respectively. Organizations were purposively sampled from these three categories to be able to examine potential differences in perceptions of challenges and responses by organizational networks. Data collection took place June–December 2014. Twenty-three organizations were invited to participate based on geographical variation and recommendations of the authors (MB, CH, NL). Twelve agreed to participate, three refused to participate, and eight did not respond.

The sample is described in Table 1. Organizations all provided a range of services and operated across Massachusetts, including in both urban and rural areas. Regardless of organization type, organizations were also affiliated with larger systems, including health delivery systems, social service systems, and a multi-state SUD treatment organization. Five organizations were affiliated with a general hospital.

Of the ten organizations that reported the percentage of revenue from public and private sources, nine received less than a third of their revenue from private insurance. Medicaid was the dominant payer at many organizations. There was a wide range in size. The number of unique clients served annually ranged from 400 to 100,000 (Data not shown).

Interview procedure

Organizational interviews were conducted by an investigator (AQ) with 12 SUD treatment organizations, with a total of 31 executive, clinical, and financial leaders, a sufficient sample size to identify meaningful themes for analysis for qualitative research in health sciences using semi-structured interviews (Guest, Bunce, & Johnson, 2006). Interviews were conducted with one-to-four respondents per organization to gain an organizational perspective. Interviews addressed challenges and opportunities of the ACA, participation in delivery and payment reforms (e.g., coordinated care, Accountable Care Organizations), and organizational changes in response to the ACA. Table 2 presents the questions addressed in the interviews. On average, semi-structured interviews lasted an hour and were digitally

recorded and transcribed. A debrief of each interview was written following the interview to reflect on and summarize the interview.

This protocol was approved by the Brandeis University Institutional Review Board. A waiver of written informed consent was granted because subjects were asked about organizational and professional opinions only. Participants gave verbal consent before data collection. Three interviews were conducted with only one participant, two at Detox + Outpatient organizations and one at an Outpatient-only organization. While there may be concerns about combining individual interview and group interview data (Morgan, 1996), all interviews were analyzed from an organizational perspective and data were reduced in the analysis process, so nuanced differences between individual's responses, language, and tone were not taken into account.

Qualitative analysis

Transcribed interviews were imported into NVivo qualitative software version 10. Data were analyzed using a framework analysis approach (Ritchie & Spencer, 1994), which allows themes to be developed both from the research aims and from the data collected (Pope, Ziebland, & Mays, 2000). Framework analysis involves five stages: (1) familiarization with the data from readings transcripts, debriefs, and listening to recordings; (2) identification of a thematic framework (i.e., a coding guide was developed from the interview guide which was revised after coding two transcripts and if new themes emerged); (3) indexing (i.e., thematic framework systematically applied to all transcripts using NVivo); (4) charting (i.e., a matrix was generated by abstracting and summarizing data from each code for each organization); and (5) mapping and interpretation (i.e., analyses completed by reviewing matrix). Two authors consulted during data analysis (AQ, MB).

Results

Most organizations acknowledged that the ACA presented challenges and contributed to changes in insurance coverage, payment arrangements, services offered, and system design. Challenges were considered similar to those faced by the organizations before the ACA, but were exacerbated by the ACA.

Insurance coverage

ACA insurance expansions were not considered a sea change because of the 2006 Massachusetts reform, but organizations were still concerned about the consequences of ACA insurance expansions. The ACA did not further increase the number of people covered, but it did change which types of insurance people had. For example, clients were moved from the state Medicaid plan to Medicaid managed care plans.

Organizations recognized their payment streams were shifting away from state contracts and other state agency funding to insurance reimbursement. One organization was actively building up the proportion of their revenue from private insurance reimbursement because it observed private insurers paid more than public payers.

Increased insurance coverage was also seen as posing challenges both to organizations and their clients. An organization noted the challenge of billing insurance companies. Respondents also noted that clients with public or private insurance are required to pay co-pays, which they were not required to pay when their care was reimbursed with public funding. These copays were considered a potential barrier to treatment for clients.

Payment arrangements

Organizations generally perceived fee-for-service (FFS)—the dominant insurance reimbursement model—as misaligned with the provision of quality SUD care because it often does not support non-billable services, which are important and may become more important with service integration promoted by the ACA. Low reimbursement rates were also a common concern.

Organizations were concerned with the fiscal solvency of their own organizations and of other SUD and safety-net providers. Organizations reported that they had small operating margins or were losing money. Some organizations that were not profitable on their own were able to continue to operate because they were part of a larger agency. Small outpatient organizations were perceived as most vulnerable in the changing payment environment.

Some organizations did not experience changes in how they are paid while others organizations are being paid in new ways. Organizations were also using funds creatively to pay for new initiatives. One organization reported it now has risk-based contracts as part of its Medicare ACO demonstration and that being at risk for total medical spending partially led to its affiliated health care system's new focus on SUD treatment. A different organization had a pay-for-performance contract with one of its payers and was working on improving payer relationships, including being responsive to payers' reform ideas.

However, organizations discussed being required to follow different policies simultaneously for different payers. Health care reform was perceived as adding to organization's administrative burden because different payers are trying different initiatives and each initiative comes with its own regulations and requirements. This was perceived as particularly challenging for organizations with a social service compared to those with a medical care orientation. One organization perceived that payer regulations limited its autonomy in choosing clinical pathways for their clients and hoped payment reforms would allow for more flexible care delivery.

Service and Capacity Expansion

Organizations were also considering expanding their services and capacity to improve access and meet growing demand. One organization was offering numerous group counseling sessions daily. Another strategy used by multiple organizations was operational policies to increase access to services, such as urgent care phone lines, expanded hours, immediate referrals, and more flexible appointment scheduling.

Another organization was developing a large psychiatric hospital facility, specifically to build acute psychiatric care capacity to be well-positioned to accept alternative payments targeting expensive services, such as inpatient psychiatric care. Detox organizations were

considering expanding detox services and adding outpatient services. Conversely, an outpatient organization was opening a detox, specifically to facilitate growth in its private insurance business to build revenue to support expanded services for all clients.

System Design

Organizations were involved in efforts to change how SUD care was delivered, including coordination and integration efforts, workforce development, and health information technology.

Coordination and integration of behavioral health and medical care—All but one organization was involved in behavioral health and general medical care coordination and integration. Many initiatives were partnerships with local community health centers (CHCs). These initiatives ranged across the continuum of coordination and integration. While some of these initiatives involved only facilitated referrals, others delivering SUD services in medical settings or delivering primary care at SUD treatment organizations.

In some cases, organizations engaged in these activities prior to the passage of ACA. Others began more recently. Organizations did not perceive that their integration efforts were related to the ACA. However, one organization saw integration as an opportunity under the ACA, because it begins to break down some of the stigma around SUDs and other behavioral health disorders.

Most integration efforts were funded by grants; organizations found it difficult to fund such efforts without grants. However, one organization offset the cost of a social worker placed in a primary care office through revenue generated by the social worker billing under one of the licenses of the general medical system of which it was a part. Two organizations were hopeful that after grants ended, alternative payments for integrated services would be developed. Screening and brief intervention was an important strategy across these initiatives. Connecting patients with primary care providers who prescribe Suboxone (medication that combines buprenorphine and naloxone to treat opioid use disorder) was another strategy.

An organization with a negative perspective on integration was principally concerned about the impact of integration on access to care for patients of all socioeconomic statuses. Integration could increase the already large shortage of trained addiction and mental health professionals, because hospitals and primary care may hire staff clinicians from the specialty behavioral health system to deliver services for the medical system rather than partner with a behavioral health care provider. Respondents noted this could lead to the closure of specialty behavioral health treatment organizations.

While the medical focus of coordination and integration was acknowledged by organizations, they also noted a number of social services to be considered in new care delivery models. Other social services were viewed as very important for individuals receiving SUD treatment, including signing clients up for health insurance and connecting them with housing services, food and nutrition assistance, local courts, and other state

agencies. Offering services in multiple languages and trauma-focused care were also noted as important.

Workforce—Organizations observed there was a shortage of behavioral health treatment professionals, including psychiatrists, psychologists and social workers. Organizations perceived this was due to low salaries and the type of work involved. One organization in a more rural part of the state reported it was challenging to find staff who wanted to work there.

In addition to this shortage of providers, workforce development was also a continuing challenge. Organizations expected the workforce would grow to meet the needs of coordinated and integrated care. Organizations added new positions, such as licensed care managers, behavioral health care managers, and health care coaches to expand integrated care services and peer support services.

One organization suggested that if outpatient clinicians were paid salaries, it would encourage team-based care and shared decision making with patients. The salary time could cover non-billable services, like huddles, phone calls with patients, and care coordination, all important for facilitating integrated care.

Workforce development was seen as not only important for clinical staff. One organization discussed challenges they faced with their front-line intake and administrative staff. These staff members struggled to keep up with administrative regulations, and sometimes misunderstandings lead to care being denied.

Health information technology—Managing clinical, utilization, and financial data was considered a challenge within the SUD treatment system and for integrating with the general health care system. Many health reforms required development of health information technology infrastructure to manage clients, staff, and relationships with other organizations. One organization noted these infrastructure developments would be “impossible” for independent behavioral health providers to implement. Another organization suggested streamlining clinical, billing, and reporting systems to improve efficiency and to help meet the data and reporting needs of the organization. Electronic Health Records (EHRs) could be an important part of infrastructure development; however, the cost was more than what some agencies reported they could afford. Organizations noted medical providers received subsidies and incentives to implement EHRs, but behavioral health providers did not, which further disconnected the SUD treatment system from medical care. One organization conducted a needs assessment project to develop its own EHR.

Differences between Organizations

Involvement in innovative delivery and payment reforms varied by organization. Organization type (i.e., Detox, Detox+Outpatient, and Outpatient) did not seem to be the driving factor of organizational differences. Organizations within or connected to medical systems and organizations that offered a wide continuum of SUD and other behavioral health services were more likely to be aware of ACA-related initiatives and changes.

Specialty SUD organizations that offered a range of services and those that offered only one service were equally concerned about the survival of specialty SUD treatment organizations.

Some organizations were actively working on strategic plans to remain autonomous and vital to larger medical systems. While many organizations were working with local CHCs, other organizations were developing connections with local medical systems, including Accountable Care Organizations (ACOs). Organizations connected to larger social service organizations were more vocal about connecting patients to other social services.

Organizations clearly had unique cultures and approaches to clients. CEOs seemed to have a strong role establishing the culture, vision, and values of the organizations. Organizations in rural areas noted the benefit of technological innovations that could improve access to services. Both Detox organizations and one Outpatient organization did not think the ACA affected the SUD treatment system.

Discussion

Results indicate organizations were engaged in efforts to remain open and relevant in a dynamic health care landscape and to improve access to treatment through expanding services and changing care delivery. Despite a few organizations' perception that the ACA was not affecting the SUD treatment system, most organizations seemed to be responding to provisions of the ACA or initiatives promoted by the ACA, such as payment and delivery reforms. These responses moved beyond the initial insurance expansion experienced by these providers after the 2006 Massachusetts health reform and by SUD treatment providers across the United States after the ACA.

A qualitative study of publically funded SUD treatment programs in Los Angeles found that clinical supervisors primarily expected ACA implementation to lead to increased use of SUD services, shifts in the duration and intensity of SUD services, and workforce professionalization and that supervisors were not prepared for actions to align their programs' strategic change plans with policy expectations (Guerrero, Harris, Padwa, Vega, & Palinkas, 2015). While changes in services and workforce development were also identified as response to the ACA in Massachusetts, many organizations were moving forward with delivery changes in their own organizations and some were developing relationships with large medical providers. Developing relationships with general health care organizations is a necessary (Betty Tai & Volkow, 2013) and important step for SUD treatment programs to align with ACA policy expectations and is supported by SSAs, despite their lack of support in other areas (Andrews et al., 2015). To respond to the ACA, the SUD treatment workforce needs to expand the use of health information technology (B. Tai, Wu, & Clark, 2012) and provider training and development (Mechanic, 2012), which participants were doing in this study.

The integration of SUD and general health care is promoted by the ACA and was expected as a result of increased public and private insurance reimbursement for SUD services (Buck, 2011). All but one organization was participating in coordination and integration of behavioral health and medical care projects. The integration of SUD treatment and general

medical care has the potential to change the view of SUDs as different from other illnesses and to improve access, choice, and quality of care because SUDs will be treated more like physical health problems and the locations where treatment is received will expand into the general medical sector (McLellan & Woodworth, 2014). All but one organization was working with a local community health center on coordination and integration initiatives. Community health centers are well positioned to provide SUD treatment because they are set up to bill Medicaid, receive an enhanced Medicaid rate, and many already offer SUD services (Gurewich, Prottas, & Sirkin, 2014; Gurewich, Sirkin, & Shepard, 2012).

Not all organizations were comfortable working with the medical system. However, other organizations were already part of medical systems and saw the value they added to the overall organization. SUD treatment generally is provided in a specialty service sector in predominately small, stand-alone nonprofit or government-operated facilities (Substance Abuse and Mental Health Services Administration, 2010). While the majority of mental health care occurs in general health settings (Wang et al., 2006), the majority of SUD treatment occurs in specialty settings (Buck, 2011). This is an important distinction that could impact the redesign of the SUD and general health care system.

The changes observed in this study, however, may not be directly caused by the ACA, so it is possible changes in SUD care delivery may continue even if the ACA is altered or replaced under the new administration. Changes could be driven by market innovations, which may continue if the ACA is repealed or replaced. Alternatively, these changes might be influenced by the ACA's payment reform innovations, such as Medicare's ACOs and bundled payments. The Centers for Medicare and Medicaid (CMS) is increasingly focused on moving beneficiaries away from FFS and into alternate payment mechanisms. States are also initiating financing changes, such as Massachusetts Medicaid's recently approved Section 1115 Waiver to implement Medicaid ACOs (Slavitt, 2016). These changes in how care is financed could have a dramatic effect on how it is delivered.

Conversely, changes in how care is delivered also need payment mechanisms to support them. Results of this study indicate many organizations are participating in integrated care models that lack sustainable funding. This points to the need for payment models that support integrated care and for the field to develop some integrated care models that can work in new funding arrangements promoted by CMS (Quinn, Rubinsky, Fernandez, Hahm, & Samet, 2017). Creating SUD systems of care to maximize the effect of the ACA on SUD treatment by supplementing existing SUD services and reorganizing treatment components can help address historic separations from the general health care system and other challenges, such as access and continuity of care (Padwa et al., 2016). Creating SUD systems of care could also potentially maximize the effect of SUD treatment if the ACA is repealed. State innovations, including continued use of Section 1115 Waivers, may be critical if the ACA is repealed or key insurance and benefit expansions are overturned.

As new payment mechanisms and systems of SUD care are developed and implemented, SUD treatment organizations' relationships with general health care organizations and other SUD treatment organizations are likely to affect how they respond. This study examined differences in organizations' responses based on the structure of relationships between detox

and outpatient SUD specialty treatment. However, participants' relationships with general health care organizations strongly influenced their perspectives on and responses to health care reform. SUD treatment organizations that own a range of services and are part of general health care organizations are more likely to successfully respond to payment and delivery reforms. SUD treatment organizations that can foster the development of systems of SUD care and contract with general health care organizations could also be successful. Yet, SUD treatment organizations that only deliver one service and are not affiliated with other SUD treatment systems or health care systems are at risk of not being able to adapt to payment and delivery reforms. Results of this study indicate responding to payment reforms may be more challenging for organizations that have more of a social service than medical care orientation. Independent SUD providers may want to consider affiliating with providers that offer different SUD services or general health care providers to develop networks that spread financial risk and facilitate a coordinated response to the shifting policy environment. If changes in networks result in closure of SUD treatment organizations, it will be important to examine the effect on vulnerable populations. For example, the decrease of publicly owned SUD treatment organizations has been found to disproportionately affect Blacks (Cummings, Wen, & Ko, 2016).

The results highlight important challenges and changes to the SUD treatment system in response to the ACA and can inform future research and SUD treatment leaders as the health care reform landscape continues to evolve. The study has a diverse sample of participants in Massachusetts. However, the sample also presents limitations. Firstly, the participants were not randomly selected. Organizations were purposively sampled, but those interviewed were a self-selected group from those contacted. Secondly, a small number of organizations participated. While it was an adequate sample to identify major themes, more granular data could have been generated with a larger sample. While the results of this study cannot be used to make broad generalizations about responses to the ACA, the results are strengthened by the use of framework analysis. Framework analysis is an ideal analysis method for policy research (Pope et al., 2000), particularly to assess policies from perspectives of those affected (Srivastava & Thomson, 2009). The analysis would have been strengthened by the use of additional analysts to independently code data and review interpretations.

In conclusion, these results indicate that in the face of many challenges, publicly funded SUD treatment organizations are engaging in activities to increase access to SUD services through expanding services and capacity as well as redesigning the delivery system by implementing coordinated and integrated care, developing the workforce, and expanding the use of health information technology. Implementing changes like these to respond to insurance expansions or other health care reforms is important in order to ensure individuals with new benefits or new insurance coverage are able to get the care they need. In the midst of the sweeping changes precipitated by the ACA and in the face of potential ACA repeal, the range of SUD services that organizations offer and SUD treatment organizations' relationships with the general health care system and social service agencies are likely to affect how they respond.

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Table 2**Organizational interview health care reform questions**

For the substance abuse treatment system, what do you see as the primary challenge of the Affordable Care Act?
For the substance abuse treatment system, what do you see as the primary opportunity of the Affordable Care Act?
For your organization specifically, what do you see as the primary challenge of the Affordable Care Act?
For your organization specifically, what do you see as the primary opportunity the Affordable Care Act?
Are you participating in any of the following reforms?
Patient-Centered Medical Homes
Integration of behavioral health and primary care
Accountable Care Organizations
Other?
Tell me about changes your organization has made or plans to make in order to respond to state and federal health care reform, such as Chapter 224 and the Affordable Care Act?
How have the changes your organization made impacted the operations of your organization? Think about:
How your organization is paid
Relationships with referral/referring organizations
How staff is paid
The delivery of care

Table 1

Characteristics of Interviewed Substance Use Disorder Treatment Organizations in Massachusetts, 2014

	N=12	
	N	%
Organization Type		
Detox	2	17%
Detox + Outpatient	5	42%
Outpatient	5	42%
Region		
Boston and metro area	4	33%
Central Massachusetts	1	8%
Northeast	2	17%
Southeast	3	25%
Western Massachusetts	2	17%
Part of larger system		
No	4	33%
Health system	5	42%
Social service system	2	17%
Operates outside Massachusetts	1	8%
Affiliated with a general hospital	5	42%
Services provided		
Pharmacotherapy	11	92%
Provide other mental health services	10	83%
Provide other health services	3	25%
Social services	7	58%
Clinically managed detoxification services	7	58%
Medically monitored inpatient detoxification	7	58%
Transitional support services (short term residential)	4	33%
Residential rehabilitation	8	67%
Methadone dosing and counseling	5	42%
Case consultation	8	67%
Intensive outpatient	7	58%
Outpatient counseling/therapy	9	75%
Structured outpatient addictions program	5	42%
Community support provider	7	58%
Locations services delivered		
Different sites	9	75%
One site	3	25%