Minnesota's Plan for the Prevention, Treatment and Recovery of Addiction

Background

Beginning in June 2016, the Alcohol and Drug Abuse Division (ADAD) of the Minnesota Department of Human Services convened a core stakeholder workgroup for the first of five 3-hour work sessions to continue efforts to modernize Minnesota's substance use disorder (SUD) treatment system. The workgroup incorporated and built on the recommendations of the 2013 Legislative Report: Minnesota's Model of Care for Substance Use Disorder and the input collected in the fall 2015 ADAD listening sessions.

A fiscal stakeholder workgroup has also been convened and had its first meeting on August 12, 2016. This workgroup will make recommendations related to funding, including who will be responsible to pay for what.

This document reflects the ongoing stakeholder engagement and policy recommendation work and the recommendations of ADAD. Some of the policy recommendations require legislative action and some are within ADAD's existing authority.

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Recommendations overview

It is necessary to transform our state's SUD treatment system from an acute, episodic model of treatment to a chronic disease, longitudinal model of care. Creating a person-centered recovery-oriented system of care in Minnesota will expand and enhance the nature of services available for substance use disorder, while improving integration and coordination with the rest of health care.

In order to ensure timely access to services, direct access to providers will be a necessary part of the redesign. To effectively address the chronic nature of substance use disorders, we must make available the right level of service at the right time in the right amount. Services that support a person's recovery process over time, such as care coordination and peer recovery support services, must be included in the state's continuum of care.

Access to services will be enhanced by a system that supports services outside of treatment centers, such as at recovery community organizations or other facilities, including schools, clinics, hospitals and jails. This will allow for increased access by decreasing geographic and transportation barriers. Expanded access points would be made possible by permitting Rule 31 services to be provided in the community and through direct reimbursement of appropriately credentialed professionals, who will be eligible for reimbursement of services provided independent of a Rule 31 program.

The availability of culturally specific, special population and inclusive programs and culturally and linguistically appropriate services across the care continuum, is essential to ensure effective treatment for every individual in the state. Adequate availability of these services will help decrease disparate outcomes for cultural and other special populations. Recent legislation that further defined SUD programs serving culturally specific/special populations has laid an important foundation for continuing this effort.

Another important priority for the state is to address the stigma of SUD and its harmful impact on individuals in need of services and support. Stigma creates a barrier for people seeking treatment, can influence funding priorities, often results in prosecution and incarceration (when prevention and treatment may be a more appropriate and effective response), and at times can result in an uninviting reception from non-SUD health care providers who might be unfamiliar with the population (a problem may increase as more SUD clients are moved into integrated health care). Achieving parity for SUD services can also be challenged by stigma.

Reduced duplication, streamlined paperwork requirements and a sustainable rate structure are priorities identified by stakeholders and are important to sustain an effective continuum of care. In order to be truly client-driven, person-centered care will require treatment plans to evolve and be prioritized according to client need and focus. System reform efforts will be informed by these priorities and should be reflected in any modifications or additions to SUD program requirements.

ADAD is pursuing available avenues to resolve lost funding for newly designated Institutions for Mental Diseases (IMD) SUD providers. These proposals over time will align Minnesota's service continuum to maximize federal funding. Currently, Medicaid does not reimburse for Rule 31 residential substance use disorder treatment programs with more than 16 beds, which are designated IMDs. On July 27, 2015, the Centers for Medicare and Medicaid Services (CMS) announced a new opportunity for demonstration projects under Section 1115 of the Social Security Act, and ADAD is currently preparing to submit an application to be a demonstration site (see appendix). One component of the 1115 demonstration project is the opportunity to request authority for federal financial participation for SUD treatment provided to individuals in an IMD. ADAD has begun an ongoing analysis of the substantial changes that will be needed to the current substance use disorder treatment system to achieve the requirements for the 1115 demonstration project.

Recommended Policy Initiatives

Some of the recommendations require legislative action to implement. Recommendations for the 2017 Session are noted with an asterisk*

Model of Care

- ***Direct access/comprehensive assessment.** Modify the access system to allow clients to go directly to a provider for a comprehensive assessment by a credentialed professional to determine intensity and duration of client placement in treatment services. Placements should be subject to utilization review to measure for appropriateness of level and duration of care recommended. The comprehensive assessment would serve the dual purposes of placement and informing the development of a treatment plan. This process eliminates the placing authority function. Seek CMS approval to bill the comprehensive assessment under a new service code reimbursable when performed by an appropriate clinician.

- ***Withdrawal management.** Add Minnesota Statutes, Chapter 245F withdrawal management services to the state's Medicaid benefit set. Withdrawal management services include the provision of treatment services, including care coordination and peer support services. Withdrawal management programs will increase linkages for clients and provide support through either more treatment or connection to support in their community. In addition to freestanding withdrawal management programs, opportunities for programs to provide 245F services in Rule 31 and other appropriate settings will be explored.

- ***Direct reimbursement.** Add appropriately credentialed individuals as eligible vendors of SUD treatment services and change rule and statutory requirements to permit use of the Consolidated Chemical Dependency Treatment Fund (CCDTF) to support the provision of SUD services in settings other than treatment programs, such as in schools, primary care settings, jails.

- ***Care coordination.** Add care coordination as a reimbursable treatment service billable in 15-minute increments. Identify eligible vendors. Care coordination treatment services should be available to a person early, potentially preventing the need for more intensive outpatient or inpatient programming. Care coordination is treatment services provided by individuals credentialed to provide chemical dependency treatment services. If care coordination were available to individuals at early stages of progression, we would expect to see a decrease in the number of individual treatment sessions required, and an individual may not need to attend a 12-week or 20-week program, for example. We also recommend availability of care coordination as a treatment service for those persons who present at a lower level of risk ratings in the dimensions on the Minnesota Matrix than would historically permit treatment services to be delivered. Early intervention via care coordination could address mild SUD severity to prevent progression to moderate or severe SUD and avoid future, higher-intensity services.

- ***Peer support.** Add peer support as a reimbursable treatment service billable in 15-minute increments. Identify eligible vendors—such as Rule 31 and detox and withdrawal management programs, recovery community organizations, primary care clinics, hospitals and other business entities—equipped to provide appropriate supervision of these services and the individuals providing the service. Direct reimbursement is not recommended for this service.

Culturally Specific/Special Populations

- * **Modify the enhanced rate requirements.** Currently, to qualify as a culturally specific/special populations program, at least 50 percent of treatment staff must be of the culture or special population. We recommend legislation to modify the enhanced rate requirements to allow non-treatment program staff to count toward the 50 percent when providing cultural services.
- **Stakeholder engagement.** Conduct meaningful stakeholder engagement that is transparent and committed to honestly and persistently working through conflicts and challenges.
- **Quality assurance for enhanced rates.** Commit to ongoing stakeholder engagement to identify quality assurance methods for the enhanced rate for culturally specific/special population services. Seek any necessary statute or rule changes to require that clients seeking treatment services be screened for culturally specific needs and ensure that those requesting culturally specific treatment services are provided access to them.
- **Funding for culturally specific providers.** Seek non-Medicaid funding opportunities for culturally specific providers such as traditional healers or other unlicensed individuals who provide cultural services to support a client's treatment goals.
- **Decrease disparities in outcomes.** Support the development of culturally appropriate and effective treatment modalities that decrease disparities in outcomes.
- **Develop standards with stakeholders**. Work with stakeholders to consider external standards that could be undertaken to improve the quality and inclusiveness of a program. Explore how culturally competent and inclusive services could also be achieved through staff training requirements and specific attention to clients' needs and desires.
- **Workforce development.** Work with stakeholders to support workforce development that increases the number of providers competent to provide culturally specific services and encourages a workforce with increased demographic diversity.
- **Prevention funding for underserved communities.** Seek increased prevention funding to target underserved communities experiencing disparities. Develop prevention efforts with a holistic and tailored focus for different populations.

Opioid Related Recommendations

- * **Per diem reimbursement**. Eliminate the per diem reimbursement methodology of opioid treatment programs, but retain the basic per diem for the medications and allow opioid treatment programs to bill hourly for non-residential behavioral support services.
- * **Prescription Monitoring Program.** Require programs to ask patients to voluntarily sign a written consent to permit the disclosure of medications dispensed for the treatment of opioid addiction to the Minnesota Prescription Monitoring Program. Not giving consent would have no effect on their ability to receive treatment services.
- ***Positive drug test reporting**. Require opioid treatment programs to report to DHS how many clients receiving "take-home" doses have unexpected drug test results and mandating under what circumstances the program must revoke client's right of "take-homes" following problematic drug tests.
- **Support persons on medically assisted treatment.** Identify incentives for providers to accept people receiving medically assisted treatment (MAT) for opioid dependence. Currently clinics treating people using MAT may not offer a full range of behavioral treatment services. Meanwhile, many treatment providers who focus on behavioral strategies may feel a disincentive to accepting MAT patients. Therefore, treatment providers who focus on behavioral strategies need to be incentivized to accept MAT clients to insure people receive a full range of needed services.
- * **Expanded definition of opioid treatment programs.** Expand the definition of opioid treatment programs to include both agonist and antagonist medications and to serve not only intravenous drug users.
- **Naloxone availability**. Support the increased availability of naloxone and support providing clients with access to Naloxone upon discharge.
- **Barriers to behavioral support.** Monitor barriers to behavioral support services for individuals who use medication-assisted treatment. Continue stakeholder engagement to ensure appropriate access to behavioral supports across the state for all clients, including those engaging in medication assisted treatment.

Primary Prevention

- * **Prevention planning and implementation.** Expand the Prevention Planning and Implementation Program, which focuses on environmental strategies and has demonstrated positive outcomes and improved health.
- * **More RPCs.** Increase the number of Regional Prevention Coordinators (RPCs), which provide training and technical assistance on substance use prevention. Currently, the state is divided into seven large geographical areas covered by RPCs. Increased investment in this program would allow each RPC to have a smaller geographical area and permit more concentrated efforts.

Problem Gambling

- **Cross-addiction education.** Support increased education regarding the risks of cross-addiction when treating gambling disorder or substance use disorder. Support increased cross-referral, integrated treatment services and continuing care when providing services to individuals with gambling and substance use disorder.
- **Ensure best practices.** Work with stakeholders to enhance the current requirements to ensure the use of best practices and person-centered recovery-driven outcomes.
- **Telehealth.** Support increased use of telehealth to expand access to problem gambling treatment. Increase awareness of telehealth technical assistance opportunities and the availability of teleconferencing services.
- **Research.** Establish and develop research to provide data-driven decision-making.

Tobacco Prevention

- **Screening for and addressing nicotine addiction**. The department will provide external communication to SUD treatment providers about screening for and addressing nicotine addiction in treatment as part of an integrated treatment process. Communication will include information on the effectiveness and value of including tobacco cessation as a part of the individual's treatment plan.
- **Support smoking cessation**. Alcohol and Drug Abuse Division will continue to work with treatment providers to explore initiatives to support smoking cessation and to increase awareness of the nicotine cessation services available to all Minnesotans.

Appendix

Section 1115 Demonstration Project

On July 27, 2015, the Centers for Medicare and Medicaid Services (CMS) informed State Medicaid Directors of a new opportunity for demonstration projects under Section 1115 of the Social Security Act. CMS identified the aim of the Section 1115 demonstration initiative as "…to better identify individuals with SUD in the Medicaid population, increase access to care for these individuals, increase provider capacity to deliver effective treatments for SUD and use quality metrics to evaluate the success of these interventions."

One component of the 1115 demonstration project is the opportunity to request authority for federal financial participation (FFP) for SUD treatment provided to individuals residing in Institutions for Mental Diseases (IMD), provided the programs are providing specific American Society of Addiction Medicine (ASAM) levels of residential service. We recognize the significance of the federal funding exclusion for IMDs and the value of seeking FFP for these expenditures. It is important note that the 1115 demonstration project must be budget neutral, meaning the demonstration project cannot cost the federal government more than it would absent the demonstration.

ADAD has begun an ongoing analysis of the substantial changes that will be needed to the substance use disorder delivery system as it is today to achieve the requirements for the 1115 demonstration project. In addition to the normal application process for an 1115 demonstration project, there are additional expectations that are required in order to be considered by CMS. In our ongoing analysis, we have determined that there is some alignment currently with the project requirements, and by the end of this year, ADAD anticipates being able to submit an 1115 demonstration project application to CMS. However, there are some additional conditions that will need to be addressed to support that application, such as:

- Development of a comprehensive evidence-based benefit package. The benefit package must include a full continuum of evidence-based best practices designed to address the immediate and long-term physical, mental and SUD care needs of the individual. The benefit package must incorporate industry-standard benchmarks for defining medical necessity criteria, covered services and provider qualifications;
- Implement a process to assess and demonstrate that residential providers meet ASAM criteria prior to participating in the Medicaid program under the demonstration project and rendering services to beneficiaries;
- Assess individuals for placement in SUD services must be performed by an independent third party who is competent to use ASAM placement criteria. CMS states specifically that an "entity other than the rendering provider" must assess clients for placement, including recommendation of appropriate levels of service and length of care;
- A statewide provider network and resource plan to ensure sufficient access for individuals seeking SUD treatment and sufficient capacity to accommodate a provider's exit from the system;
- Development of processes that ensures seamless transitions and information sharing between care providers and collaboration between primary, mental health, pharmacological and long-term care;

- Creation of a plan and timeframe for coordinating physical and behavioral health services (including section 2703 homes, integrated care models, accountable care organizations and primary care medical homes, including a commitment to implement of such approach within two years after the demonstration;
- Use of program integrity safeguards in SUD, including risk-based screening of newly enrolling providers and a revalidation of existing providers and ensure that there is a process to address billing and other compliance issues;
- Use of a regular utilization review process to ensure services are medically necessary in clinically intensive settings. For example, prior authorization, targeted post-payment claims review and billing system edits to deny claims beyond a time span;
- Demonstrated compliance with Mental Health Parity and Addiction Equity Act (if financial or treatment limitations are introduced);
- Development of plans to incorporate requirements of Home and Community Based Services regulations for person-centered planning;
- Creation of a plan to implement proven strategies to address prescription drug abuse at the state, plan, patient, pharmacy and provider level;
- Demonstrated compliance with benefit, services and timely access requirements for youth and adolescent populations with SUD; and
- Report relevant quality measures from the Medicaid Adult and Children's Core Sets for individuals with SUD, including:
    - the Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF #0004);
    - SUB-3 Alcohol and Other Drug Use Disorder Treatment Provided or Offered at Discharge; and
    - SUB-3a Alcohol and Other Drug Use Disorder Treatment Discharge.

  CMS also asks that states measure the impact of providing SUD service on
    - readmission rates to the same level of care or higher,
    - emergency department utilization, and
    - inpatient hospital utilization.

It is our intention that the 1115 demonstration project application will support the larger SUD reform package and policy initiatives that have been developed with stakeholder engagement over the past several years.

Alcohol and Drug Abuse Division, Department of Human Services

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