Substance Use Disorder Reform

Process and Overview

Improving services, increasing access and building a continuum of care for all of Minnesota

DEPARTMENT OF HUMAN SERVICES
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DHS “... has been working proactively with our partners, providers, stakeholders and citizens of Minnesota to identify strategies to ensure that everyone who needs treatment can access the right service, at the right time, and in the right amount.”

— Substance Use Disorder System Reform Report and Recommendations January 2017 (pg. 6)
SUD reform overview

The Department of Human Services (DHS) is working to make sure that people get timely access to services, that there is a continuum of care across the state, that people can stay in their own home whenever possible, and that services support people’s choices so that they are in control of the care they receive.

While progress is being made, challenges persist. Long wait times for substance use disorder (SUD) assessment and services have created a barrier for many people to getting the care they need. In addition, a number of treatment options that would expand choice, availability and save money have not been reimbursable.

In response to these challenges, in the 2017 legislative session the State made a $2.427 million investment for the biennium in Minnesota’s SUD treatment system:

- The process for accessing treatment will be streamlined by allowing individuals to go directly to providers to receive an assessment.
- Licensed providers will be allowed to provide and be directly reimbursed for services outside of site-based treatment programs.
- The continuum of care will be expanded by adding treatment coordination, peer support services and withdrawal management to the Medical Assistance (MA) benefit set.
- An analysis will be conducted of the payment rate structure and treatment models for SUD services serving people with the highest needs, all toward making sure the system meets people’s needs while being fiscally sustainable for state and local governments.
- The Legislature also passed 2.427 million for a rate increase for SUD providers.

More information

Process: What got us here

The 2017 legislative package was the result of a multi-year process tracing its roots to 2012. DHS has worked closely with counties, tribes, providers and the community, holding community meetings from across the state. In the summer of 2016, DHS convened a core and fiscal stakeholder workgroup to modernize Minnesota’s SUD treatment system. The result was the Policy Recommendations Report and finally the 2017 legislative SUD reform package.

More information
The 2012 Minnesota Legislature directed DHS to collaborate with counties, tribes, and other stakeholders to “develop a model of care to improve the effectiveness and efficiency of Minnesota’s current service continuum for chemically dependent individuals.”

To meet this goal, in 2012 DHS established a steering committee of statewide representative stakeholders and constituents. The steering committee met bi-weekly from September 2012 to February 2013. The steering committee focused on five priorities:

- Improving access to treatment and the assessment process for SUD treatment
- Improving treatment coordination and continuing care for people with SUD
- Increasing diversity and capacity of SUD workforce
- Supporting adoption of electronic records by SUD treatment providers
- Promoting telemedicine as one SUD treatment and recovery support strategy.

The steering committee findings were prepared into a report: 2013 Minnesota’s Model of Care for Substance Use Disorder report. The steering committee concluded that:

- Current wait times for an assessment and for authorization to access SUD treatment are significant deterrents to individuals seeking help.
- Continuing care and peer support expansion could address a gap in Minnesota’s continuum due to lack of availability of enough services to meet the current need.

More information
Model of care pilot

Building on the Minnesota’s Model of Care for Substance Use Disorder report, legislation was passed during the 2013 session directing DHS to establish pilot projects to begin implementing the measures recommended in the report. The first pilot site began operating in late 2014 and the second site began in early 2015.

The main features of the pilot were:

- **Direct access**: Direct access was available via a provider-conducted comprehensive assessment completed by a licensed professional. Direct access eliminates the use of the Rule 25 assessment and reimburses programs for the comprehensive assessment. Pilot assessments are completed within 7 days of request, and placement determinations and authorization of services are within 3 days. Timelines from requesting an assessment to placement approval is 10 days, down from 30 days with Rule 25.

- **Peer support**: Peer recovery support services were available and reimbursable in the pilots. Pilot sites identified culturally specific considerations, recruiting, training and retention opportunities and challenges.

- **Treatment coordination**: Pilots provided treatment coordination by individuals credentialed to provide treatment services. The service is reimbursable in the pilots in 15-minute increments.

- **Telehealth technology**: Pilot services were reimbursable via telehealth. DHS has provided pilot sites training and support for utilization of telehealth services in the pilots.

- **Systems**: The pilots tested measurement and payment systems.

“**Current wait times for an assessment and for authorization to access SUD treatment are significant deterrents to individuals seeking help.**”

— 2013 Minnesota’s Model of Care for Substance Use Disorder report
2015 Listening sessions

In 2015, listening sessions were conducted in eight regions and Tribal communities.

- American Indian Forum—Onamia
- Metro Region—St. Paul and Minneapolis
- Northeast Region—Duluth
- Northwest Region—Thief River Falls
- Southeast Region—Rochester
- Southwest Region—Granite Falls
- West Central Region—Fergus Falls
- Youth Listening Session—Health Occupations Students of America (HOSA) Conference-St. Paul

325 people participated in the listening sessions. The attendees represented a variety of local stakeholders from multiple sectors and organizations. The diverse insights provided by listening session attendees proved invaluable and resulted in the consistent themes identified through the project.

Seven consistent themes were identified from the listening sessions:

- Recognize the importance of culture, tradition, and spirituality. Focus funds on these concepts throughout the services continuum: prevention, intervention, withdrawal management, treatment, treatment coordination, and recovery support
- DHS should improve the availability of and funding for transportation, mental health services and sober housing. DHS should address related workforce shortages, especially in rural areas
- Address the consistent themes within a larger conversation of how to normalize SUD prevention, intervention, treatment and recovery services within healthcare
- Integrate prevention, intervention, treatment and the recovery oriented service continuum into behavioral and physical health care by challenging stigma that has historically kept it separate
- There is a need for safe, affordable housing
• Invest in services to: 1) families with children and adolescents, 2) partner with schools, 3) faith communities, and 4) other local supports
• The state should lead the way with collaborative efforts among state agencies and partner with local agencies and providers.

A final report, Alcohol and Drug Abuse Division 2015 Listening Sessions Summary Report, was issued in March 2016.

More information

2016 workgroups

In 2016, the DHS convened three workgroups to continue stakeholder engagement to redesign the chemical health system: A core stakeholder workgroup, fiscal workgroup and internal DHS workgroup.

The Core Stakeholder Workgroup was comprised of 20 representatives from organizations, stakeholders and interested individuals. The workgroup held five meetings and incorporated and built on the recommendations of the 2013 Model of Care for Substance Use Disorder report, as well as input collected in the fall 2015 ADAD listening sessions.

The Fiscal Stakeholder Workgroup was comprised of 13 representatives from organizations, stakeholders and interested individuals. Fiscal workgroup members held seven meetings to make funding recommendations, including the responsibilities of the state and counties in funding SUD services. A combined meeting between the Core Workgroup and Fiscal Workgroup was held in December of 2016.

The Internal DHS Workgroup was convened, comprised of DHS staff in multiple administrations such as Community Supports, the Office of Inspector General, Health Care, Financial Operations, and Community and Partner Relations.

2016 Outreach and engagement activities

In addition to the workgroups, the DHS conducted outreach and engagement activities to key stakeholders. Key stakeholders were provided with potential reform changes and asked for feedback, and stakeholders were invited to meet with the DHS staff to discuss their priorities for transforming the system to meet the needs of their constituents. These key stakeholders included but were not limited to DHS Alcohol and Drug Abuse Division’s advisory councils, mental health organizations and licensing boards.
2016 community presentations

In October 2016, the Alcohol and Drug Abuse Division facilitated community presentations on Minnesota’s Plan for the Prevention, Treatment and Recovery of Addiction policy recommendations. 127 people participated in the community presentations. Presentations were held in:

- Bois Forte Reservation
- Brainerd
- Mankato
- Minneapolis
- St. Cloud
- St. Paul

At these community meetings, more input was collected to inform redesign of the State’s chemical health system.

Report: Substance Use Disorder System Reform Report and Recommendations, January 2017

A final report to the legislature of the work of the 2016 workgroups, 2016 outreach and engagement activities, and community presentations was published in January 2017. This report served as a foundation for the 2017 SUD reform package.
The report concluded that:

- It was 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 SUD, 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 SUD, 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 treatment 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.
- Direct reimbursement of appropriately credentialed professionals, who will be eligible for reimbursement of services provided independent of a licensed 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.
- 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.
- 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.
- DHS should pursue all available avenues to address any impact of lost federal Medicaid funding due to certain residential SUD programs being newly designated as Institutions for Mental Diseases (IMD). This would include pursuing a 1115 Substance Use Disorder Waiver.

More information
Online meetings

August 3, 2017, DHS Alcohol and Drug Abuse Division and Licensing Division began hosting ongoing, bi-weekly, one-hour webinars from 11:30-12:30 for partners and providers to provide information about SUD reform.

1115 SUD waiver demonstration application listening sessions

An important issue informing SUD reform has been challenges with Medicaid reimbursement. Federal Medicaid funding cannot be used for residential SUD treatment programs with more than 16 beds, so called IMDs. However, as of 2015, the Centers for Medicare and Medicaid Services has allowed for demonstration projects under Section 1115 of the Social Security Act that would allow services at IMDs to be reimbursed by Medicaid.

Therefore, during the month of June 2017, DHS held five 90-minute listening sessions about the 1115 waiver and its implications.

As a result, DHS is seeking a 1115 waiver from the federal government to provide Minnesota the flexibility to meet the needs of more people in more parts of the state by paying for services provided in treatment programs with over 16 beds. The 1115 demonstration project would be for five years, test innovative concepts that increase care and provide higher quality and lower costs, and increase treatment options.

Community meetings

In the fall of 2017, DHS held six community listening events. These community meetings for people receiving services and providers of services for prevention, treatment, and recovery from addictions and mental illness, the deaf and hard of hearing communities, and housing.

- 9/27/17 St. Paul
- 10/10/17 Mahnomen
- 10/11/17 Winona
- 10/25/17 Marshall
- 11/1/17 Brooklyn Center
- 11/8/17 Grand Rapids
DHS is charged with implementing the 2017 SUD treatment reform legislation, including:

**Treatment coordination**

Treatment coordination was added as a reimbursable treatment service. Treatment coordination is services provided by individuals credentialed to provide chemical dependency treatment services outside of the regular treatment system. This would both increase access to services early and provide a more appropriate level of care for many. With treatment coordination, we would expect to see a decrease in the number of individual treatment sessions required and/or a decrease in more intensive treatment services. Expected to launch July 1, 2018.

**Withdrawal management**

Withdrawal management services were added to the state’s Medicaid benefit set in order to expand the continuum of SUD services beyond treatment. Withdrawal management services include treatment, treatment 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. Expected implementation July 1, 2019.

**Direct reimbursement**

Add appropriately credentialed individuals as eligible vendors of SUD treatment services in settings such as in schools, primary care and jails. By permitting the use of the Consolidated Chemical Dependency Treatment Fund to support SUD services in settings other than treatment programs, a wider range of services will be available to more people.
Peer support

Make peer support reimbursable, to both provide a needed service and to help address the need for more workforce. DHS will identify vendors equipped to provide appropriate supervision of these services and the individuals providing the service. Examples of possible vendors include Rule 31, detox, withdrawal management programs, recovery community organizations, primary care clinics, and hospitals. Direct reimbursement is not recommended for this service.

Direct access

The current process for accessing treatment is for a person to get a Rule 25 assessment from a placing authority (county, tribe or MCO), who then authorizes a treatment placement.

The 2017 SUD reform legislation permits DHS to allow direct access while maintaining the existing rule 25 process as well. In the short term, these dual processes allow the state to build up to the capacity to do direct access statewide.

Effective July 2020, there will no longer be a Rule 25 process. At that time, people seeking treatment will need to have a comprehensive assessment done by a licensed alcohol and drug counselor or by an individual with another license that includes the scope of practice to do addictions counseling. This typically will mean going directly to a treatment program.
Counties will remain the payer of the county share of the CCDTF fund. The county will continue to be responsible for a share, approximately 30 percent, of the non-federal share.

More information