
Substance Use Disorder Reform

Study Guide

Behavioral Health Division

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Introduction

Implementation of substance use disorder (SUD) reform requires a core knowledge base to effectively and efficiently work with the state to transform the state's SUD system.

The "SUD Reform Study Guide" has been developed as a study aid for obtaining a minimal baseline knowledge of SUD reform, demonstrated with successful completion of the bronze, silver and gold SUD Reform quizzes. Individuals will need to score 70% to pass each quiz. A certificate of completion will be provided to participants who complete each quiz with a passing score.

The quizzes are based on the following competencies needed to understand and implement SUD Reform.

SUD Reform Competencies

1. Understand the purpose of SUD Reform.
2. Know and understand the implications for the new standards in Chapter 245G.
3. Understand the parallel process.
4. Understand the functions of a comprehensive assessment, staff qualifications, and eligible vendors.
5. Awareness of direct reimbursement and required credentials to be eligible for direct reimbursement.
6. Knowledge of Peer Recovery Support services including definitions, recovery peer qualifications and eligible vendors.
7. Knowledge of Treatment Coordination Services including definitions, treatment coordination provider qualifications and eligible vendors.
8. Awareness of withdrawal management (WM) services, the WM statute (245F), and characteristics that differentiate the new levels of services with those required by Rule 32 (detox programs).
9. Familiar with the requirements for providing telehealth services.
10. Have the ability to find SUD Reform resources on the Alcohol and Drug Abuse Division and DHS Licensing websites.

SUD Reform

Competency: Understand the purpose of SUD Reform

Since 2012, and beginning with the development of the Model of Care Legislative Report, ADAD has worked diligently to transform our state's substance use disorder (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 to expand and enhance the nature of services available for substance use disorder, while improving integration and coordination with the rest of health care.

These efforts support the efforts of the Institute for Healthcare Improvement (IHI) Triple Aim. The IHI Triple Aim is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance. New designs must be developed to simultaneously pursue three dimensions, the "Triple Aim":

- Improving the patient experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health care.

The transformed SUD treatment system includes:

- Client centered care
- For publically funded clients, supporting client choice of service provider and level of care wherever medical necessity has been determined.
- A two year parallel process, which will allow Direct Access operated parallel to the Rule 25 process for two years. During the two years, capacity to support direct access in the state will be increased over time, while the Rule 25 Assessment process will be concurrently phasing out. Following the two year parallel process, all publically funded clients will access SUD services via direct access.
- Increasing access to services
- Decreasing barriers and wait times for services by streamlining the access process and making services available during the interim before entering a treatment program.
- Adding recovery support services
- Adding treatment coordination services
- Increasing equitable outcomes

Chapter 245G: New Standards

Competency: Know and understand the implications for the new standards in Chapter 245G

After many years of planning reform, significant legislation was brought during the 2017 session that would provide the authority to move forward with several reform components. In addition, the regulations for substance use disorder treatment programs were codified in statute, and the corresponding rules reformed. In addition to the codification, the standards were enhanced with additional quality assurance measures.

- All Rule 31 programs were required to transition to the standards in Chapter 245G on January 1, 2018. However, the timeline for implementation of the new standards was not immediate upon enactment of the bill. The projected effective date of treatment coordination, peer recovery and comprehensive assessment are July 1, 2018, or upon federal approval, whichever is later.
- Initial Services Plan
 - 245G requires that the initial services plan be completed on the day of service initiation, whereas, Rule 31 required that it was completed during or immediately following the intake interview. The updated language ensures an individual's immediate needs will be identified the day the client enters treatment, while with the old language, if the intake interview was pushed back for a day or several days, the requirement for the initial services plan did not get triggered for several days.
- Comprehensive Assessment and Assessment Summary
 - Added to the Medicaid benefit set on July 1, 2018, or upon federal approval, whichever is later.
 - The comprehensive assessment must be completed by an individual qualified as an alcohol and drug counselor under 245G.11, subdivision 5.
 - 245G requires that the comprehensive assessment be completed by an alcohol and drug counselor. Rule 31 required that a comprehensive assessment be *coordinated* by an alcohol and drug counselor.
 - When the comprehensive assessment is being done in order to place a client in treatment, the assessment summary must be completed on the same date as the comprehensive assessment. This is to ensure that clients are not experiencing delays in getting into treatment, and that access is timely.
 - The current process for accessing treatment is for a person to get a Rule 25 assessment from a placing authority (MCO, county or tribe), who then authorizes a treatment placement. SUD Reform does not repeal this process. However, it creates the legal framework to implement a parallel, concurrently operating, direct access process. We will be running both access processes (Rule 25 and comprehensive assessment), until June 30, 2020. This will provide time to build up the capacity to do direct access state-wide.

- Licensed programs, eligible licensed professionals in private practice and counties are eligible vendors for comprehensive assessments.
- Timelines: 1) done within three days for a residential client; 2) during the initial session for a non-residential client. 3) If the comprehensive assessment cannot be completed for a non-residential client during the initial session, the provider must document the client centered reason, and the planned date it will be completed. 4) When the comprehensive assessment is being done to refer a client to treatment, the assessment summary must be completed on the same date as the comprehensive assessment.
- If a client has had a comprehensive assessment elsewhere that results in a referral to a subsequent program, that program can use the comprehensive assessment to satisfy the requirements of 245G.05 if the earlier assessment is reviewed by an alcohol and drug counselor to confirm it is current and complies with the requirements, and information must be updated or corrected as needed.
- When using a comprehensive assessment to make a referral to treatment, if the assessor gathered sufficient information from the referral source or the client to apply the criteria in parts 9530.6620 and 9530.6622 (Placement Information and Placement Criteria (six dimensions)), a collateral contact is not required.
- A utilization review process is required by statute.
- Individual Treatment Plan
 - New legislative language for the individual treatment plan focuses on person-centered treatment planning, looking at the issues and concerns of the client. The client must have active, direct involvement in selecting the anticipated outcomes of the treatment process and developing the treatment plan. The individual treatment plan must be signed by the client and the alcohol and drug counselor and document the client's involvement in the development of the plan. (245G.06, subdivision 1)
 - Does not need to cover all six dimensions if there are no needs identified in that dimension.
 - Developed within seven days of service initiation for residential and within three sessions for non-residential treatment.
- Group Size Limit
 - Minnesota Statutes, 245G.10, subdivision 4, states that 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.
 - Programs can submit a variance request for therapeutic recreation and educational groups allowing for group size to exceed 16 through June 30, 2020.

- The variance request form DHS-3141 is posted on the [DHS Licensing website](#).
- Location of service provision
 - 245G.07, subdivision 4 permits services to be provided outside of the facility at another suitable location, upon notification and approval of commissioner.
 - 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.
 - The license holder is required to identify the location where client records for the secondary location will be maintained. All records for discharged clients must be stored at the license holder's main location.

- Service termination policy

Requirement that before discharging a client from a residential setting, for not reaching treatment plan goals, the license holder must confer with other interested persons to review the issues involved in the decision. The documentation requirements for a staff-requested service termination must describe why the decision to discharge is warranted, the reasons for the discharge, and the alternatives considered or attempted before discharging the client. (245G.14, subd. 3, clause 3)

Direct Access

Competency: Understand the parallel, concurrently operating, direct access process with comprehensive assessments, including the role of Counties

- 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, identifying the quantity and nature of service authorized, the date span within which the individual must access the services, and the particular provider at which the client must receive the services.
- The SUD reform legislation directs us to implement a parallel, concurrently operating, direct access process. This direct access process allows an individual to go to any provider for a comprehensive assessment (a billable clinical service and different than a Rule 25 Assessment), who then makes a clinical recommendation for the level and nature of treatment services based on the severity of the client's symptoms, thus paving the way for an individual to then directly enter treatment at the intensity level recommended, or any intensity level less than the highest level recommended. The individual is able to go the provider of their choice, and there is no date span within which the client needs to enter treatment in order to have coverage. To ensure that clients are not delayed in accessing treatment while we transform the state to direct access, we will be running both access processes in parallel while we build up statewide capacity for direct access.
- Our timeline is to have comprehensive assessments for placement purposes Medicaid reimbursable by July 1, 2018. We are projecting that some providers and counties will be poised to be early implementers beginning almost immediately after this date. However, we also recognize that other counties and providers will be in different circumstances and this timeline might be too ambitious. While the new process is gradually phasing in, the existing placing authority system will continue to function in parallel to the new process.
- We will be running both access processes (Rule 31 and comprehensive assessment), until June 30, 2020. This will provide time to build up the capacity to do direct access state-wide. After 2020, the only counties who will still be providing substance use assessments will be those who have elected to become a vendor of these Comprehensive Assessments. Counties who do not choose to become a vendor will not be authorized to complete comprehensive assessments, however, a county can choose to permit a credentialed professional to provide comprehensive assessments on-site at a county if the professional bills the state directly for this clinical service.
- Once a client enters treatment, the comprehensive assessment, if done elsewhere, should be obtained with an appropriate release by the program that ultimately admits the client.
- The program must confirm the assessment meets the requirements for a comprehensive assessment in 245G, and then the assessment will be used for treatment planning.
- Much of the comprehensive assessment is the same as comprehensive assessment that was required in Rule 31. However, there are a few changes, and it has the added function of identifying the nature and intensity level of services recommended. Comprehensive Assessment and Assessment Summary are defined at 245G.05, subdivisions 1 and 2.

- Counties and licensed professionals eligible for direct reimbursement are identified as eligible vendors for providing comprehensive assessments, and will not be required to have a substance use disorder program license to provide a comprehensive assessment.

Direct Access Process: Role of the Counties

- Initially, as we run the Rule 25 process parallel to the new direct access process, some counties will continue to provide Rule 25 assessments.
- During that time, we will also be implementing the new services, and counties may choose to become eligible vendors for comprehensive assessments and treatment coordination.
- Each county will be in a position to make its own determination to what extent it will provide these new services.
- The county will continue to be responsible for a share of the cost of SUD services when the comprehensive assessment is used for placement.
- Counties that choose to become eligible vendors of comprehensive assessments will receive reimbursement for each comprehensive assessment they complete.
- Counties completing a comprehensive assessment used for a placement recommendation would assist the client in accessing the program chosen by the client, which could be billed as treatment coordination, and the county would forward the comprehensive assessment to the treatment program, thus facilitating a quick entry into treatment.
- To access publically funded SUD services, as with the rest of publically funded health care services, a determination of financial eligibility and enrollment in Medical Assistance or approval of Consolidated Chemical Dependency Treatment Fund (CCDTF) funding must be obtained. The process for doing this is unaffected by the reform at this stage. As we move forward in the future, ADAD will work with counties and providers to identify a streamlined process for clients to obtain enrollment in Medical Assistance to support quicker access to treatment and to support clients being able to obtain an array of health care coverage for all of their medical needs. Increased use of navigators is one route discussed, as well as looking to Recovery Community Organizations to support this need.
- There is not a utilization review for direct access developed yet, but this is required by the statute. We will be working with counties, MCOs and providers to develop a utilization review process that monitors for appropriate client- centered placements that meet medical necessity, while allowing client choice, and that does not create barriers to access.

Direct Reimbursement

Competency: Awareness of direct reimbursement

- SUD reform allows for credentialed providers to bill directly for comprehensive assessments and other treatment services by adding individually licensed professionals as eligible vendors for publically-funded SUD treatment services. (254B.05, subdivision 1, paragraph b)
- Individuals must have licensure that provides a scope of practice to provide addiction treatment services. In addition, a concentrated education in alcohol and drug counseling and supervised internship experience with individuals with substance use disorder are required to be an individual vendor.
- Eligible vendors will need to be enrolled through Minnesota Health Care Programs.

Peer Recovery Support Services

Competency: Knowledge of Peer Recovery Support services including definitions, recovery peer qualifications and eligible vendors

- Peer support services can be provided before, during and after SUD treatment to help individuals connect with resources that support recovery. Peers are individuals who are willing to share their personal recovery experience, and often engage quickly with individuals to offer reassurance, reduce fears, answer questions, support motivation and convey hope.
- Added to the Medicaid benefit set on July 1, 2018, or upon federal approval, whichever is later.
- The peers themselves would not be eligible for direct reimbursement. For the service to be reimbursable, the peer providing the peer support service must be employed and supervised by an eligible vendor of the service.
- 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.
- Recovery peer qualifications. (245G.11, subd. 8)

A recovery peer must:

- (1) have a high school diploma or its equivalent;
 - (2) have a minimum of one year in recovery from substance use disorder;
 - (3) hold a current credential from a certification body approved by the commissioner that demonstrates skills and training in the domains of ethics and boundaries, advocacy, mentoring and education, and recovery and wellness support; and
 - (4) receive ongoing supervision in areas specific to the domains of the recovery peer's role by an alcohol and drug counselor or an individual with a certification approved by the commissioner.
- Peer Recovery Support services will be reimbursed at a 15 minute billing unit.

- Recovery Community Organization description. (254B.01, subdivision 8)

"Recovery community organization" means an independent organization led and governed by representatives of local communities of recovery. A recovery community organization mobilizes resources within and outside of the recovery community to increase the prevalence and quality of long-term recovery from alcohol and other drug addiction. Recovery community organizations provide peer-based recovery support activities such as training of recovery peers. Recovery community organizations provide mentorship and ongoing support to individuals dealing with a substance use disorder and connect them with the resources that can support each person's recovery. A recovery community organization also promotes a recovery-focused orientation in community education and outreach programming, and organize recovery-focused policy advocacy activities to foster healthy communities and reduce the stigma of substance use disorder.

- SUD programs, withdrawal management programs, and Recovery Community Organizations are eligible vendors of peer support services. A Recovery Community Organization must have a certification approved by the commissioner to be an eligible vendor. (254B.05, subdivision 1, paragraph (a))

SUD Reform Resources

Competency: Have the ability to find SUD Reform resources on the Alcohol and Drug Abuse Division and DHS Licensing websites

Additional SUD Reform resources are available at the [Alcohol and Drug Abuse Division website](#) and the [DHS Licensing website](#)

The following resources are available on the ADAD website:

- a. FAQs
- b. SUD Reform WebEx Presentations
- c. 1-pagers on SUD Reform, treatment coordination, peer recovery, direct reimbursement and withdrawal management
- d. Rule 31 to 245G Table of Legislative Changes document

The following forms and examples are available on the DHS Licensing website:

- a. Variance request form
- b. Secondary location request form
- c. Comprehensive Assessment example and Comprehensive Assessment Summary example
- d. Discharge Summary example and Initial Services Plan example

The Department of Human Services, Alcohol and Drug Abuse Division hosts monthly WebEx broadcasts for partners and providers in an effort to provide ongoing communication about Substance Use Disorder reform. [Registration is now available for the monthly SUD Reform WebEx's](#). Please register to stay connected with SUD Reform implementation.

Telehealth Services

Competency: Familiar with the requirements for providing telehealth services

- Telemedicine is defined as the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site.
- Effective January 1, 2016, Minnesota Health Care Programs (MHCP) allows for payment for expanded telemedicine services in substance use disorder treatment for services that are otherwise covered as direct face-to-face services.
- Credentials needed to provide substance use disorder services are unaffected when the service is delivered via telemedicine.
- To be eligible for reimbursement, providers must self-attest that they meet all of the conditions of the MHCP telemedicine policy by completing the [Provider Assurance Statement for Telemedicine](#).
- Comprehensive assessments on July 1, 2018, or upon federal approval, whichever is later can be provided by Telemedicine.
- Rule 25 assessments are not eligible for telehealth because they are NOT a Medicaid service.
- Limit of three sessions per week per individual.
- Vidyo is an approved platform.
- Requirements for providing telehealth are found in the [MHCP Provider manual](#).

Treatment Coordination Services

Competency: Knowledge of Treatment Coordination Services including definitions, treatment coordination provider qualifications and eligible vendors. Note: the statute identifies this service as “care” coordination; however, this service is being approved by CMS as “treatment coordination” and going forward should be referred to as such.

- Individuals with SUD often experience needs in other life areas (e.g. medical, mental health, family, employment, criminal justice, housing, finances), and treatment coordination addresses these issues concurrently to improve treatment outcomes. Treatment coordination is a treatment service involving the deliberate, collaborative planning of SUD services with the client and other professionals involved in the client’s care.
- Added to the Medicaid benefit set on July 1, 2018, or upon federal approval, whichever is later.
- Treatment coordination defined at 245G.07, subdivision 1, paragraph (a), clause (6).

[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 treatment coordination services in the client's file.

- Treatment coordination provider qualifications. (245G.11, subd. 7)

(a) Treatment coordination must be provided by qualified staff. An individual is qualified to provide treatment coordination if the individual:

(1) is skilled in the process of identifying and assessing a wide range of client needs;

(2) is knowledgeable about local community resources and how to use those resources for the benefit of the client;

(3) has successfully completed 30 hours of classroom instruction on treatment coordination for an individual with substance use disorder;

(4) has either:

(i) a bachelor's degree in one of the behavioral sciences or related fields; or

(ii) current certification as an alcohol and drug counselor, level I, by the Upper Midwest Indian Council on Addictive Disorders; and

(5) has at least 2,000 hours of supervised experience working with individuals with substance use disorder.

(b) A care coordinator must receive at least one hour of supervision regarding individual service delivery from an alcohol and drug counselor weekly.

- LADC's will not need to complete the 30 hours of classroom instruction on treatment coordination for an individual with substance use disorder as it is already part of an LADC's core functions.
- SUD programs, withdrawal management programs, licensed professionals in private practice and counties are eligible vendors.
- Treatment coordination will be reimbursed at a 15 minute billing unit.

Withdrawal Management

Competency: Awareness of the withdrawal management statute (245F)

- Withdrawal management services improve the current model of detoxification services in Minnesota by addressing medical and clinical issues, with strategies to better engage and transition to appropriate services. A withdrawal management program is a licensed program that provides short-term medical services on a 24-hour basis for the purpose of stabilizing intoxicated patients, managing their withdrawal, and facilitating access to substance use disorder treatment as indicated by a comprehensive assessment.
- Adds withdrawal management services to the Medicaid benefit set on July 1, 2019, or upon federal approval, whichever is later.
- The Withdrawal Management statute (245F) was enacted in 2015 to add two new levels of service to the SUD service continuum to address intoxication and withdrawal:
 - **"Clinically managed program"** means a residential setting with staff comprised of a medical director and a licensed practical nurse. A licensed practical nurse must be on site 24 hours a day, seven days a week. A qualified medical professional must be available by telephone or in person for consultation 24 hours a day. Patients admitted to this level of service receive medical observation, evaluation, and stabilization services during the detoxification process; access to medications administered by trained, licensed staff to manage withdrawal; and a comprehensive assessment. (245F.02, subdivision 7)
 - **"Medically monitored program"** means a residential setting with staff that includes a registered nurse and a medical director. A registered nurse must be on site 24 hours a day. A medical director must be on site seven days a week, and patients must have the ability to be seen by a medical director within 24 hours. Patients admitted to this level of service receive medical observation, evaluation, and stabilization services during the detoxification process; medications administered by trained, licensed staff to manage withdrawal; and a comprehensive assessment. (245F.02, subdivision 14)