DRAFT: Small Policy Changes to 245G and Technical Fixes with Bill Language

- **Update the current title of Chapter 245G** from “Chemical Dependency Licensed Treatment Facilities” to “Substance Use Disorder Treatment Facilities” to reflect the modernized language in the body of the chapter. There currently is no use of the term “Chemical Dependency” in this statute that regulates substance use disorder programs. [Note to Revisor: If it is possible to have search queries for “chemical dependency” show the same results as searches for “substance use disorder” then this would be valuable while people transition to the new terminology. Thank you for your consideration of this]

- **Small policy change.** To ensure that the discharge summary contains current information, the change will require that the discharge summary to be done within 5 days of discharge, irrespective of the date of the decision to discharge. Also expands requirements for certain information to be contained in a discharge summary to include all clients instead of just those that complete the program.

*Minnesota Statutes, section 245G.06, subdivision 4, is amended to read:*

**Subd. 4. Service discharge summary.**

(a) An alcohol and drug counselor must write a discharge summary for each client. The summary must be completed within five days of the client's service termination or within five days from the client's or program's decision to terminate services, whichever is earlier.

(b) The service discharge summary must be recorded in the six dimensions listed in section 245G.05, subdivision 2, paragraph (c), and include the following information:

- (1) the client's issues, strengths, and needs while participating in treatment, including services provided;
- (2) the client's progress toward achieving each goal identified in the individual treatment plan;
- (3) a risk description according to section 245G.05; and
- (4) the reasons for and circumstances of service termination. If a program discharges a client at staff request, the reason for discharge and the procedure followed for the decision to discharge must be documented and comply with the program's policies on staff-initiated client discharge. If a client is discharged at staff request, the program must give the client crisis and
other referrals appropriate for the client's needs and offer assistance to the client to access the services.

(c) For a client who successfully completes treatment, the summary must also include:

(45) the client's living arrangements at service termination;

(26) continuing care recommendations, including transitions between more or less intense services, or more frequent to less frequent services, and referrals made with specific attention to continuity of care for mental health, as needed;

(37) service termination diagnosis; and

(48) the client's prognosis.

- Small policy change that is responsive to stakeholder concerns by permitting educational groups to exceed 16 if a 16:1 client:ADC is maintained for the number of clients that exceed 16; Requires ADAD to maintain a list of individuals who do not meet the staff qualification requirements for alcohol and drug counselor but who are still qualified to provide treatment services by a different credential; Providing clarity that individual and group counseling services must always be provided by an individual who meets the staffing qualification requirements of an alcohol and drug counselor.

Minnesota Statutes, section 245G.07, subdivision 1, is amended to read:

245G.07 TREATMENT SERVICE.
Subdivision 1. Treatment service.

(a) A license holder must offer the following treatment services, unless clinically inappropriate and the justifying clinical rationale is documented:

(1) individual and group counseling to help the client identify and address needs related to substance use and develop strategies to avoid harmful substance use after discharge and to help the client obtain the services necessary to establish a lifestyle free of the harmful effects of substance use disorder. Notwithstanding subdivision 3, individual and group counseling services must be provided by an individual who meets the staff qualifications of an alcohol and drug counselor in section 245G.11, subdivision 5;

(2) client education strategies to avoid inappropriate substance use and health problems related to substance use and the necessary lifestyle changes to regain and maintain health. Client education must include information on tuberculosis education on a form approved by the commissioner, the human immunodeficiency virus according to section 245A.19, other sexually transmitted diseases, drug and alcohol use during pregnancy, and hepatitis.
must not exceed a group size of 16 when it is provided by a qualified individual identified in subdivision 3 who does not meet the staff qualification in section 245G.11, subdivision 4. An educational group may exceed a group size of 16 if a ratio of 16 clients to 1 alcohol and drug counselor is maintained for the number of clients that exceed 16. A licensed alcohol and drug counselor must be present during an educational group;

(3) a service to help the client integrate gains made during treatment into daily living and to reduce the client's reliance on a staff member for support;

(4) a service to address issues related to co-occurring disorders, including client education on symptoms of mental illness, the possibility of comorbidity, and the need for continued medication compliance while recovering from substance use disorder. A group must address co-occurring disorders, as needed. When treatment for mental health problems is indicated, the treatment must be integrated into the client's individual treatment plan;

(5) on July 1, 2018, or upon federal approval, whichever is later, peer recovery support services provided one-to-one by an individual in recovery. Peer support services include education, advocacy, mentoring through self-disclosure of personal recovery experiences, attending recovery and other support groups with a client, accompanying the client to appointments that support recovery, assistance accessing resources to obtain housing, employment, education, and advocacy services, and nonclinical recovery support to assist the transition from treatment into the recovery community; and

(6) on July 1, 2018, or upon federal approval, whichever is later, care coordination provided by an individual who meets the staff qualifications in section 245G.11, subdivision 7. Care coordination services include:

(i) assistance in coordination with significant others to help in the treatment planning process whenever possible;

(ii) assistance in coordination with and follow up for medical services as identified in the treatment plan;

(iii) facilitation of referrals to substance use disorder services as indicated by a client's medical provider, comprehensive assessment, or treatment plan;

(iv) facilitation of referrals to mental health services as identified by a client's comprehensive assessment or treatment plan;

(v) assistance with referrals to economic assistance, social services, housing resources, and prenatal care according to the client's needs;

(vi) life skills advocacy and support accessing treatment follow-up, disease management, and education services, including referral and linkages to long-term services and supports as needed; and
(vii) documentation of the provision of care coordination services in the client's file.

(b) A treatment service provided to a client must be provided according to the individual treatment plan and must consider cultural differences and special needs of a client.

Subd. 2. **Additional treatment service.**

A license holder may provide or arrange the following additional treatment service as a part of the client's individual treatment plan:

(1) relationship counseling provided by a qualified professional to help the client identify the impact of the client's substance use disorder on others and to help the client and persons in the client's support structure identify and change behaviors that contribute to the client's substance use disorder;

(2) therapeutic recreation to allow the client to participate in recreational activities without the use of mood-altering chemicals and to plan and select leisure activities that do not involve the inappropriate use of chemicals. Therapeutic recreation does not include planned leisure activities;

(3) stress management and physical well-being to help the client reach and maintain an appropriate level of health, physical fitness, and well-being;

(4) living skills development to help the client learn basic skills necessary for independent living;

(5) employment or educational services to help the client become financially independent;

(6) socialization skills development to help the client live and interact with others in a positive and productive manner; and

(7) room, board, and supervision at the treatment site to provide the client with a safe and appropriate environment to gain and practice new skills.

Subd. 3. **Counselors.**

A treatment service, including therapeutic recreation, must be provided by an alcohol and drug counselor according to section 245G.11, unless the individual providing the service is specifically qualified according to the accepted credential required to provide the service. The Alcohol and Drug Abuse Division must maintain a current list of individuals qualified to provide treatment services, notwithstanding the staff qualification requirements in section 245G.11, subdivision 4. Therapeutic recreation does not include planned leisure activities.
Subd. 4. Location of service provision.

The license holder may provide services at any of the license holder’s licensed locations or at another suitable location including a school, government building, medical or behavioral health facility, or social service organization, upon notification and approval of the commissioner. If services are provided off site from the licensed site, the reason for the provision of services remotely must be documented.

- **Technical fix.** Clarifies that the intent of 245G.08, subdivision 3 includes injectable naloxone.

*Minnesota Statutes, section 245G.08, subdivision 3, is amended to read:*

A license holder that maintains a supply of naloxone available for emergency treatment of opioid overdose must have a written standing order protocol by a physician who is licensed under chapter 147, that permits the license holder to maintain a supply of naloxone on site, and must require staff to undergo specific training in the mode of administration of naloxone used at the program, which can include intranasal administration or intramuscular injection, or both.

- **Technical fix.** The requirement for OTPs to maintain a 1:50 ratio is currently in an area of 245G that applies to all SUD licensed programs, this technical fix will move the requirement to an area of the chapter that only applies to OTPs, which aligns with how the rest of the OTP-only regulations are organized.

*Minnesota Statutes, section 245G.10, subdivision 4, is amended to read:*

**245G.10 STAFF REQUIREMENTS.**

... Subd. 4. Staff requirement.

It is the responsibility of the license holder to determine an acceptable group size based on each client's needs except that treatment services provided in a group shall not exceed 16 clients. A counselor in an opioid treatment program must not supervise more than 50 clients. The license holder must maintain a record that documents compliance with this subdivision.
Minnesota Statutes, section 245G.22, subdivision 15 is amended to read:

Subd. 15. **Nonmedication treatment services; documentation.**

(a) The program must offer at least 50 consecutive minutes of individual or group therapy treatment services as defined in section 245G.07, subdivision 1, paragraph (a), clause (1), per week, for the first ten weeks following admission, and at least 50 consecutive minutes per month thereafter. As clinically appropriate, the program may offer these services cumulatively and not consecutively in increments of no less than 15 minutes over the required time period, and for a total of 60 minutes of treatment services over the time period, and must document the reason for providing services cumulatively in the client's record. A counselor in an opioid treatment program must not supervise more than 50 clients. The program may offer additional levels of service when deemed clinically necessary.

- **Technical fix. 245G.11, subd 10, update reference to paperwork requirements.**

Minnesota Statutes, section 245G.11, subdivision 10, is amended to read:

Subd. 10. **Student interns.**

A qualified staff member must supervise and be responsible for a treatment service performed by a student intern and must review and sign each assessment, progress note, documentation of treatment services and treatment plan review, and individual treatment plan prepared by a student intern. A student intern must receive the orientation and training required in section 245G.13, subdivisions 1, clause (7), and 2. No more than 50 percent of the treatment staff may be students or licensing candidates with time documented to be directly related to the provision of treatment services for which the staff are authorized.

- **Technical fix: align language in 245G.13, subdivision 1 with chapter and definitions by changing “chemical” to “substance”**

Minnesota Statutes, section 245G.13, subdivision 1, is amended to read:

**245G.13 PROVIDER PERSONNEL POLICIES.**

Subdivision 1. **Personnel policy requirements.**

A license holder must have written personnel policies that are available to each staff member. The personnel policies must:

… (5) identify how the program will identify whether behaviors or incidents are problematic substance use, including a description of how the facility must address:
(i) receiving treatment for substance use within the period specified for the position in the staff qualification requirements, including medication-assisted treatment;

(ii) substance use that negatively impacts the staff member's job performance;

(iii) substance chemical use that affects the credibility of treatment services with a client, referral source, or other member of the community;

(iv) symptoms of intoxication or withdrawal on the job; and

(v) the circumstances under which an individual who participates in monitoring by the health professional services program for a substance use or mental health disorder is able to provide services to the program's clients;

• Technical fix. Corrects citation.

Minneapolis Statutes, section 245G.15, subdivision 1 is amended to read:

245G.15 CLIENT RIGHTS PROTECTION.
Subdivision 1. Explanation.
A client has the rights identified in sections 144.651, 148F.165, 253B.03, and 254B.02, 254B.03, subdivision 2, as applicable. The license holder must give each client at service initiation a written statement of the client's rights and responsibilities. A staff member must review the statement with a client at that time.

• Technical fix: 245G.22, subd 15 (3) uses the term “progress notes”, which was amended in 2017 session

Minneapolis Statutes, section 245G.22, subdivision 15, is amended to read:

245G.22, Subd. 15. Nonmedication treatment services; documentation.

…

…(c) Notwithstanding the requirements of individual treatment plans set forth in section 245G.06:

(1) treatment plan contents for a maintenance client are not required to include goals the client must reach to complete treatment and have services terminated;

(2) treatment plans for a client in a taper or detox status must include goals the client must reach to complete treatment and have services terminated;

(3) for the initial ten weeks after admission for all new admissions, readmissions, and transfers, progress notes documentation of treatment services and treatment plan review must
be entered in a client's file at least weekly and be recorded in each of the six dimensions upon the development of the treatment plan and thereafter. Subsequently, the counselor must document progress in the six dimensions at least once monthly or, when clinical need warrants, more frequently; and

(4) upon the development of the treatment plan and thereafter, treatment plan reviews must occur weekly, or after each treatment service, whichever is less frequent, for the first ten weeks after the treatment plan is developed. Following the first ten weeks of treatment plan reviews, reviews may occur monthly, unless the client's needs warrant more frequent revisions or documentation.

- Technical fix. Corrects a cite error. Clause 6 is care coordination, and there actually is no clause 7.

*Minnesota Statutes, section 254B.05, subdivision 1(c), is amended to read:*

**254B.05 VENDOR ELIGIBILITY.**

Subdivision 1. Licensure required.

(c) On July 1, 2018, or upon federal approval, whichever is later, a county and a tribal government are eligible vendors for a comprehensive assessment and assessment summary when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 4, and completed according to the requirements of section 245G.05. A county is an eligible vendor of care coordination services when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 7, and provided according to the requirements of section 245G.07, subdivision 1, clause (7) (6).

- Small policy change to provide additional identification options for individuals seeking treatment in an opioid treatment program who do not have a government issued photo identification card. The reason for the change is that we do not want clients to be turned down for services if they don’t have government issued photo identification care if the client is able to provide other, equally competent, identification documents.
Minnesota Statutes, section 245G.22, subdivision 14, is amended to read:

Subd. 14. Central registry

(a) A license holder must comply with requirements to submit information and necessary consents to the state central registry for each client admitted, as specified by the commissioner. The license holder must submit data concerning medication used for the treatment of opioid use disorder. The data must be submitted in a method determined by the commissioner and the original information must be kept in the client's record. The information must be submitted for each client at admission and discharge. The program must document the date the information was submitted. The client's failure to provide the information shall prohibit participation in an opioid treatment program. The information submitted must include the client's:

(1) full name and all aliases;
(2) date of admission;
(3) date of birth;
(4) Social Security number or Alien Registration Number, if any;
(5) current or previous enrollment status in another opioid treatment program;
(6) government-issued photo identification. If a client does not have photo identification, the program must submit one of the following forms of identification:
   i. an identification card containing the client’s name and date of birth;
   ii. an identification card containing the client’s name and social security number; or
   iii. the client’s state assigned Person Master Index (PMI) number.
(7) driver's license number, if any.

- Eliminate statement of need requirement. Amend §254B.03 and Repeal Minnesota Rules 9530.6800 and 9530.6810 statement of need requirement for a proposed substance use disorder program regulated by chapter 245G. This requirement has been in place since 1987, and requires a commissioner determination of a need for an additional or expanded substance use disorder program in a county prior to a license being issued. This requirement has become antiquated and cumbersome over the years, losing much of its original intent and purpose. Substance use disorder programs are the only licensed programs required to get a commissioner-issued statement of need prior to issuance of a license.
Subd. 2. Chemical dependency fund payment.

(a) Payment from the chemical dependency fund is limited to payments for services other than detoxification licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, that, if located outside of federally recognized tribal lands, would be required to be licensed by the commissioner as a chemical dependency treatment or rehabilitation program under sections 245A.01 to 245A.16, and services other than detoxification provided in another state that would be required to be licensed as a chemical dependency program if the program were in the state. Out of state vendors must also provide the commissioner with assurances that the program complies substantially with state licensing requirements and possesses all licenses and certifications required by the host state to provide chemical dependency treatment. Vendors receiving payments from the chemical dependency fund must not require co-payment from a recipient of benefits for services provided under this subdivision. The vendor shall not require the client to use public benefits for room or board costs. This includes but is not limited to cash assistance benefits under chapters 119B, 256D, and 256J, or SNAP benefits. Retention of SNAP benefits is a right of a client receiving services through the consolidated chemical dependency treatment fund or through state contracted managed care entities. Payment from the chemical dependency fund shall be made for necessary room and board costs provided by vendors certified according to section 254B.05, or in a community hospital licensed by the commissioner of health according to sections 144.50 to 144.56 to a client who is:

(1) determined to meet the criteria for placement in a residential chemical dependency treatment program according to rules adopted under section 254A.03, subdivision 3; and

(2) concurrently receiving a chemical dependency treatment service in a program licensed by the commissioner and reimbursed by the chemical dependency fund.

(b) A county may, from its own resources, provide chemical dependency services for which state payments are not made. A county may elect to use the same invoice procedures and obtain the same state payment services as are used for chemical dependency services for which state payments are made under this section if county payments are made to the state in advance of state payments to vendors. When a county uses the state system for payment, the commissioner shall make monthly billings to the county using the most recent available information to determine the anticipated services for which payments will be made in the coming month. Adjustment of any overestimate or underestimate based on actual expenditures shall be made by the state agency by adjusting the estimate for any succeeding month.
(c) The commissioner shall coordinate chemical dependency services and determine whether there is a need for any proposed expansion of chemical dependency treatment services. The commissioner shall deny vendor certification to any provider that has not received prior approval from the commissioner for the creation of new programs or the expansion of existing program capacity. The commissioner shall consider the provider's capacity to obtain clients from outside the state based on plans, agreements, and previous utilization history, when determining the need for new treatment services.

Repealer.

Minnesota Rules, parts 9530.6800 and 9530.6810 are repealed.

- **Technical fix.** The change removes peer support services as a service that an individual in private practice can provide. This is correcting a mistake, not changing policy, as individuals in private practice eligible for direct reimbursement as an alcohol and drug counselor are not permitted to have the dual role of peer.

  *Minnesota Statutes, section 254B.05, subdivision 1, is amended to read:*

  254B.05, subdivision 1. Licensure Required
  (b) On July 1, 2018, or upon federal approval, whichever is later, a licensed professional in private practice who meets the requirements of section 245G.11, subdivisions 1 and 4, is an eligible vendor of a comprehensive assessment and assessment summary provided according to section 245G.05, and treatment services provided according to sections 245G.06 and 245G.07, subdivision 1, paragraphs (a), clauses (1) to (5), and (b); and subdivision 2.

  - **Paperwork reduction.** This policy change removes the annual requirement for licensed SUD programs to provide financial information to DHS indicating the costs of their program operation.

    *Minnesota Statutes, section 254B.12, subdivision 1, is amended to read:*

    254B.12 RATE METHODOLOGY.
    Subdivision 1. CCDTF rate methodology established.
The commissioner shall establish a new rate methodology for the consolidated chemical dependency treatment fund. The new methodology must replace county-negotiated rates with a uniform statewide methodology that must include a graduated reimbursement scale based on the patients' level of acuity and complexity. At least biennially, the commissioner shall review the financial information provided by vendors to determine the need for rate adjustments.