A Plan to Include Detoxification Services as a Covered Medical Assistance Benefit

Alcohol and Drug Abuse Division
Minnesota Department of Human Services

December 2014

Legislative Report

Minnesota Department of Human Services

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I. Executive Summary

Overusing drugs and alcohol to the point of acute intoxication and overdose is one of the most dangerous symptoms experienced by citizens with the disease of addiction. Acute intoxication, as with any poisoning, is a serious, life-endangering health condition that requires immediate medical treatment. We should expect that all life-threatening conditions are treated the same way: immediate transport to a health care facility, assessment and treatment during medical transport, equal access to treating facilities across the state, and admission to the facility based on a set of health indicators that are agreed upon by medical professionals.

This is not the case for people experiencing acute intoxication or withdrawal from drugs and alcohol. Individuals frequently go without any health care, either unable to access admission into a facility or triaged inappropriately to the wrong level of care. Some individuals are driven home by law enforcement or travel for as long as two hours to the nearest facility in the back of a squad car. Although law enforcement provides rides to hospitals and detoxification centers in situations where no other transportation is available, officers aren't able to care for the person while driving.

Some people in need of care are denied access to a facility because there is no source of reliable funding to cover their services. Detoxification in facilities other than hospitals is not a Medical Assistance benefit. Services provided in detoxification centers are mostly funded by counties, which are statutorily mandated to pay for services but receive no state or federal funding to cover those costs. Some counties struggle to pay for detox services. Facilities are closing, creating huge service gaps across the state. The statutory mandate is not a sustainable funding mechanism for providing adequate services.

Detoxification services must be restructured and modernized. Since the Affordable Care Act and the Mental Health Parity and Addiction Equity Act were passed into law, the Minnesota Department of Human Services (DHS) has worked with stakeholders to design a new service delivery system referred to, for the first time in Minnesota, as "withdrawal management." For the sake of clarity, it's important to note that detoxification describes the biological process of ridding the body of harmful substances while withdrawal management describes the continuum of services available to people who require a safe and effective medical intervention to avoid more illness or even death.

Within a withdrawal management model, services will focus on a on a medical model. Transportation will be available for all citizens in need of service. To align with a modernization initiative for all substance use disorder treatment, known as the "continuum of care," withdrawal management will be recognized as the first step to services as well as a type of urgent care for individuals who are acutely intoxicated. Withdrawal management facilities will accommodate the burgeoning need for opioid withdrawal in the state and will assist patients in accessing long-term treatment for addiction.

This report recommends that Minnesota develop a model for withdrawal management that incorporates needed medical services, and then seek federal approval for Medicaid reimbursement for the new services. It is recommended that the model include two new levels of withdrawal management service, to either supplant or add to current service standards.

II. Legislation

Laws of Minnesota 2014, chapter 312, article 29, sec. 14.

Sec. 14. **DETOXIFICATION SERVICES PLAN.**
The commissioner of human services shall develop a plan to include detoxification services as a covered medical assistance benefit and present the plan to the members of the legislative committees having jurisdiction over health and human services provisions and funding by December 15, 2014.

III. Introduction

The 2012 Minnesota Legislature directed the Minnesota Department of Human Services (DHS) to collaborate with counties, tribes, and other stakeholders to develop "a community-based integrated model of care to improve the effectiveness and efficiency of the service continuum for chemically dependent individuals." In response, DHS' Alcohol and Drug Abuse Division (ADAD) began a reform effort that same year. To align with best practices for treating substance use disorders (SUD), promoted by the Substance Abuse and Mental Health Services Administration (SAMHSA), ADAD launched a project to encourage providers to provide long-term care instead of episodic care. The shift in how SUD treatment should be provided recognizes that substance use disorders are chronic illnesses that respond best to long-term care and not short-term programming. The value of providing longitudinal care for those suffering with substance use disorders is described in the DHS 2012 *Model of Care* report.[1] As ADAD developed the continuum of care pilot project, the Division also began reform efforts for detox services. Detoxification services are part of the larger continuum, designed to treat acute intoxication and withdrawal from drugs and alcohol. Since 2012, ADAD has collaborated with stakeholders and SAMHSA to transform detox from a service with minimal medical intervention to a medical service with added continuum of care services. The proposed changes for detox services are designed to meet the Centers for Medicare and Medicaid (CMS) medical services criteria for Medicaid reimbursement.

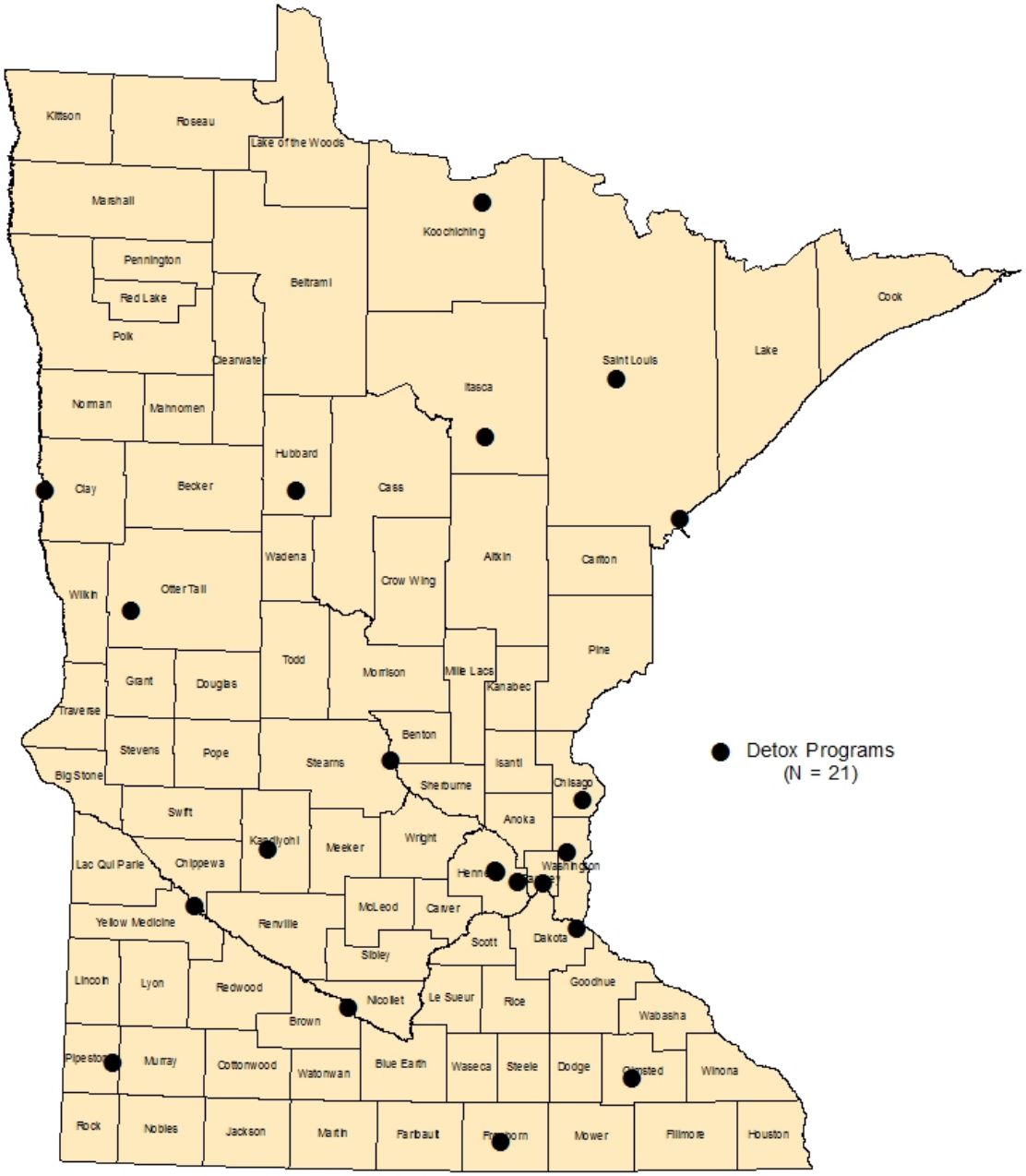
The standards that govern detoxification services in Minnesota are found in Minnesota Rules, 9530.6510 to 9530.6590, referred to as Rule 32. Rule 32 services were not designed to provide a high level of medical care but to provide enough service for an individual to safely detoxify after consuming dangerous amounts of drugs and/or alcohol. Since 1973, counties have been required to provide detox services. With the exception of tribes, managed care plans, Medical Assistance for hospital-based detox services, and private pay, the counties are responsible for 100% of the cost of the service.[2] To meet this requirement, a county may choose to deliver detox services (e.g., Ramsey, Brown); however, most counties contract with a licensed detox provider. The number of licensed detox facilities increased during the 1980s and 1990s. In 2001, there were 27 detox facilities in the state.

Since 2001, the number of detox facilities has been decreasing. Currently, there are 18 licensed detox programs in the state that accept any individual who meets admission criteria. There are another three programs that only admit people to their detox program if they have also been accepted into their residential treatment program. Sixty-nine counties do not have a detox facility operating in their jurisdiction. For counties without detox facilities, individuals must access services in other counties or in hospitals. In the rural and remote parts of the state, detoxification facilities are sparsely distributed. To access a facility, some individuals may need to be transported for hundreds of miles. As the map below shows, there are few detox programs located in greater Minnesota, requiring counties to provide transportation to programs, adding another cost to the county.

[1] https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6706-ENG

[2] https://www.revisor.mn.gov/statutes/?id=254A.08

Minnesota Detox Programs



Source: Minnestoa Department of Human Services (7/30/2014)

Additionally, because of the immediate and often complex medical needs of people in need of detox services, transporting over longer distances is dangerous.

With the implementation of the Affordable Care Act well underway in Minnesota by 2014, including the decision to extend Medicaid coverage to single adults between the ages of 18 and 64, whose incomes are below 138% of the poverty level, it is estimated that many more individuals who need substance abuse treatment services will be eligible for Medical Assistance. Examining the extent to which detox services could now be provided under Medical Assistance to newly eligible single adults, who are the most frequent users of the service, might relieve counties of some of the financial cost of providing detox services.

Also of importance as we consider the service needs of all citizens, there are no detox programs on American Indian tribal lands in Minnesota. Tribal residents can receive detox services in hospitals, medical clinics, or in detox programs not located on tribal lands or administered by tribal governments. The American Indian section of the Alcohol and Drug Abuse Division and the Division's American Indian Advisory Council report extreme hardships for American Indian families that seek detoxification services for their loved ones, only to find there are limited to no services available. Several tribal governments have indicated interest in developing withdrawal management programs for their members if a sustainable financing model is approved in Minnesota.

In 2014, the Legislature directed the Department to develop a plan to include detox services as a covered benefit in the State's Medical Assistance program. As discussed below, the state will need to develop new licensing standards for medical services that are not provided under existing detox standards; address transportation and access issues, especially in greater Minnesota; and identify challenges to financing the new service that must be resolved to meet CMS criteria for reimbursement.

IV. Developing a Medical Service for the Treatment of Acute Intoxication

A. Current Detox Standards Provide Minimal Medical Intervention

Medical services can't simply be added to Rule 32 standards. In order to add a new service to the State Medicaid Plan, it must be approved by CMS as a medical service. Existing detox standards, in current form, do not meet the medical criteria necessary for CMS approval. When compared with other states that have sought and obtained federal approval, there are clear differences between what those states are providing and what we currently require under our detox standards, contained in Rule 32. For example, Oregon includes detox as a covered Medicaid benefit and has developed two levels of medical services that meet federal standards for coverage.

Medical care is provided by doctors, advanced practice registered nurses, registered nurses (RN) and licensed practical nurses (LPN). The costs associated with adding doctors and nurses for on-site medical care greatly surpass the budgets of detox facilities. In detox programs, licensed as Rule 32 programs, doctors are available primarily to approve policies and procedures and rarely to see a patient. Rule 32 programs have minimum requirements for an RN to develop procedures for the provision of nursing care. The RNs that serve in this managerial capacity do not provide much direct service to patients. Most of the hands-on medical care is provided by LPNs, whose scope of practice is too limited to provide much more than a basic health assessment and the administration of a small list of medications. There are several detox facilities that staff with medical technicians and no licensed medical staff during evening and night shifts. Technicians are trained to take vital signs, administer CPR and First Aid, and monitor patients for safety.

The American Society of Addiction Medicine (ASAM) identifies five levels of care for withdrawal management services and sets universal standards for each. The intensity of the levels varies from minimally intensive services to hospital-based medically-managed intensive inpatient programs.

The standards for the operation of detoxification programs are prescribed in Minnesota Rules 9530.6510-9530.6590 (Rule 32). Though these standards promote safety for the highly intoxicated individual, they only set minimal standards for medical care. Rule 32 provides standards for licensing detoxification programs not operated in or by hospitals. Detoxification programs are licensed programs that provide short-term care on a 24-hour basis for the purpose of detoxifying clients and facilitating access to chemical dependency treatment programs as indicated by an assessment of client needs.

DHS recognizes there are many detox service needs that are not addressed in Rule 32 programs, contributing to what is sometimes called a "revolving door" for services. DHS is proposing to add two new levels of service that are similar to ASAM's Level 3.2-WM and Level 3.7-WM. The first level service is called **Clinically Managed Withdrawal Management**, defined as the following:

- Medical evaluation and consultation with licensed practical nurses 24 hours a day
- Initial health assessment conducted by a nurse

- Medical director or delegated licensed practitioner available for emergency consult 24 hours a day

The second level is called **Medically Monitored Withdrawal Management**, defined as the following:

- Medical evaluation and consultation with a registered nurse 24 hours a day
- Initial health assessment conducted by a nurse
- Patients to be seen by the medical director or delegated licensed practitioner within 24 hours of admission, or sooner if medically necessary
- Medical director or designated licensed practitioner able to provide on-site monitoring seven days a week

Adding levels of service will allow providers to offer increased medical services when necessary or offer a less intensive, therefore less expensive level of care when indicated. Individuals with complex medical needs will receive medical care without admission into hospital services. Patients will receive the right amount of care based on the severity of their intoxication, the type of substance used, the severity of their substance use disorder and related health conditions.

In addition to two new levels of service, as part of the modernization of services for substance use disorder, DHS proposes that comprehensive assessment, care coordination, and peer recovery support services are added to the new service standards. A comprehensive assessment will assist with placement into treatment programs that best fit the patient's needs as well as provide a clinical diagnosis. Preparing the patient for treatment can be facilitated through behavioral counseling with an alcohol and drug counselor and through peer recovery services. Linking patients to other services can be facilitated through care coordination services. Assessment, peer recovery services and care coordination are not part of the current service standards but are included in the proposed standards pending legislation. It should be noted here that in order to add more services and subsequently more staff to each withdrawal management program, the service requires more robust financing than an unfunded mandate borne by county governments.

Beginning in 2012, the Alcohol and Drug Abuse Division convened stakeholder work groups representing the state, tribes and counties, managed care organizations, law enforcement, and withdrawal management and substance abuse treatment service providers. Stakeholders discussed gaps in the state's framework for detox services, as well as the shrinking availability of services across the state. The work group identified barriers to accessing existing detoxification services and made recommendations for the integration of detoxification services into the state's substance use disorder (SUD) continuum of care.

In 2014, a department wide workgroup was assembled which included the Alcohol and Drug Abuse Division, the Office of the Inspector General, the Licensing Division, the Health Care Administration, Reports and Forecasts, Transportation Services, the Rates Division and a County Liaison. The workgroup is sponsored by the Office of the Inspector General. After exploring

the benefits of increasing medical services in detox programs, the challenges associated with adding services and taking on higher costs, and the requirements to qualify for federal cost-sharing, the workgroup recommended adding two levels of medical service, seeking a state plan amendment to add withdrawal management as a medical assistance benefit, developing new standards of care, and presenting the standards to stakeholders. External stakeholders include detox providers, SUD treatment providers, counties, tribes and consumers.

B. Transportation Must be Included in New Service

Unless detox services are received in a hospital, there is no payment mechanism for medical transport to detoxification services. Acute intoxication and severe withdrawal are potentially lethal medical conditions. In 2013, the Health Department reported 507 Minnesotans died of all types of drug overdoses including 329 in the 11-county metro area.[3] A 2012 Minnesota Department of Health report titled "The Health of Minnesota," stated "the number of non-fatal, hospital-treated, unintentional poisonings has more than doubled between 1998 and 2008,[4]" which parallels the timeline of detox closings. If a person in need of detox services is driven to a facility located 100 miles from where they were picked up, they receive no medical care for as long as two hours. The risks incurred are greater than any medical patient should experience.

Usually law enforcement is called when an individual needs transport to detox. For especially long trips, law enforcement's responsibility to provide ongoing medical care is beyond their scope as a first responder. This type of service from law enforcement is necessary because transportation is not otherwise available, not because it is considered appropriate duty and duration for law enforcement. Also, since law enforcement agencies are not reimbursed for transportation services, the service demand to drive individuals to detox facilities can divert public safety personnel from other urgent duties.

If withdrawal management is covered as a Medical Assistance benefit, transportation services will be reimbursable.

[3] http://www.startribune.com/lifestyle/health/277974231.html

[4] http://www.health.state.mn.us/healthymnpartnership/sha/docs/1205healthofminnesotasupp.pdf

V. Challenges to Obtaining Federal Approval as Medicaid Benefit

A. Institute for Mental Disease (IMD) Exclusion

The greatest barrier to Medicaid reimbursement for withdrawal management services is the Institute for Mental Disease (IMD) exclusion, a federal law that prohibits reimbursement for services provided in a facility with more than 16 beds, of which more than 50% of the beds are dedicated to treating "mental disease." Despite the fact that patients in a withdrawal management facility will receive medical care, detox facilities are considered IMDs. One option to avoid the IMD exclusion is to provide Medicaid reimbursable services in facilities with 16 or fewer beds. This is how Oregon chose to avoid the IMD barrier.

Also, existing residential treatment programs for people with substance use disorders or mental health disorders could add withdrawal management services, if they already were comprised of 16 or fewer beds. Such an innovation would reduce service gaps created by geographical disparities in this state. It should be noted that not all treatment programs with 16 or fewer beds want or can adopt new withdrawal management standards easily, if at all.

B. Impacts Existing Infrastructure

Rule 32 service providers are in varying states of readiness to provide services under a new set of standards. Consideration of readiness includes a workforce shortage for health care professionals, particularly in the rural and remote areas of the state. Some providers may not be able to access physicians who will provide services on-site. Some may find it difficult to add advanced practice and registered nurses to their staff. Licensed alcohol and drug counselors are also in short supply in greater Minnesota. Some providers may not want to change their services or provide new services. Rates will have to reflect increased costs for adding medical and counseling staff and providing more services. Also, providers will need assistance with complying with new service standards.

C. Clarifying Role of Counties under Withdrawal Management Model

If counties pay a portion of the non-federal share of withdrawal management services, they would expect some control of patient placement, service costs, and how long a client remains a patient in a program. Costs for services is expected to increase, with a return on investment over time as more people stop accessing the "revolving door" of detoxification services. Counties expressed support to include detoxification as a Medicaid eligible service has been two-fold: first, it potentially could reduce property tax burdens, and; secondly, it will enable low income residents to have access to medically necessary services.

VI. Report Recommendations

- The Department should seek approval for a state plan amendment to add withdrawal management as a medical assistance benefit.
- The Medical Assistance benefit should include utilization of medical transportation to detoxification services.
- The Department should submit standards for two new levels of service to the Centers for Medicare and Medicaid Services.
- The Department should add comprehensive assessment, care coordination and peer recovery support to the new standards.
- The Department should establish approved rates that are commensurate with the costs incurred through added levels of medical service.
- The Department should assist with implementation of new standards by providing training to participating providers.
- The Department should encourage the integration of withdrawal management with residential substance use disorder treatment and residential treatment service for mental health disorders to reduce service gaps across the state and assist with seamless transition from withdrawal management services to long-term residential treatment.