

# **Minnesota Substance Use Disorder System Reform**

## **Section 1115 Waiver Demonstration Request**

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May 2018

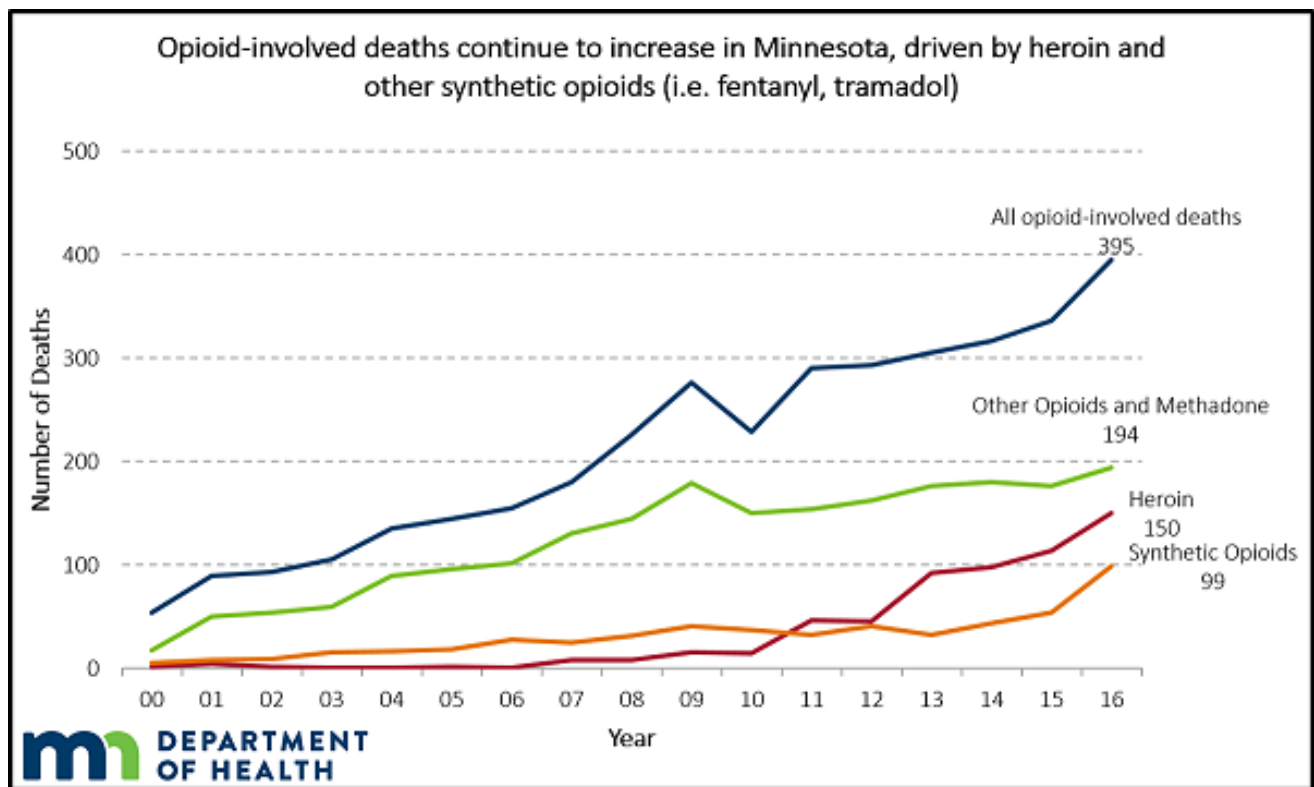
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## Section I – Background

Like many other states, Minnesota is facing a public health crisis with the continued increase in the rates of addiction and mortality from substance use disorder (SUD) related to prescription drug overdose. According to the Minnesota Department of Health (MDH), in 2008, less than ten Minnesotans died from heroin overdose, but by 2015 that number grew to 115. All drug overdose deaths in Minnesota increased by 11 percent from 2014 to 2015. Of the 572 total drug overdose deaths, 216 residents died from an overdose related to prescription opioid analgesics, and 115 died from a heroin overdose in 2015.<sup>1</sup>

As illustrated below, preliminary analysis of drug overdose death data for 2015 indicates that the number of deaths has increased. In fact, for the first half of 2016, the total deaths due to drug overdose was already 15 percent higher than the first half of 2015, at 327 deaths.



This epidemic affects Minnesotans statewide. In 2014 and 2015, the state experienced a spike in the rate of deaths due to drug overdose, with the greatest increase in the Twin Cities Metropolitan Area at 11.6 deaths per 100,000 residents, compared to 9.3 per 100,000 in greater Minnesota.<sup>2</sup> Men in Minnesota are more likely to die of a drug overdose than women (e.g. 964 vs. 651 deaths, respectively, from 2013-to-2015).<sup>3</sup> In addition, American Indians, African Americans, women, pregnant mothers and infants with Neonatal Abstinence

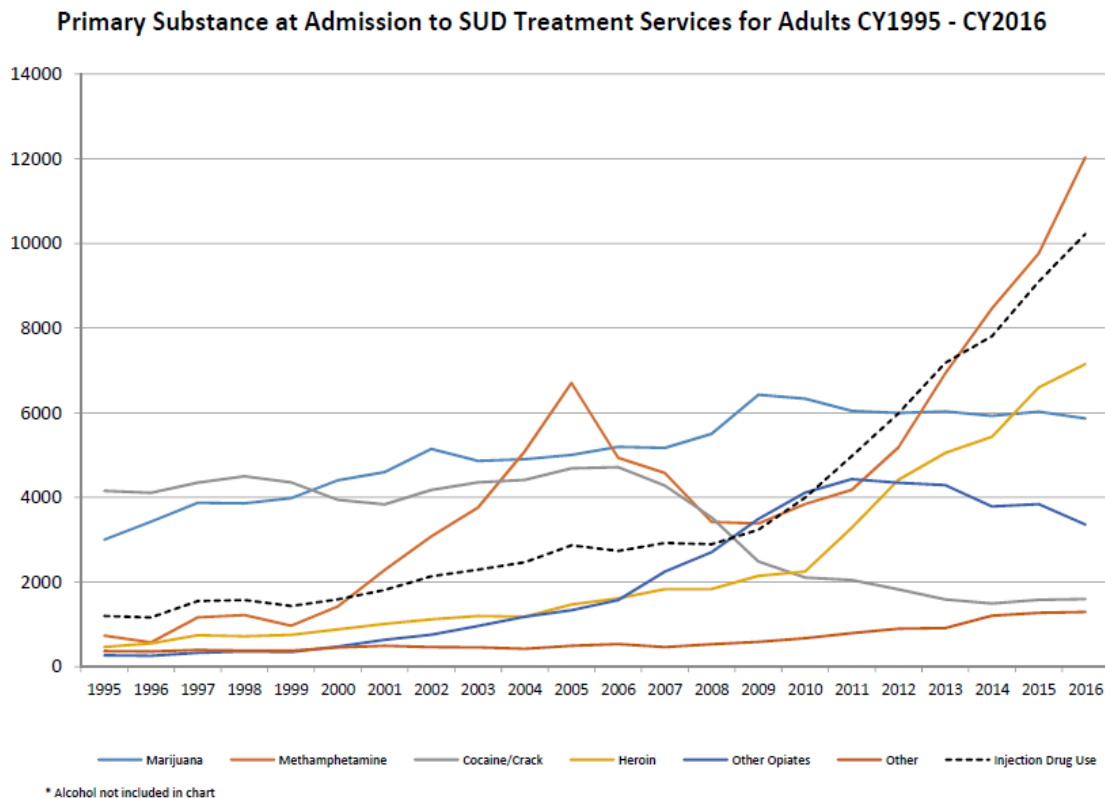
<sup>1</sup> Minnesota Department of Health. Injury and Violence Prevention Unit. Drug overdose deaths among Minnesota residents: 2000-2015. Available at: <http://www.health.state.mn.us/divs/healthimprovement/data/reports/drugoverdose.html>. Accessed November 1, 2017.

<sup>2</sup> Minnesota Department of Health. Drug overdose deaths among Minnesota residents, 2000-2015. Available at: <http://www.health.state.mn.us/divs/healthimprovement/content/documents/2015OpioidDeathReport.pdf>. Accessed November 1, 2017.

<sup>3</sup> Minnesota Death Certificate data.

Syndrome (NAS) are experiencing alarming rates of opioid use disorder. Pregnant American Indian women are 8.7 times more likely to be diagnosed with maternal opiate dependency or abuse during pregnancy compared to non-Hispanic whites and their infants are 7.4 times more likely to be born with neonatal abstinence syndrome.<sup>4</sup>

The Alcohol and Drug Abuse Division (ADAD) at the Minnesota Department of Human Services monitors state data regarding the number of publicly funded treatment services received by recipients, including Medicaid. ADAD has reported an increase in treatment rates for adults with SUD, especially in treatment rates for methamphetamines, heroin, and other opiates in 2016. ADAD also estimates that about 290,000 adults are in need of treatment in Minnesota.



To address this crisis, Minnesota is pursuing multiple approaches across its agencies, including this waiver, to ensure people who need treatment get high quality, effective treatment as quickly as possible across the state. As further described below, the state intends to test a new way to strengthen the state’s behavioral health care system by maximizing new federal Medicaid funding opportunities for SUD services provided to patients within intensive residential settings (i.e. Institutions for Mental Disease (IMDs)) that have established referral arrangements with other SUD providers. This includes other health care professions like community mental health to ensure all of the recommended levels of care for effectively treating SUD are readily available and integrated into the larger health care system.

<sup>4</sup> Minnesota Department of Human Services. Minnesota State Targeted Response to Opioid Crisis: A Project Narrative, April 2017. Available at: [https://mn.gov/dhs/assets/mn-opioid-str-project-narrative-april-2017\\_tcm1053-289624.pdf](https://mn.gov/dhs/assets/mn-opioid-str-project-narrative-april-2017_tcm1053-289624.pdf).

## Section II – Demonstration Description

Over the last five years, Minnesota has been exploring its options to reform the state’s provider and delivery system for SUD treatment with the goals of providing a more person-centered approach that supports a longer trajectory for recovery for people with SUD. More recently, in 2016, Minnesota enacted legislation aligned with these goals and directed the Minnesota Department of Human Services (referred to as “the Department” hereinafter) to seek all necessary federal authority to transform the Medicaid and publicly-funded delivery system for SUD treatment to one that is more accessible and integrated with the larger health care provider system. *See* Minn. Stat. § 254(B)(15).

As part of this larger reform package, the state law directs the Department to seek necessary federal authority to request Medicaid matching funds for residential programs that have been determined as Institutions for Mental Disease (IMDs) to ensure continued access to this level of care for individuals with the most intensive treatment needs. Accordingly, the state proposes a five-year demonstration project for its SUD delivery system under section 1115 of the Social Security Act, entitled “Minnesota’s SUD System Reform Demonstration,” which will test the impact of evidence-based provider referral arrangements and practices on improving SUD outcomes for Medicaid enrollees, while controlling projected Medicaid costs for SUD services in Minnesota. This project is an important component of the state’s larger reform effort to address the opioid crisis as well as to transform the health care delivery system for Medicaid enrollees seeking SUD treatment and services.

This demonstration will evaluate whether the state should invest in these evidence-based referral networks and models in order to support providers for statewide implementation of such practices. This demonstration will also build on broader state reform efforts for a more integrated and coordinated SUD delivery system that, over time, will lead to better health outcomes for Medicaid enrollees with substance use conditions, including those in need of the most intensive residential service settings.

### A. Overview of Demonstration

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Under this new demonstration, the state intends to evaluate whether requiring provider referral networks for SUD treatment that are designed to provide Medicaid beneficiaries access to each of the levels of care for SUD treatment, as well as community mental health services, will improve health outcomes among Medicaid beneficiaries. Consistent with guidance from the Centers for Medicare & Medicaid (CMS) to State Medicaid Directors, the levels of care will be modeled after the levels of care recommended by the [American Society of Addiction Medicine \(ASAM\)](#), also known as ‘[ASAM Criteria](#)’ for treating addictive, substance-related and co-occurring conditions.

The ASAM Criteria describes treatment for SUD as a continuum marked by five broad levels of care, including early intervention services. Within these broad levels of care (0.5, 1,2,3,4), decimal numbers are used to further express gradations of intensity of services.

Providers seeking to participate in this demonstration will verify to the Department that they have, or will have, established the necessary partnerships or referral arrangements with other SUD providers to provide all levels of care for beneficiaries during the waiver period. The goal is to ensure placements or referrals of Medicaid beneficiaries for SUD treatment are consistent with the levels of care listed by the ASAM Criteria. Verification of such relationships may include signed agreements, such as memoranda of understanding, with other SUD or health care providers in other parts of the state to ensure Medicaid beneficiaries have access to each of the recommended levels of care for SUD treatment.

In place of the state's existing process for assessment and placement through Rule 25<sup>5</sup>, participating providers will be required to assess and record their Medicaid patients' treatment needs based on evidence-based assessment guidelines called the [ASAM Six Dimensions of Multidimensional Assessment](#).<sup>6</sup> The Department will work with participating providers to ensure these guidelines are followed and applied appropriately by providers. Given the success of the independent software tool called the ASAM CONTINUUM, the Department will encourage providers to invest in this online tool by listing it as a preferred qualification for participation in the demonstration.

## ASAM Criteria: Levels of Care

### **0.5 – Early Intervention**

#### **1.0 – Outpatient Services**

#### **2.0 – Intensive Outpatient/Partial Hospitalization Services**

2.1 – Intensive Outpatient Services

2.5 – Partial Hospitalization Services

#### **3.0 – Residential/Inpatient Services**

3.1 – Clinically Managed Low-Intensity Residential Services

3.3 – Clinically Managed Population-Specific High-Intensity Residential Services

3.5 – Clinically Managed High-Intensity Residential Services

3.7 – Medically Monitored Intensive Inpatient Services

#### **4.0 – Medically Managed Intensive Inpatient Services**

\*Bolded levels above are considered the five broader levels of care needed for an effective care continuum for SUD.

<sup>5</sup> Rule 25 refers to Minnesota Rules, parts 9530.6600 to 9530.6660, which is the administrative rule that addresses chemical use assessment, administrative requirements, and appeal and fair hearing rights of the client.

<sup>6</sup> Individuals seeking Medicaid-covered SUD services in the demonstration will not be required to be evaluated by their county or tribal agency, like other enrollees. Instead, participating providers can assess beneficiaries using the ASAM Criteria to determine the level of need for a Medicaid enrollee's placement. Providers will also be required to provide assurances that all services, including those provided within their ASAM network, will meet or exceed the ASAM standards of care. This approach is consistent with the state's efforts to move to a system that allows direct access to SUD providers, instead of using a placing authority. Legislation from 2016 directs the Department to establish a transition plan for such direct access for enrollees seeking SUD services. Plans for this transition are underway.

All providers participating in this demonstration will also be required to apply at least three of the four evidence-based practices listed below that were recently identified as cost-effective (i.e. as producing overall savings) by the Minnesota Management and Budget agency when applied to adults receiving SUD treatment.

Evidence-Based Practice and/or Service Related to SUD	Type	BCA (Overall)	BCA (Taxpayers)	Years for benefits	Breakeven years (total)	Breakeven years (taxpayers)
1. 12-step Facilitation Therapy	Treatment	\$4.70	\$0.70	3 years	1	n/a
2. Brief cognitive behavioral intervention	Treatment	\$13.40	\$0.90	3 years	1	n/a
3. Motivational Interviewing to enhance treatment engagement	Treatment	\$16.10	\$2.20	3 years	1	1
4. Contingency Management	Treatment	\$11.70	\$.080	3 years	1	n/a

\*BCA = Benefit-Cost Analysis

Participants will be asked to report expected and actual applicable cost and benefit savings per individual provider capacity and their ability to implement. For more information on this benefit-cost analysis, see [Adult and Youth Substance Use: Benefit-Cost Analysis](#).

## 1. Proposed Timeline for Implementation

To implement this demonstration, the Department will take a phased-in approach, with the first year of the waiver (July 1, 2018 to June 30, 2019) concentrated on building the capacity of interested SUD providers across the state to build ASAM-based referral networks. As of the date of this application, 14 Minnesota SUD provider agencies have expressed interest in applying to participate in this demonstration.

In the second year of the waiver (July 1, 2019 to June 30, 2020), the state proposes to integrate community mental health services into the demonstration by permitting each of the state’s six [Certified Community Behavioral Health Clinics \(CCBHCs\)](#), to apply to participate in the project and maintain their existing model and payment structure as a CCBHC in accordance with the Excellence in Mental Health Act, which established an eight-state demonstration project to test CCBHCs. See Protecting Access to Medicare Act, Section 223; Public Law 113-93. The intent is to require interested CCBHCs to demonstrate that Medicaid beneficiaries will have access to each of the ASAM-recommended levels of care in addition to their other required practices under this SUD reform.

CCBHCs will be permitted to provide such services through their existing provider system, if available, or through new provider referral arrangements with SUD providers across the state, which may or may not include an IMD. All participating providers, including CCBHCs, will be required to use the evidence-based assessment guidelines,

the [ASAM Six Dimensions of Multidimensional Assessment](#), to assess the SUD-related needs of their Medicaid beneficiaries before determining their placements for treatment. In May of 2018, the state plans to post a Request for Proposals that emphasizes ASAM Continuum™ Software as a preferred qualification for participation in the waiver project.

In year three and thereafter, the demonstration would be fully implemented and the state would continue evaluating the effectiveness of these new provider arrangements and relationships to improving outcomes among people seeking treatment for SUD and OUD.

Because the demonstration relies on evidence-based practices and recommended national standards for behavioral health, this waiver will further the objectives of the Medicaid program under Title XIX of the Social Security Act. Specifically, the demonstration aims to improve access to services and to transform and modernize Minnesota’s SUD delivery system, which, in turn, will improve the health outcomes of Medicaid enrollees seeking treatment.

Please refer to the maps at **Attachment A1 and A2** for the geographic location of potential SUD provider participants and the six CCBHC provider locations.

## 2. New Federal Financing

Consistent with CMS guidance for section 1115 waiver demonstrations related to SUD reform, the goal of this demonstration is to provide enrollees access to the appropriate levels of treatment for SUD, from early intervention services to high-intensity treatment in residential settings, including IMDs, as well as other integrated behavioral health care services. In return, the state requests new federal Medicaid funds to help support the state’s capacity to address the growing need for SUD treatment services.

If approved, this waiver would allow for federal Medicaid matching funds for the following services when provided to Medicaid beneficiaries under the demonstration:

### Proposed Waiver Timeline

*May 30, 2018 | First Request for Proposals*

#### **July 1, 2018 | Waiver-Year One Begins**

- SUD Providers with ASAM Referral Networks Established

*May 30, 2019 | Second Request for Proposals*

#### **July 1, 2019 | Waiver-Year Two Begins**

- CCBHC with ASAM Referral Networks Established
- Existing SUD Provider ASAM Referral Networks Continue

*May 30, 2020 | Full Implementation*

#### **July 1, 2020 | Waiver-Year Three Begins**

- Existing CCBHC and SUD providers with ASAM Referral Networks continue

#### **July 1, 2021 | Waiver-Year Four Begins**

- Existing CCBHC and SUD providers with ASAM Referral Networks continue

#### **July 1, 2022 | Waiver-Year Five Begins**

- Existing CCBHC and SUD providers with ASAM Referral Networks continue and assessment of need for statewide approach begins

*June 30, 2023 | Waiver Period Ends*

- Findings from final evaluation will be used to make a recommendation to the state for statewide approach to use of ASAM referral networks, along with CCBHCs.



- a) SUD services provided to Medicaid beneficiaries residing in participating IMDs for up to two nonconsecutive stays of 30 days or less, within a one-year period;
- b) Withdrawal management services (i.e. ASAM 3.2 and 3.7) provided by participating providers during waiver-year one, prior to full state plan implementation of this benefit on July 1, 2019;
- c) Withdrawal management services provided by participating IMD providers (i.e. ASAM 3.2 and 3.7) during each year of the waiver period; and
- d) Services provided through the CCBHC model with additional ASAM referral networks that meet the qualifications of this SUD reform demonstration. (While the state is able to expand CCBHCs statewide under federal law with federal Medicaid funding, it is proposing a more incremental approach over time through this waiver, which will allow the state to further evaluate, support, and build capacity for future implementation state-wide).

### 3. Rationale, Hypothesis & Goals

In light of the opioid and drug overdose epidemic, an influx of new federal Medicaid funding for SUD services provided by participating IMDs and withdrawal management services will be important to expanding the state's capacity and to support its Medicaid provider system in its efforts to meet the needs of this population over the next five years or more. This demonstration will also build on the state's efforts to transform its SUD delivery system to improve access to appropriate treatment and greater integration of SUD services with the broader health care system, including community mental health providers, with the inclusion of the CCBHC model. Over time, the state expects that these referral networks or partnerships that follow ASAM criteria will lead to better health outcomes for Medicaid enrollees, including those in need of the most intensive services in residential settings like IMDs.

Through this demonstration, the state will test the impact of these networks on enrollee access to services, including IMDs. The state will also evaluate the impact, over time, of the application of ASAM recommendations on quality of care and health outcomes. After the first year of the demonstration, the state will also assess the impact of integrating community mental health care providers into an ASAM-based provider referral network with SUD providers or other health care professionals as needed. This will also allow the state to maintain existing federal requirements for the evaluation of the CCBHC model beyond its current project expiration date of June 30, 2019. Please see [Certified Community Behavioral Health Clinics \(CCBHCs\)](#) for more information on these requirements and program administered by SAMHSA.

For more information on the state's proposed evaluations for its new ASAM referral networks, SUD and/or CCBHC, including questions, metrics, and data for testing its hypothesis related to SUD outcomes, please see **Attachment B1 and B2**.

## B. Characteristics of Demonstration

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Unless otherwise specified below, this demonstration will not affect or modify the characteristics of the state's Medicaid program beyond the information described below with respect to eligibility, benefits, cost-sharing and delivery systems.

### 1. Eligibility

In general, the state will use the same standards and methodologies to determine Medicaid eligibility for all populations in the Demonstration as used in the state plan. The state expects that all enrollees affected under the demonstration would be otherwise eligible for Medical Assistance, and that any enrollees eligible and enrolled in Medicaid seeking or receiving services from a participating provider would be included in this demonstration's population. The state is proposing no changes in eligibility procedures for populations under the Demonstration.<sup>7</sup> No enrollment limits will apply for this demonstration including the expansion populations under this demonstration.

Please see the budget neutrality worksheets at **Attachment H** for the projected eligible member months for those enrollees who are expected to participate in the demonstration (i.e. receive SUD services eligible for Medicaid reimbursement from a participating provider in the demonstration). Eligible member months may be divided by twelve to approximate the number of unique individuals who will be eligible under the demonstration.

### 2. Benefits and Cost-Sharing

Other than the differences described below, the benefits for Medicaid enrollees participating in this demonstration will be the same as those for all other beneficiaries under the Medicaid State plan. Long-term services and supports will not be provided through this demonstration.

The benefits provided under the demonstration will differ from those provided under the state plan in two ways:

- (1) Participating providers that are not IMDs may bill for withdrawal management as a Medicaid-covered service under this waiver, which will not be permissible under the state plan prior to CMS' approval of this state plan benefit in Minnesota on July 1, 2019; and
- (2) Participating IMD providers may bill for withdrawal management as a Medicaid-covered service during the five-year waiver period.

The cost-sharing requirements under this Demonstration will not differ from those provided under the Medicaid state plan. No premium assistance for employer-sponsored coverage will be available through this demonstration.

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<sup>7</sup> Note that the use of the ASAM-based Assessment instead of the state's Rule 25 assessment does not impact one's eligibility for Medicaid. Instead, it impacts an individual's placement with a provider or treatment system. Therefore, all enrollees under this demonstration would have otherwise still been eligible for Medicaid.

The state intends to apply the permissible benefit arrangements as provided under the CCBHC model, see **Attachment C** for more information.

### 3. Delivery Systems and Payment Rates

Minnesota currently utilizes both fee-for-service (FFS) and managed care systems as specified under its state plan for delivering SUD services, both of which currently operate statewide. The state has authority to mandatorily enroll certain special populations, otherwise exempt under federal law, into managed care through its Minnesota Senior Care Plus (MSC+) § 1915(b) Waiver. This waiver is in effect for the period of July 1, 2016 through June 30, 2021.

- For SUD services provided through the state’s FFS system under this demonstration, the state expects to follow the state plan with respect to SUD payment rates. For services not otherwise covered, including withdrawal management in waiver-year one covered as a benefit under this demonstration until it receives CMS’ approval to be included in the state plan, the rate methodology used will be consistent with that described in the state plan amendment for this benefit. However, as previously described, participants in this demonstration who are in FFS will not be subject to the assessment and placement process through the county or tribe (i.e. placing authority) that is currently required per the state’s 1915(b)(4) CCDTF waiver. Instead, participating providers in this demonstration will act as the placing authority through the use of ASAM criteria for evaluating patients and determining the appropriate placement.
- For SUD-service payments made through managed care entities on a capitated basis, the state shall ensure that Medicaid-eligible SUD services received by a participating beneficiary under this demonstration shall be covered by the managed care entity, including IMD services and withdrawal management services authorized under this demonstration. To be eligible, these services must have been determined necessary for a beneficiary’s placement and treatment based on the ASAM Assessment guidelines by the participating SUD or CCBHC provider. At this time, the state does not expect any changes to existing contracts or capitation rates to accommodate the limited number of providers participating in this demonstration. However, the state reserves the right to update and amend its contracts mid-year as needed.

There will be no differences in the delivery system used to provide benefits to demonstration participants than those provided under the state plan, except for those beneficiaries receiving assessments and services for treatment through the federal model for the CCBHC program. The state intends to maintain the cost-based payment model currently permitted by federal law for the CCBHC model. See **Attachment D** for more information on these requirements which the state plans to carry over into this demonstration, including the payment model.

## C. Implementation of Demonstration & Milestones

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### 1. Implementation of Demonstration Project

The Department is proposing to release a request for proposals (RFP) for participation in the demonstration in March 2018. The RFP will outline all provider requirements for the demonstration, aligned with those requirements described earlier in this waiver proposal. The intent is to begin the waiver on July 1, 2018.

The Department will use data collected through the payment of claims to attribute beneficiaries of SUD services to the demonstration providers for purposes of monitoring budget neutrality and monitoring outcomes related to the demonstration each quarter.

The state does not intend to conduct a new MCO procurement action to implement this demonstration project. The state expects that existing contracts with the MCOs will accommodate this limited demonstration. As permitted by recent guidance from CMS, the state will submit a full implementation plan for both SUD and CCBHC providers in May 2018, which will include a proposal for provider adequacy and utilization review of demonstration providers and how this will align with the state's efforts to conduct utilization reviews of all SUD providers with the state's implementation of direct access for SUD treatment in the state's Medicaid program.

### 2. CMS-Recommended Milestones to Transform Minnesota's SUD System

The state will begin implementing this demonstration project simultaneously with several other efforts that are intended to transform Minnesota's SUD system. In addition to the reforms previously mentioned, the state enacted legislation in 2017 that instructs the Department to transition its care model for SUD services to a model in which individuals can directly access care from a SUD provider without a county or tribe acting as an intermediary. The Department is currently in the initial planning stage of this process. This new model will still require a Medicaid beneficiary to receive a comprehensive assessment to determine the level of intensity and duration of services needed for SUD treatment.

The legislature enacted other changes in 2017 that will further transform the state's SUD treatment system, including the development of an utilization review process for SUD providers that will be conducted in partnership with counties and tribes, expanding direct reimbursement for services provided in settings outside treatment programs, such as schools, jails, and primary care, and the addition of new SUD services to the Medicaid benefit set, including early treatment interventions, care coordination, peer support services, and withdrawal management.

As described in more detail below, these additional efforts are aligned with the expectations or milestones recently outlined by CMS for SUD reform waivers with an IMD funding component.

CMS Expectation for SUD System Transformation	Minnesota's Effort and Timeline
<p>Development of a comprehensive evidence-based benefit design that ensures access to critical levels of care.</p>	<p>Minnesota currently has a robust Medicaid benefit design for SUD, which includes coverage of outpatient, intensive outpatient services, medication assisted treatment, counseling, and intensive levels of care in residential and inpatient settings, all of which are covered under Minnesota's Medicaid State Plan.</p> <p>Most recently, the state legislature expanded this benefit design to include care coordination, withdrawal management, and peer recovery supports, all of which will be implemented through the Medicaid State plan by July 1, 2019. Please see table at <b>Attachment E</b> Minnesota Services by ASAM Level of Care.</p> <p>*As previously mentioned, this waiver will allow participating non-IMD providers to bill for Medicaid-funded withdrawal management services prior to implementation of the state plan. For IMD providers, it will provide authority for Medicaid payment of withdrawal management services during the five-year waiver period.</p>
<p>Application of evidence-based, SUD-specific patient placement criteria</p>	<p>Participating SUD providers in this demonstration will be required to assess treatment needs based on ASAM-recommended criteria, which will help to ensure an appropriate placement based on a patient's level of need.</p> <p>Other enrollees outside the demonstration will continue to be assessed by the county or tribe using the Rule 25 assessment which is aligned with ASAM standards. The state is in the process of developing a transition plan over the next year to move toward a direct-access provider model for people seeking SUD services, which will remove the county or tribal authority's assessment.<sup>8</sup></p>

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<sup>8</sup> The state expects that the implementation of direct access for SUD treatment will require a phased-in approach; therefore, the state will likely need to continue its 1915(b)(4) waiver authority beyond the expiration date to ensure that it has the appropriate authority to transition the system, including providers, enrollees, and counties or tribes, to model that ensures enrollees have direct access to SUD treatment.

CMS Expectation for SUD System Transformation	Minnesota’s Effort and Timeline
	<p>The state intends to develop a utilization review process over the next two years to ensure patient placements by providers are appropriate and reflect evidence-based clinical treatment guidelines.</p> <p>The state intends to apply a process for utilization review that will help the state monitor for appropriate access to necessary levels of care and for appropriate treatment or services at each level of care, as well as creating an independent process for reviewing placement in the residential treatment setting. More details about this utilization review will be provided to CMS with the state’s implementation plan for this demonstration.</p>
Establishment of appropriate standards of care (ASAM criteria).	SUD providers statewide are required to meet certain standards of care that are aligned with ASAM standards. For more information about these standards and how they compare to ASAM, please see <b>Attachment F</b> .
Development of a strong provider network and resource plan including the use of nationally recognized SUD-specific program standards to set provider qualification for residential treatment facilities.	<p>Through this waiver demonstration, Minnesota will be testing the effectiveness of a new provider partnership or referral network for SUD providers, as well as community mental health providers, that will be based on the levels of care recommended by ASAM for SUD services, also referred to as the ASAM Criteria. Through the evaluation of these efforts over the next five years, the state intends to strengthen its SUD resource and provider network statewide.</p> <p>Under state law, the Department has rulemaking authority to outline qualifications and licensure requirements for residential treatment providers. Currently these requirements are provided under Minn. Stat. § 245G, with program standards under <a href="#">Minnesota Rules, parts 9530.6405 to 9530.6590</a></p>
Sufficient provider capacity at critical levels of care including for Medication Assisted Treatment	Currently, the Department allows residential providers to choose whether they provide medication assisted treatment (MAT) on site or offsite. See <b>Attachment G1 and G2</b> for a geographic illustration of access to MAT in Minnesota, along with other residential and non-residential settings.

CMS Expectation for SUD System Transformation	Minnesota’s Effort and Timeline
<p>Implementation of strategies to address prescription drug abuse and opioid use disorder</p>	<p>Minnesota has implemented several strategies to address prescription drug abuse and OUD, including the following:</p> <ul style="list-style-type: none"> <li>• <b>Opioid Abuse Prevention Pilot Projects</b> – In 2017, Governor Dayton and the Minnesota Legislature provided a \$1 million one-time grant to build on a successful treatment approach, establishing opioid abuse prevention pilot projects in Minnesota. This grant will build capacity among health care and other service providers to prevent and treat opioid addiction, especially in rural Minnesota. The 2017 Health and Human Services budget also included a \$1 million one-time investment for a chronic pain rehabilitation therapy demonstration project.</li> <li>• <b>Federal Strategic Prevention Framework for Prescription Drugs</b> – In 2016, Minnesota received a \$1.5 million federal grant over five years to prevent and reduce opioid abuse and reduce opioid overdoses. The grant requires that state agencies: 1) design, implement, enhance, and evaluate primary prevention efforts using evidence-based methods; 2) work with pharmaceutical and medical communities on risks of overprescribing; and 3) raise community awareness and bring opioid abuse prevention activities and education to schools, communities, parents, prescribers, and their patients.</li> <li>• <b>Limiting Opioid Prescriptions and Improving Warning Efforts</b> – In 2017, Governor Dayton and the Legislature passed a law requiring opiate prescriptions to contain a label that says “Caution: Opioid: Risk of overdose and addiction.” The bill also limits opiates to a four-day supply for certain situations of dental or ophthalmic pain but provides health care providers discretion if he/she determines that a larger quantity is needed.</li> <li>• <b>Opioid Prescribing Workgroup at the Minnesota Department of Human Services</b>– In 2015, the Minnesota Legislature established an Opioid Prescribing Workgroup at the Department to reduce opioid dependency and substance use due to the prescribing of opioids by health care</li> </ul>

CMS Expectation for SUD System Transformation	Minnesota's Effort and Timeline
	<p>providers. The group is developing statewide guidelines on appropriate opioid prescribing for acute pain, post-acute pain, and chronic pain, which will be published later this year. The group is also charged with developing resources for providers to communicate with patients about pain management, as well as implementing an opioid prescribing quality improvement program for health care providers whose practices do not meet required standards.</p> <ul style="list-style-type: none"> <li> <b>Pharmacy Drop-Off Sites</b> – In 2016, the Legislature passed and the Governor signed legislation allowing any Minnesota pharmacy to be a drop-off site for unused prescriptions, including opioids. </li> </ul> <p>The treatment and recovery efforts are here:</p> <ul style="list-style-type: none"> <li> <b>Federal State Targeted Response Grants for Collaborative Treatment Efforts</b> – Minnesota received more than \$10 million in federal grants over two years, starting this fall, to help establish more collaborative treatment efforts statewide. The goal of this program is to encourage collaborative care between opioid treatment programs, health care clinics, care coordinators, and County and Tribal entities. Grants will focus on increasing provider capacity to identify and treat opioid addiction (including neonatal cases) and improving access to Naloxone to treat opioid overdoses. </li> <li> <b>Substance Use Disorder Treatment Reform</b> – In 2017, Governor Dayton and the Minnesota Legislature enacted new reforms to Minnesota's substance use disorder (SUD) treatment system to move from an acute, episodic-based system to a client-centered model of care, with an emphasis on managing SUD as a chronic disease. These changes remove barriers that have prevented Minnesotans on Medical Assistance from accessing substance abuse treatment. The reform package allows patients to more quickly access services, and adds important services like withdrawal management, care coordination and peer support. </li> </ul>



CMS Expectation for SUD System Transformation	Minnesota’s Effort and Timeline
	<ul style="list-style-type: none"> <li>• <b>Medication-Assisted Treatment (MAT) for Opioids</b> – In 2017, Governor Dayton and the Minnesota Legislature provided \$825,000 for health care providers to purchase direct injectable drugs to treat opioid addiction. The Minnesota Department of Corrections is also developing a strategic plan to expand access to MAT for the criminal justice-system. The Minnesota Department of Human Services has also received a \$6 million MAT expansion grant. The project is a partnership with the Red Lake Nation, the White Earth Nation, and Fairview Health Services.</li> <li>• <b>Integrated Care for High-Risk Pregnancies</b> – This Legislation passed and was signed by the Governor in 2015 to support five Minnesota tribes to provide integrated services to identify and treat pregnant mothers and infants exposed to opioids, including community supports.</li> </ul>
Improved care coordination and patient transitions between levels of care	<p>Through this waiver, the state intends to evaluate the use of provider partnerships that are modeled after ASAM Continuum of Care to determine whether they improve care coordination between residential and inpatient facilities and community-based services, as well as increase efficiencies in the system over time.</p> <p>The state will also be implementing a new Medicaid benefit statewide that is related to care coordination as part of its state plan amendment package to include additional SUD services as Medicaid-eligible in Minnesota.</p>

## D. Budget Neutrality & Financing

Please refer to the Waiver Budget Neutrality Spreadsheet at **Attachment H** for information regarding the basis of the budget neutrality calculations and trend rates.

## E. Waiver and Expenditure Authorities

Below is a list of proposed waiver and expenditure authorities for this demonstration project, under section 1115 of the SSA—the Minnesota SUD System Reform Waiver.

**Proposed Waiver Authorities of the Social Security Act (the Act)**

Statewideness & Uniformity	To the extent necessary to permit the State to operate the demonstration on a less than statewide-basis to the geographic area served by the participating providers in the pilot project.	Section 1902(a)(1) of the Act as implemented by 42 CFR 431.50
Comparability	To the extent necessary to permit the State to include withdrawal management as a Medicaid-covered benefit for demonstration beneficiaries only prior to its approval in the State Medicaid Plan for all beneficiaries.	Section 1902(a)(17) of the Act

**Proposed Expenditure Authorities of the Social Security Act (the Act)**

IMD Expenditure Authority	To the extent necessary to allow the state to operate its section 1115 demonstration and to provide federal funding to cover services, otherwise ineligible for federal financial participation, when furnished to Medicaid beneficiaries in facilities participating in this demonstration that meet the federal definition of an Institution for Mental Disease.	Section 1903
CCBHC Expenditure Authority	To the extent necessary to allow the state to operate its section 1115 demonstration and to provide federal funding to cover services through a cost-based payment structure, when furnished to Medicaid beneficiaries in clinics participating in this demonstration that meet the federal definition of a CCBHC under section 223 of the Protecting Access to Medicare Act, which is currently administered by SAMHSA.	Section 1903

## F. Public Comment

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### 1. Public Notice & Process for Comment

A notice requesting public comment on the proposed SUD Model of Care waiver request was published in the Minnesota State Register on February 12, 2018. This notice announced a 30-day comment period from February 12, 2018 to March 13, 2018 on this waiver request.

The Department informed the public on how to access an electronic copy or request a hard copy of the waiver. Instructions on how to submit written comments were provided. In addition, the notice included information about two public hearings scheduled to provide stakeholders and other interested parties the opportunity to comment on the waiver request. The time and location for the two public hearings, along with information about how to arrange to speak at either of the hearings, was provided. Finally, the notice provided a link to the waiver web page for complete information on the waiver request including the public notice process, the public input process, planned hearings and a copy of waiver application.

The Department certifies that it provided the public with information about this waiver request on the Department's public web site. The web site is updated on a regular basis and includes information about the public notice process, opportunities for public input, planned hearings and a copy of the waiver application. After the comment period, this page will be updated to alert web visitors of the upcoming federal comment period on the SUD waiver request and to provide the link to the federal website when it is available. A copy of the final draft of the waiver request that includes modifications following the public input process will be posted on the web page for this waiver.

The Department also certifies that it convened two public hearings on the SUD Waiver request. Two public hearings were held to provide stakeholders and other interested parties the opportunity to comment on the waiver request. Teleconferencing was available at each hearing to allow interested stakeholders the option to participate in the hearing remotely.

The Department also certifies that it used an electronic mailing list to notify the public. On February 12, 2018, an email was sent to all stakeholders on the agency-wide electronic mailing list informing them of the State's intent to submit this waiver request and directing them to the web page for this waiver. A second email will be sent to provide notice that the final, submitted version of the waiver is on the web site and to alert stakeholders that a federal comment period on the request is expected soon.

On March 28, 2018, CMS requested that the Department revise the public notice on its web site to clarify certain elements of the waiver proposal. The public notice was revised, as requested, and a second 30-day comment period was held from April 11, 2018 to May 10, 2018. The notice provided information on the public comment period, the public input process, and a copy of the waiver application. A copy of the notice is provided at **Attachment I**. The Department also used electronic mailing lists to notify the public of the second public comment period and to direct them to the Department's public web site. The Department received written

comments from seven people and organizations regarding the proposed SUD waiver during the two 30-day public comment periods.

Two commenters expressed general support for the proposal.

A third commenter, the Indian Health Service, also expressed general support for this demonstration, and added the following concerns and recommendations:

- That there is an overreliance on 12-step facilitation therapy models, that these models have not been adequately studied in tribal populations for opioid use disorders, and that these models may not be widely accepted in tribal communities;
- That models to increase access to withdrawal management services in tribal communities be considered;
- That the proposed treatment model restricts access to care and services in rural areas;
- How existing relationships with tribal providers will be preserved; and
- interest in developing a demonstration model in which IHS hospitals partner with tribal SUD and other behavioral health programs, with payment at the all-inclusive rate.

**Response:** These are concerns about the overall care delivery system in the state, and warrant ongoing discussion, much of which is happening in other forums. The concerns however, are outside of the scope of this waiver request.

A fourth commenter, representing one of the managed care organizations under contract for Medical Assistance, expressed general support for the waiver, and added the following concerns and recommendations:

- That participating providers will have difficulty establishing necessary relationships to ensure the full spectrum of services across the ASAM continuum;
- That the payment rate for care coordination is not in keeping with the knowledge, skills, and abilities required for the position; and
- That we should request a waiver for the IMD exclusion for all behavioral health services, in addition to substance abuse disorder services.

**Response:** We share the concern that all levels of care may not be readily available. We plan to use this demonstration to gain a better understanding of all levels of care and their availability throughout the state, which will inform strategies to address gaps in the continuum of care. The payment rate for care coordination is outside the scope of this waiver request, as is the broader waiver of the IMD exclusion.

A fifth commenter, representing community mental health programs and the CCBHC providers, expressed general support for the program, and listed the following concerns and recommendations:

- That the evaluation plan should contain enough flexibility so that we can add new measures as appropriate; and
- That we increase payment rates for CCBHCs to accommodate any additional cost.

**Response:** The evaluation plan for the SUD waiver is due 180 days after approval of the demonstration and will provide for flexibility to modify or increase measures as needed. Payment rates for CCBHCs are outside of the scope of this SUD waiver.

A sixth commenter, representing a county agency, expressed concern about direct access under Minnesota's broader SUD system reform and the requirement that comprehensive assessments be conducted by Licensed Alcohol and Drug Counselors (LADC).

**Response:** The Department clarified that comprehensive assessments can be done by LADCs or by qualified staff whose individual licensure provides the scope of practice to conduct comprehensive assessments.

A seventh commenter submitted several questions regarding the proposed demonstration that had been addressed in various public forums.

**Response:** Staff from ADAD met with this commenter to review informational materials previously shared with stakeholders and to answer any outstanding question.

Copies of the comments received and the Department's responses are included at **Attachment J**.

In addition to the two public comment periods, the Department conducted several community hearings where staff presented an initial outline of the demonstration and requirements for SUD providers. Based on this feedback, the Department made several changes to its proposal before drafting this waiver, including not requiring the ASAM CONTINUUM software for participation. Instead, the state is proposing to encourage it as a preferred qualification.

## 2. Tribal Consultation

The Department certifies that it consulted with tribes in accordance with the process outlined in the Medicaid State plan. In Minnesota, there are seven Anishinaabe (Chippewa or Ojibwe) reservations and four Dakota (Sioux) communities. Recognizing American Indian tribes as sovereign nations, each with distinct and independent governing structures, is critical to the work of the Department. The Department has a designated staff person in the Medicaid Director's office who acts as a liaison to the Tribes.

On February 12, 2018, a letter was sent to all tribal chairs, tribal health directors, tribal social services directors, the Indian Health Service Area Office Director, and the Director of the Minneapolis Indian Health Board clinic informing them of the State's intent to submit the SUD waiver request. The letter also informed Tribes of the public input process and provided a link to the waiver web page.

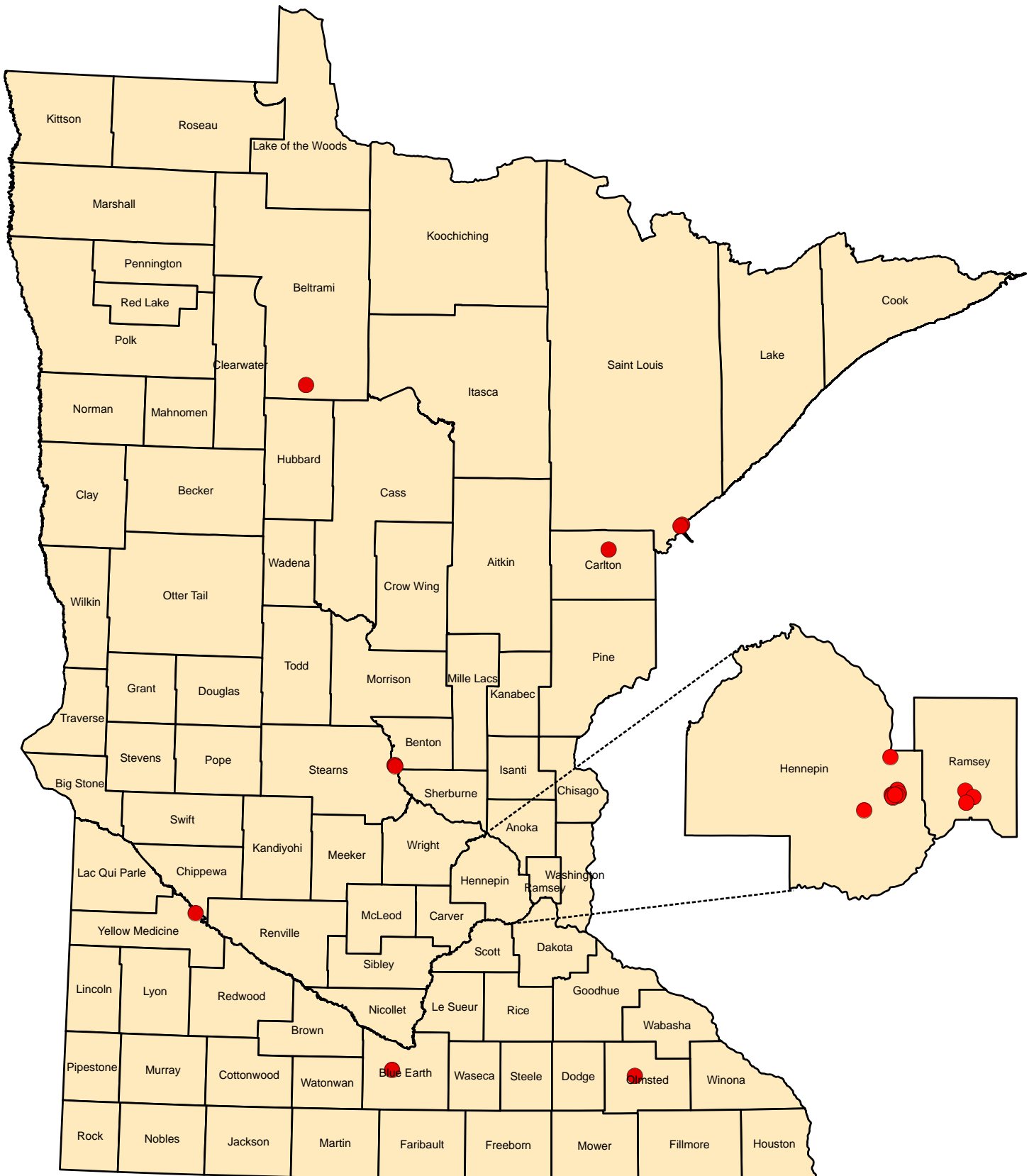
## G. Demonstration Administration

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### Contact

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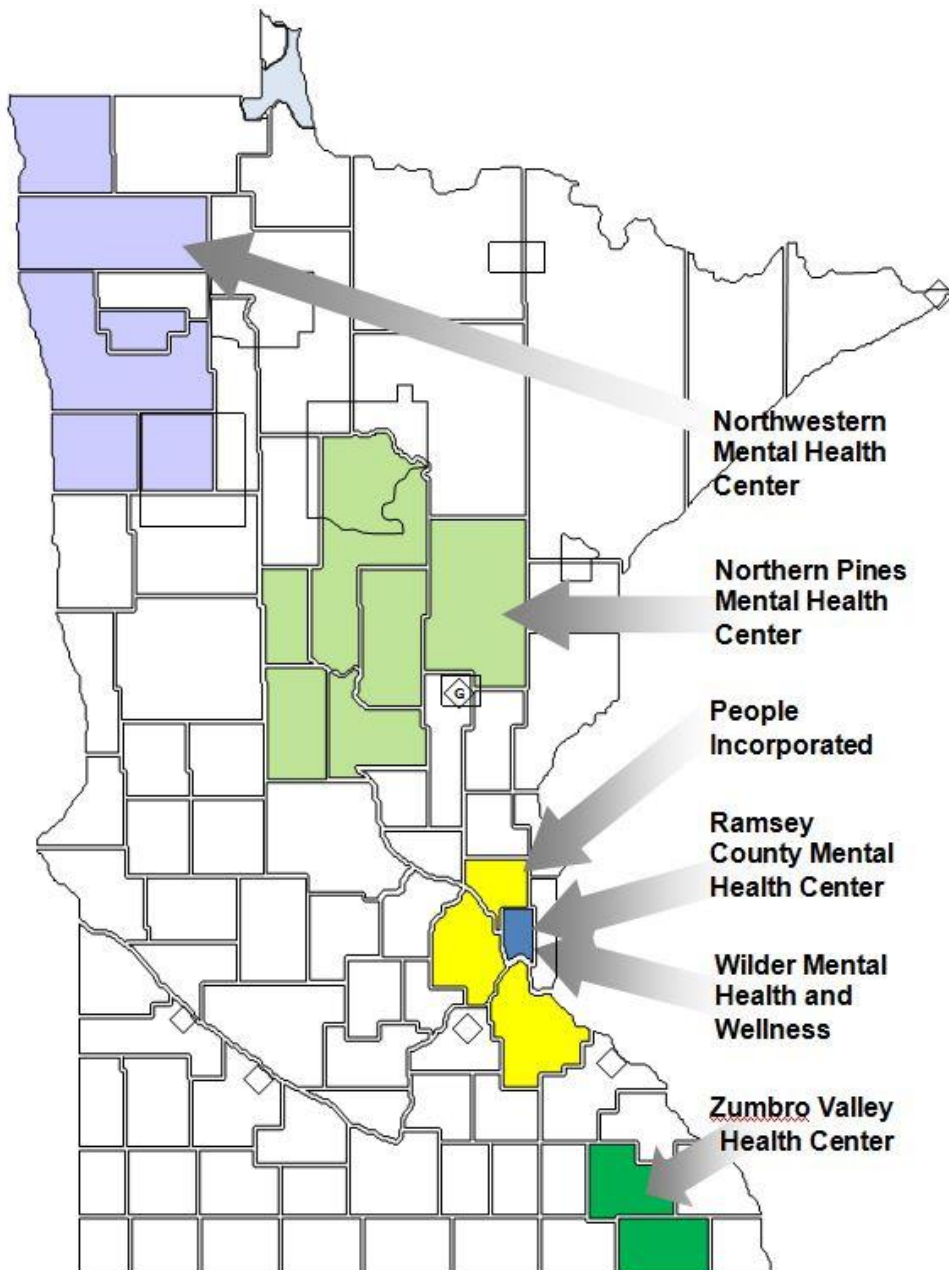
# Map of Potential SUD Provider Participants



Source: Minnesota Department of Human Services, ADAD (1/25/2018)

# Certified Community Behavioral Health Clinic

Minnesota's six CCBHC demonstration clinics



## Evaluation Plan

The table below presents an overview of a preliminary plan to evaluate the SUD waiver. This evaluation plan is subject to change and will be further defined as the program is implemented. The measures identified in the table below will be tracked and compared across demonstration years to test each hypothesis.

**Goal:** Improve patient<sup>1</sup> access and quality of care through timely initiation and engagement in treatment for SUD.

<b>Hypothesis</b>	<b>Example measures (measure type)</b>	<b>Data sources</b>
The percentage of patients age 13 and older with a new episode of alcohol or other drug (AOD) dependence who receive AOD treatment within 14 days of the diagnosis will be maintained or increased under the demonstration.	Initiation NQF 0004	MMIS
The percentage of patients age 13 and older who initiated treatment and who received two or more additional services with a diagnosis of AOD within 30 days of the initiation visit will be maintained or increased under the demonstration.	Engagement NQF 0004	MMIS

**Goal:** Improve patient quality of care through adherence to treatment for SUD over time.

<b>Hypothesis</b>	<b>Example measures (measure type)</b>	<b>Data sources</b>
The percentage of emergency department (ED) visits by patients age 18 and older for mental health for which patients receive follow-up with any provider for a corresponding primary diagnosis within 7 days of discharge will be maintained or increased under the demonstration.	Successful Care Transition NQF 2605	MMIS

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<sup>1</sup>Patient is defined as a Medicaid beneficiary who receives an eligible service for SUD from a provider participating in the demonstration.



<b>Hypothesis</b>	<b>Example measures (measure type)</b>	<b>Data sources</b>
The percentage of ED visits by patients age 18 and older for mental health for which patients receive follow-up with any provider for a corresponding primary diagnosis within 30 days of discharge will be maintained or increased under the demonstration.	Successful Care Transition NQF 2605	MMIS
The percentage of ED visits by patients age 18 and older for alcohol or other drug dependence for which patients receive follow-up with any provider for a corresponding primary diagnosis within 7 days of discharge will be maintained or increased under the demonstration.	Successful Care Transition NQF 2605	MMIS
The percentage of ED visits by patients age 18 and older for alcohol or other drug dependence for which patients receive follow-up with any provider for a corresponding primary diagnosis within 30 days of discharge will be maintained or increased under the demonstration.	Successful Care Transition NQF 2605	MMIS

**Goal:** Improve health outcomes for patients through a reduction in the rate of deaths due to opioids in Minnesota.

<b>Hypothesis</b>	<b>Example measures (measure type)</b>	<b>Data sources</b>
The number of opioid overdose deaths per 1,000 Medicaid beneficiaries per month will be maintained or reduced under the demonstration.	Opioid overdose death rate	MMIS and MDH Death Certificates

<b>Hypothesis</b>	<b>Example measures (measure type)</b>	<b>Data sources</b>
The number of opioid overdose deaths per 1,000 Medicaid beneficiaries per year will be maintained or reduced under the demonstration.	Opioid overdoses death rate	MMIS and MDH Death Certificates

**Goal:** Improve health outcomes for patients through a reduction in the utilization of emergency departments and inpatient hospital settings for SUD treatment.

<b>Hypothesis</b>	<b>Example measures (measure type)</b>	<b>Data sources</b>
Emergency department visits for SUD-related diagnoses will be maintained or reduced under the demonstration.	Emergency department visits for SUD-related diagnosis per 1,000 member months	MMIS
Inpatient hospital admissions for SUD will be maintained or reduced under the demonstration.	Inpatient admissions for SUD among Medicaid beneficiaries per 1,000 member months	MMIS
Inpatient hospital readmissions for SUD will be maintained or reduced under the demonstration.	30-day readmission rate following hospitalization for a SUD-related diagnosis	MMIS

**Goal:** Improved access to care for co-morbid physical health conditions among beneficiaries with SUDs, measured by coordination of care between physical and behavioral health providers treating Medicaid beneficiaries with a SUD diagnosis.

<b>Hypothesis</b>	<b>Example measures (measure type)</b>	<b>Data sources</b>
The percentage of SUD treatment patients (MA only) who were admitted through a referral from health care facility/professional will be maintained or increased over time under the demonstration.	Code for primary source of referral in DAANES Admission Form	DAANES
The percentage of SUD treatment patients (MA only) who had any physical health conditions at discharge and received a referral to medical care will be maintained or increased over time under the demonstration.	Code for biomedical conditions and complications in DAANES Discharge Form Code for referrals at discharge in DAANES Discharge Form	DAANES



## CCBHC Evaluation Plan

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The state's evaluation of Certified Community Behavioral Health Clinics (CCBHC) will be a continuation of the plan that Minnesota implemented on July 1, 2017. This plan includes federally-defined quality measures, consumer and family perception of care surveys, and state-selected impact measures required as a condition of participation in the Section 223 Demonstration Program for Certified Community Behavioral Health Clinics. The evaluation plan, including the state-defined measures, was submitted and approved by SAMHSA and CMS prior to the Section 223 demonstration period. If approved, the evaluation and all related quality measures will continue under Section 1115 Waiver Demonstration.

This evaluation plan measures the effectiveness of a service delivery model intended to integrate and coordinate high quality mental health and substance use disorder services and supports.

The Measurement Years are:

- Section 223 Demonstration Year One: July 1, 2017 – June 30, 2018
- Section 223 Demonstration Year Two/1115 Waiver Year 1: July 1, 2018 – June 30, 2019
- 1115 Waiver Year 2: July 1, 2019 – June 30, 2020
- 1115 Waiver Year 3: July 1, 2020 – June 30, 2021
- 1115 Waiver Year 4: July 1, 2021 – June 30, 2022
- 1115 Waiver Year 5: July 1, 2022 – June 30, 2023

## CCBHC-Lead Quality Measures

The CCBHCs are responsible for collecting and reporting on the nine federally required CCBHC-lead quality measures identified in Table 1. The CCBHC-lead measures are calculated at the CCBHC-level and are reported on the [223 data reporting templates](#) to DHS. Throughout the Section 223 demonstration program DHS will submit the calculated CCBHC-lead measures received from the CCBHCs to SAMHSA annually. To conduct quality checks throughout the demonstration, the CCBHCs will submit reports to DHS quarterly during the first demonstration year and bi-annually thereafter.

Table 1. CCBHC-Lead Quality Measures

Measure Name	Measure Steward	NQF #	CCBHC Quality Bonus Measure	Manual Page*
<b>Time to Initial Evaluation (I-EVAL)</b>	SAMHSA	NA		page 30
<b>Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up (BMI-SF)</b>	CMS	421		page 44
<b>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-BH)</b>	NCQA	24		page 50
<b>Preventive Care &amp; Screening: Tobacco Use: Screening &amp; Cessation Intervention (TSC)</b>	AMA-PCPI	28		page 66
<b>Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)</b>	AMA-PCPI	2152		page 69
<b>Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)</b>	AMA-PCPI	1365	Federal Required	page 74
<b>Major Depressive Disorder: Suicide Risk Assessment (SRA-A)</b>	AMA-PCPI	104	Federal Required	page 82
<b>Screening for Clinical Depression and Follow-Up Plan (CDF-BH)</b>	CMS	418	MN Required	page 91
<b>Depression Remission at Twelve Months (DEP-REM-12)</b>	Minnesota Community Measurement	710		page 95

\*The Technical Specifications Manual can be found on SAMHSA's webpage: <https://www.samhsa.gov/section-223/quality-measures>

## State-Lead Quality Measures

The state-lead quality measures will be calculated by DHS and submitted to SAMHSA on the [223 data reporting templates](#) following each demonstration year. The CCBHCs will receive metric reports from the state to review their own individual progress. Table 2 lists the 13 federally required state-lead quality measures.

**Table 2. State-Lead Quality Measures**

Measure Name	Measure Steward	NQF #	CCBHC Quality Bonus Measure	Manual Page*
<b>Housing Status (HOU)<sup>†</sup></b>	SAMHSA	NA		page 101
<b>Patient Experience of Care Survey (PEC)<sup>‡</sup></b>	SAMHSA	NA		page 109
<b>Youth/Family Experience of Care Survey (Y/FEC)<sup>‡</sup></b>	SAMHSA	NA		page 111
<b>Follow-Up After Emergency Department Visit for Mental Illness (FUM)</b>	NCQA	NA		Page 113
<b>Follow-Up After Emergency Department Visit for Alcohol and Other Drug Dependence (FUA)</b>	NCQA	NA		Page 118
<b>Plan All-Cause Readmission Rate (PCR-BH)</b>	NCQA	1768	MN Required	page 123
<b>Diabetes Screening for People with Schizophrenia or Bipolar Disorder who Are Using Antipsychotic Medications (SSD)</b>	NCQA	1932		page 130
<b>Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-BH)</b>	CMS	NA	Federal Required	page 158
<b>Follow-Up After Hospitalization for Mental Illness, ages 21+ (adult) (FUH-BH-A)</b>	NCQA	576	Federal Required	page 165
<b>Follow-Up After Hospitalization for Mental Illness, ages 6 to 21 (child/adolescent) (FUH-BH-C)</b>	NCQA	576	Federal Required	page 172
<b>Follow-up care for children prescribed ADHD medication (ADD-BH)</b>	NCQA	108		page 179
<b>Antidepressant Medication Management (AMM-BH)</b>	NCQA	105		page 187
<b>Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET-BH)</b>	NCQA	4	Federal Required	page 193

<sup>†</sup> Calculated from consumer level data submitted by CCBHCs

<sup>‡</sup> CCBHCs will distribute the experience of care surveys to consumers

\*The Technical Specifications Manual can be found on SAMSHA's webpage: <https://www.samhsa.gov/section-223/quality-measures>

## Experience of Care Surveys

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There are two surveys that will be completed as part of the CCBHC demonstration: Patient Experience of Care Survey and Youth/Family Experience of Care Survey. DHS will use and expand the federal Mental Health Statistics and Improvement Program (MHSIP) surveys. Each CCBHC will distribute at least 300 surveys to adults and 300 surveys to parents or guardians annually.

Distribution modes include mail, email, hand-out, phone calls, and web-based surveys. For survey distribution by phone, email, and mail, the CCBHCs must provide DHS with consumer phone numbers, emails, or mailing addresses and name (first, last), recipient ID/or other ID. For web-based survey distribution, DHS will provide a web link with some customization to the CCBHCs for survey data collection. Data comes directly to DHS via HIPAA compliant, secure methods.

### Family Mental Health Services

Web link: <https://surveys.dhs.state.mn.us/snapwebhost/s.asp?k=150402731064>

DHS Family Survey email address: [dhs.FamilyMHSurveyCTSS@state.mn.us](mailto:dhs.FamilyMHSurveyCTSS@state.mn.us)

### Adult Mental Health Services

Web link: <https://surveys.dhs.state.mn.us/snapwebhost/s.asp?k=150428484909>

DHS Adult Survey email address: [dhs.AdultMHSSurvey@state.mn.us](mailto:dhs.AdultMHSSurvey@state.mn.us)

# Minnesota-Specific Impact Measures

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Eight measures were developed collaboratively with the CCBHCs, DHS, and others to show the impact of the CCBHC service delivery model on two goals: 1) to provide a full scope of CCBHC services and 2) to increase access to and availability of services for the target populations. The below measures will be calculated annually over the two-year CCBHC demonstration period, and will continue to be calculated annually during the 1115 waiver demonstration:

## Measure 1 (Scope of Service): Track proportion of encounters and persons served by peer services in CCBHCs

$$\frac{\text{Number of Persons Served by Peers in CCBHCs}}{\text{Total Number of Persons Served in CCBHCs}}$$

(Data source: CCBHC EHRs)

$$\frac{\text{Number of Unduplicated Service Visits by Peers in CCBHCs}}{\text{Total Number of Service Visits by all Providers in CCBHCs}}$$

(Data source: Medicaid Claims)

## Measure 2 (Participation): Compare percentage of Persons of Color and Latinos/Hispanics receiving CCBHC services to their percentage of Medicaid population in the CCBHC service areas.

$$\frac{\text{Number of Persons of Color and Latinos Receiving CCBHC Services}}{\text{Total Number of Persons Receiving CCBHC Services}} \bigg/ \frac{\text{\#MA Persons of Color and Latinos in CCBHC Service Area}}{\text{Total Number of MA Recipients in CCBHC Service Area}}$$

(Data sources: CCBHC EHRs/Medicaid enrollment data)

## Measure 3 (Participation): Compare percentage of Non-Primary English speakers receiving CCBHC services versus their percentage of Medicaid population in the CCBHC service area.

$$\frac{\text{Number of non-primary English Speakers Receiving CCBHC Services}}{\text{Total Number of Persons Receiving CCBHC Services}} \bigg/ \frac{\text{\#of MA non-primary English Speakers in Service Area}}{\text{Total Number of MA Recipients in CCBHC Service Area}}$$

(Data sources: CCBHC EHRs/Medicaid Enrollment Data)

## Measure 4 (Availability): Track persons served by telemedicine for allowable services in CCBHCs.

$$\frac{\text{Number of Persons Served by Telemedicine in CCBHCs}}{\text{Total Number of Persons Served in CCBHCs}}$$

(Data source: Medicaid claims)

## Measure 5 (Access): Track the mean number of days between initial contact and evaluation of new clients.

$$\frac{\text{Sum of Number of Days Between First Contact and Initial Evaluation}}{\text{Total Number of Consumers receiving an Initial Evaluation}}$$



(Data source: CCBHC EHRs)

**Measure 6 (Participation): Track percentage of all clients receiving 2 or more services within 2 months after initial assessment.**

$$\frac{\text{Number of New Clients in CCBHCs Receiving 2 Services within 60 days After Assessment}}{\text{Total Number of New CCBHC Clients Receiving a First Assessment}}$$

(Data source: Medicaid Claims).

**Measure 7 (Participation): Track percentage of clients who are Persons of Color and Latinos/Hispanics receiving 2 or more services within 2 months after initial assessment.**

$$\frac{\text{Number of New Clients of Color and Latinos–Hispanics Receiving 2 CCBHC Services within 60 days After Assessment}}{\text{Total Number of Persons of Color and Latinos–Hispanics Receiving a First Assessment}}$$

(Data source: Medicaid Claims)

**Measure 8 (Participation): Track percentage of non-primary English speaking clients receiving 2 or more services within 2 months after initial assessment.**

$$\frac{\text{Number of New Clients who are non – primary English Speakers in CCBHCs Returning for 2 Services within 60 days After Assessment}}{\text{Total Number of non – primary English Speakers Receiving a First Assessment}}$$

(Data source: Medicaid Claims)

## Quality Bonus Measures

During the section 223 demonstration, the state opted to offer Quality Bonus Payments (QBPs) in addition to paying the Prospective Payment System (PPS) rate to any certified clinic that achieves six federally required quality measures (see Table 3). The state proposes to incentivize continuous quality improvement through maintaining a quality bonus payment program under the 1115 waiver demonstration.

Each CCBHC must meet all six measures<sup>1</sup> to qualify for a bonus payment, subject to the conditions described below regarding minimum denominator size. The state is also making a portion of the QBP fund pool available to CCBHCs who meet two additional state chosen quality measures (see Table 4) during project 223 demonstration year 2 (DY2). The state may adjust the target performance rate in response to actual CCBHC results based on an evaluation of the measures' performance after each measurement year.

**Table 3. Federally Required Quality Measures for QBPs**

Acronym	Measure	Measure Steward
<b>SRA – BH – C</b>	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	AMA - PCPI
<b>SRA – A</b>	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	AMA - PCPI
<b>SAA – BH</b>	Adherence to Antipsychotics for Individuals with Schizophrenia	NCQA
<b>FUH – BH – C</b>	Follow Up After Hospitalization for Mental Illness (child/adolescent)	NCQA
<b>FUH – BH – A</b>	Follow Up After Hospitalization for Mental Illness (adult)	NCQA
<b>IET – BH</b>	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA

**Table 4. State Chosen Quality Measures for QBPs (DY2)**

Acronym	Measure	Measure Steward
<b>PCR – BH</b>	Plan All-Cause Readmission Rate	NCQA
<b>CDF – BH</b>	Screening for Clinical Depression and Follow – Up Plan	CMS

For project 223 demonstration year 1 (DY1), minimum performance thresholds were identified for each measure that all CCBHCs must achieve to qualify for a bonus payment. See Table 5 for the thresholds for DY1. For the SRA

<sup>1</sup> The state would like the option of selecting alternate and/or additional quality measures for the quality bonus program after achieving target performance on current selected measures and based on shifting priority areas.

– BH – C, SRA – A, and CDF – BH measures DHS will collect and analyze an initial six months of data from the CCBHCs to inform the identification of the minimum performance thresholds. For DY2, DHS will review the CCBHCs' DY1 performance for each measure and identify a revised minimum performance level for each measure that will require each CCBHC to incrementally improve performance (e.g., increase of 3 or 5 percentage points) from DY 1 to DY 2.

**Table 5. DY1 Minimum Performance Thresholds for QBPs**

Acronym	Measure	Minimum Performance Threshold
<b>SRA – BH – C</b>	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	TBD
<b>SRA – A</b>	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	TBD
<b>SAA – BH</b>	Adherence to Antipsychotics for Individuals with Schizophrenia	65.07
<b>FUH – BH – C</b>	Follow Up After Hospitalization for Mental Illness (child/adolescent)	7 day – 55.06 30 day – 79.76
<b>FUH – BH – A</b>	Follow Up After Hospitalization for Mental Illness (adult)	7 day – 36.81 30 day – 68.47
<b>IET – BH</b>	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Initiation – 33.63 Engagement – 15.72

A minimum of 30 consumers/visits (i.e., denominator size) for each CCBHC must be present in order for DHS to calculate any given measure. For measures with multiple reported rates, the minimum denominator size will need to be met for all rates calculated under the measure (e.g., 7 day and 30 day follow up measures). Only consumers who are Medicaid beneficiaries, including Title XIX eligible Children's Health Insurance Program (CHIP) beneficiaries, will be counted towards payment.

All CCBHCs must meet the minimum denominator size for the following measures to qualify for the bonus payment:

- Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA – A)
- Adherence to Antipsychotics for Individuals with Schizophrenia (SAA – BH)

If a CCBHC does not meet the minimum denominator size for the remaining quality measures (SRA – BH – C, FUH – BH – C, FUH – BH – A, IET – BH), the CCBHC will still be eligible for a bonus payment based on their performance for all measures that meet or exceed the minimum denominator size of 30 consumers/visits.

Updated June 20, 2017

Scope of Services for Certified Community Behavioral Health Clinic (CCBHC) Demonstration

CPT or HCPC Code	Required Modifier	Demonstration Service	Notes and Policy Changes
S9484	none	Crisis assessment, intervention and stabilization	The state defines crisis services as those provided by state sanctioned crisis system. CCBHC or DCO must be enrolled to provide Adult and Children's MH Crisis Services (MN 256B.0624).
90882	HK	Community Intervention	The state defines crisis services as those provided by state sanctioned crisis system. CCBHC or DCO must be enrolled to provide Adult and Children's MH Crisis Services (MN 256B.0624).
H2022	none	Crisis stabilization - Alternate per day code	H2022 is an alternate code used by certain MCOs to pay for non-residential crisis stabilization on a per day basis. MCOs are not required to use this code.
See Note	none	Ambulatory withdrawal management: mild withdrawal without extended onsite monitoring (ASAM Level 1.0)	Service is covered within an assessment or evaluation. Bill using assessment or E&M procedure codes.
H0014	none	Ambulatory withdrawal management for mild to moderate withdrawal from substance abuse with extended onsite monitoring (Ambulatory ASAM Level 2).	Policy change: new service to be covered under demonstration authority. This is the only CCBHC service that is carved out from managed care. CCBHCs bill FFS for all Medicaid clients, including those in managed care.
See Note	none	2.b.1.Preliminary screening and risk assessment to determine acuity of needs	Not billable as an encounter. Included in PPS.
90791	Q2 52	Initial Evaluation - Diagnostic Assessment - Brief	The Initial Evaluation (4.d.3.), including a preliminary diagnosis is billed as 90791 (Q2) (52) or 90792 (Q2)(52) only if completed by a Licensed MH Professional or MH Practitioner Clinical Trainee. Information gathered for the Initial Evaluation by unlicensed staff is considered an activity and not a billable encounter.
90792	Q2 52	Initial Evaluation - Diagnostic Assessment (with Medical Service)- Brief	The Initial Evaluation (4.d.3.), including a preliminary diagnosis is billed as 90791 (Q2) (52) or 90792 (Q2)(52) only if completed by a Licensed MH Professional or MH Practitioner Clinical Trainee. Information gathered for the Initial Evaluation by unlicensed staff is considered an activity and not a billable encounter.
90791	52	Diagnostic Assessment - Brief	90791/90792 without a Q2 can continue to be used by CCBHCs to denote a diagnostic assessment that does not meet CCBHC criteria for Initial and Comprehensive Evaluations. This is an optional service which can be provided in special situations. Use of these codes without Q2 is subject to the same limitations that apply to other outpatient providers.
90792	52	Diagnostic Assessment (with Medical Service)- Brief	90791/90792 without a Q2 can continue to be used by CCBHCs to denote a diagnostic assessment that does not meet CCBHC criteria for Initial and Comprehensive Evaluations. This is an optional service which can be provided in special situations. Use of these codes without Q2 is subject to the same limitations that apply to other outpatient providers.
90791	Q2	Diagnostic Assessment- Standard	90791/90792 with Q2 refers to a Comprehensive Evaluation which complies with CCBHC criteria.
90792	Q2	Diagnostic Assessment (with Medical Service)- Standard	90791/90792 with Q2 refers to a Comprehensive Evaluation which complies with CCBHC criteria.
90791	Q2 TG	Diagnostic Assessment- Extended	90791/90792 with Q2 refers to a Comprehensive Evaluation which complies with CCBHC criteria.
90792	Q2 TG	Diagnostic Assessment (with Medical Service)- Extended	90791/90792 with Q2 refers to a Comprehensive Evaluation which complies with CCBHC criteria.
H0001	none	Comprehensive Substance Use Disorder Assessment (chemical dependency assessment)	90791/90792 with Q2 refers to a Comprehensive Evaluation which complies with CCBHC criteria.
90791	Q2 TS	Adult Diagnostic Assessment- Update	90791/90792 with Q2 refers to a Comprehensive Evaluation which complies with CCBHC criteria.
90792	Q2 TS	Adult Diagnostic Assessment (with Medical Service)- Update	90791/90792 with Q2 refers to a Comprehensive Evaluation which complies with CCBHC criteria.
90791	none	Diagnostic Assessment	90791/90792 without a Q2 can continue to be used by CCBHCs to denote a diagnostic assessment that does not meet CCBHC criteria for Initial and Comprehensive Evaluations. This is an optional service which can be provided in special situations. Use of these codes without Q2 is subject to the same limitations that apply to other outpatient providers.
90792	none	Diagnostic Assessment (with Medical Service)	90791/90792 without a Q2 can continue to be used by CCBHCs to denote a diagnostic assessment that does not meet CCBHC criteria for Initial and Comprehensive Evaluations. This is an optional service which can be provided in special situations. Use of these codes without Q2 is subject to the same limitations that apply to other outpatient providers.
See Note	none	Mental health (including screening for clinical depression) and substance use disorders (tobacco, alcohol, and other drugs); assessment of imminent risk (including suicide risk, danger to	Behavioral health screenings are required and are covered services as part of an Evaluation & Management (E&M) service (99201-99215) or as part of an assessment (90791 or 90792).
90785	none	Interactive Complexity	none
90887	none	Explanation of Findings	none
96101	none	Psychological Testing	none
96102	none	Psychological Testing-Technician admin	none

CPT or HCPC Code	Required Modifier	Demonstration Service	Notes and Policy Changes
96103	none	Psychological Testing-Computer admin	none
H0031	UD	Functional Assessment	Policy Change: under demonstration authority expand service availability to any CCBHC client. Current policy limits this service to ARMHS and CTSS. This code does not use Q2.
H0031	UD TS	Functional Assessment Update/Review	Policy Change: under demonstration authority expand service availability to any CCBHC client. Current policy limits this service to ARMHS and CTSS. This code does not use Q2.
H0032	Q2 UD	Comprehensive Integrated Treatment Plan	Policy Change: under demonstration authority expand service availability for a single integrated treatment plan. Current policy limits this service to ARMHS and CTSS.
H0032	Q2 UD TS	Comprehensive integrated treatment plan update or review	Policy Change: under demonstration authority expand service availability for a single integrated treatment plan. Current policy limits this service to ARMHS and CTSS.
H0032	UD	Treatment Plan Development	CCBHCs can continue to bill for H0032 without a Q2 as an optional service. Coverage is subject to the same limitations that apply to other ARMHS and CTSS providers.
H0032	UD TS	Treatment plan update or review	CCBHCs can continue to bill for H0032 without a Q2 as an optional service. Coverage is subject to the same limitations that apply to other ARMHS and CTSS providers.
90832	none	Psychotherapy, with patient and/or family member	CCBHC must meet standards for outpatient mental health services within MN 9505.0370-9505.0372
90833	none	Psychotherapy, with patient and/or family member when performed with an E&M service	CCBHC must meet standards for outpatient mental health services within MN 9505.0370-9505.0372
90834	none	Psychotherapy, with patient and/or family memberPsychotherapy, with patient and/or family member	CCBHC must meet standards for outpatient mental health services within MN 9505.0370-9505.0372
90836	none	above when performed with an E&M service	CCBHC must meet standards for outpatient mental health services within MN 9505.0370-9505.0372
90837	none	Psychotherapy, with patient and/or family memberPsychotherapy, with patient and/or family member	CCBHC must meet standards for outpatient mental health services within MN 9505.0370-9505.0372
90838	none	above when performed with an E&M service	CCBHC must meet standards for outpatient mental health services within MN 9505.0370-9505.0372
90839	none	Psychotherapy for Crisis	CCBHC must meet standards for outpatient mental health services within MN 9505.0370-9505.0372
90840	none	Psychotherapy for Crisis, (add on to 90839)	CCBHC must meet standards for outpatient mental health services within MN 9505.0370-9505.0372
90846	none	Family Psychotherapy without patient present	CCBHC must meet standards for outpatient mental health services within MN 9505.0370-9505.0372
90847	none	Family Psychotherapy with patient present	CCBHC must meet standards for outpatient mental health services within MN 9505.0370-9505.0372
90849	none	Multiple Family Group Psychotherapy	CCBHC must meet standards for outpatient mental health services within MN 9505.0370-9505.0372
90853	none	Group Psychotherapy	CCBHC must meet standards for outpatient mental health services within MN 9505.0370-9505.0372
90875	none	Individual psychophysiological therapy incorporating biofeedback, with psychotherapy	CCBHC must meet standards for outpatient mental health services within MN 9505.0370-9505.0372
90876	none	Individual psychophysiological therapy incorporating biofeedback, with psychotherapy	CCBHC must meet standards for outpatient mental health services within MN 9505.0370-9505.0372
90899	Q2	Clinical Care Consultation	Current coverage for children.
90899	none	Clinical Care Consultation	Policy Change: under demonstration authority, expand to adult population.Current policy limits this service to children.
H2027	Q2	Family Psychoeducation	Current coverage for children.
H2027	none	Family Psychoeducation	Policy Change: under demonstration authority, expand to adult population. Current policy limits this service to children and their families.
99354	none	Prolonged service code for psychotherapy services (add on to 90837)	none
96116	none	Neuropsychological Assessment - neurobehavioral status exam	Optional Service - Considered a specialized service
96118	none	Neuropsychological Assessment - interpretation, analysis, report	Optional Service - Considered a specialized service
96119	none	Neuropsychological Testing - Technician administered	Optional Service - Considered a specialized service
96120	none	Neuropsychological Testing - Computer administered	Optional Service - Considered a specialized service
H2012	HK	Cognitive Rehabilitative Therapy	Optional Service - Considered a specialized service
99499	HE	Psychiatric Consultation for primary care--face-to-face	Optional Service - Considered a specialized service
H2012	none	Adult Behavioral Health Day Treatment	Optional Service - Considered a specialized service
H2019	U1	DBT Therapy	Optional Service - Considered a specialized service
H0046	none	Mental Health Provider Travel Time	Included in PPS rate to the extent staff travel is required to provide a CCBHC service. Must be billed together with the associated service.
H2035	none	Outpatient substance use disorder treatment	CCBHC must be licensed to provide CD services under MN rules, parts 9530.6405 to 9530.6505
H0047	none	Medication-assisted therapy (all other)	Optional Service - Considered a specialized service
H0020	none	Medication-assisted therapy (methadone)	Optional Service - Considered a specialized service
99201 - 99205	See note	New patients: have not received professional services from the physician or qualified health care professional or any other physician or qualified health care professional in the same practice in the exact same specialty and subspecialty in the previous three years (99201-99205)	Treating provider must have a mental health specialty code.

CPT or HCPC Code	Required Modifier	Demonstration Service	Notes and Policy Changes
99211 - 99215	See note	Established patients: received prior professional services from the physician or qualified health care professional or another physician or qualified health care professional in the practice of the exact same specialty and subspecialty in the previous three years (99211-99215)	Treating provider must have a mental health specialty code.
T2023	HE	Mental Health Targeted Case Management Services	REQUIRED SERVICE - CCBHC/DCO must meet state and federal standards for Adult and Children targeted case management.
H2017	none	Psychosocial Rehabilitation – basic social and living skills	REQUIRED SERVICE - CCBHC/DCO must be certified ARMHS provider
H0034	none	Medication Education	REQUIRED SERVICE - CCBHC/DCO must be certified ARMHS provider
90882	none	Community Intervention	REQUIRED SERVICE - CCBHC/DCO must be certified ARMHS provider
H2014	UA	Skills Training & Development	REQUIRED SERVICE - CCBHC/DCO must be certified CTSS provider
H2015	UA	Comprehensive Community Support Services (Crisis Assistance)	REQUIRED SERVICE - CCBHC/DCO must be certified CTSS provider
H2019	UA	Therapeutic Behavioral Services	Optional Service - Considered a specialized service
H2012	UA	Behavioral Health Day Treatment	Optional Service - Considered a specialized service
S9480	none	Behavioral Health Day Treatment - - Alternate per day code	Optional Service - S9480 is an alternate code used by certain MCOs to pay for day treatment on a per day basis. MCOs are not required to use this code.
H0038	none	Certified Peer Specialist Self-Help/Peer Services, Certified	Policy Change: under demonstration authority include coverage of Certified Peer Specialist & Certified Peer Recovery Specialist Services. Current policy limits Certified Peer Specialist Services to individuals receiving Adult Rehabilitative Services. Certified Peer Recovery Specialist is a new service to be covered under demonstration authority
H0038	Q2	Certified Peer Recovery Specialist	Policy Change: under demonstration authority include coverage of Certified Peer Specialist & Certified Peer Recovery Specialist Services. Current policy limits Certified Peer Specialist Services to individuals receiving Adult Rehabilitative Services. Certified Peer Recovery Specialist is a new service to be covered under demonstration authority
H0038	HA	Family Peer Services, Certified Peer Recovery Specialist Services	Policy Change: under demonstration authority include coverage of Certified Peer Specialist & Certified Peer Recovery Specialist Services. Current policy limits Certified Peer Specialist Services to individuals receiving Adult Rehabilitative Services. Certified Peer Recovery Specialist is a new service to be covered under demonstration authority
See Note	none	Adult Body Mass Index (BMI) Screening and Follow-up	Primary care screening services are required and are covered services as part of an Evaluation & Management (E&M) service (99201-99215) or as part of an assessment (90791 or 90792).
See Note	none	Weight Assessment & Counseling for Nutrition and Physical	Primary care screening services are required and are covered services as part of an Evaluation & Management (E&M) service (99201-99215) or as part of an assessment (90791 or 90792).
See Note	none	Preventive Care and Screening: Tobacco Use: Screening &	Primary care screening services are required and are covered services as part of an Evaluation & Management (E&M) service (99201-99215) or as part of an assessment (90791 or 90792).
See Note	none	Preventative Care and Screening: Unhealthy Alcohol Use:	Primary care screening services are required and are covered services as part of an Evaluation & Management (E&M) service (99201-99215) or as part of an assessment (90791 or 90792).
See Note	none	Diabetes Screening (for people with Schizophrenia or Bipolar	Primary care screening services are required and are covered services as part of an Evaluation & Management (E&M) service (99201-99215) or as part of an assessment (90791 or 90792).

<b>Descriptive Modifier</b>	<b>Definition (Some services require one or more modifiers)</b>
AG	Primary Care Provider receiving Psychiatric Consultation
AM	Consulting Psychiatrist to primary care provider
GT	Telemedicine
GY	Not Medicare Covered
HA	Child or Adolescent
HE	Mental Health
HH	Integrated Mental Health/Substance Use Disorder Program
HK	Intensive or Children's Day Treatment
HN	Mental Health Practitioner or Bachelor Degree Level (Clinical Trainee)
HM	Adult MH Rehabilitation Worker or Mental Health Behavioral Aide Level II
HO	Master's Level (Optional Code- no impact on billing)
HQ	Group Modality
HR	Family/Couple with Client Present
HS	Family w/o Client Present
Q2	CCBHC Demonstration
TF	Psychiatric Consultation, intermediate
TG	Extended Diagnostic Update/Psychiatric Consultation complex/lengthy
TS	Adult Diagnostic Update
UA	CTSS service package/Children's crisis service package
UD	ARMHS Transitioning to community living
UD	ARMHS/CTSS Timed Unit
U1	Dialectical Behavior Therapy (DBT)
U4	Service provided via non face-to-face contact, e.g., telephone
U5	Certified Peer Specialist Level II/
U6	Psychiatric Consultation, complex or lengthy
U7	Physician Extender
U8	Clinical care consultation, face to face 5 to 10 min.
U9	Clinical care consultation, face-to-face 11 to 20 min.
UB	Clinical care consultation, face-to-face 21 to 30 min.
UC	Clinical care consultation, face-to-face 31 min. and above
52	Reduced
77	Repeat procedure in same day
76	Repeat procedure in same day

CCBHCs should follow the MHCP Provider Manual in deciding when to use the above modifiers. Except as indicated above, these modifiers are not required to differentiate these procedure codes from non-CCBHC uses.

## Part 3: Prospective Payment System Methodology Description - Minnesota

### Section 1: Introduction

*Section 223 of the Protecting Access to Medicare Act of 2014 (known as PAMA or “the statute”), requires payment using a prospective payment system (PPS) for Certified Community Behavioral Health Clinic (CCBHC) services provided by qualifying clinics and related satellite sites established prior to April 1, 2014. The Centers for Medicare & Medicaid Services (CMS) offers a state the option of using either the Certified Clinic (CC) PPS (CC PPS-1) or the CC PPS alternative (CC PPS-2) demonstration-wide for payments that are either fee for service (FFS) or made through managed care payment systems. The PPS guidance (Appendix III from the Planning Grant for CCBHCs) provides information about each of the allowed PPS payment methodologies.*

### Section 2: CCBHC PPS Rate-Setting Methodology Options

*CMS offers a state the option of either the CC PPS-1 or CC PPS-2 for use demonstration-wide. The state chooses the following methodology (select one):*

- Certified Clinic PPS (CC PPS-1) (Continue to Sec 2.1)**
- Certified Clinic PPS (CC PPS-2) (Continue to Sec 2.2)

#### Section 2.1: Certified Clinic PPS (CC PPS-1)

*The CC PPS-1 methodology is implemented as a fixed daily rate that reflects the expected cost of all CCBHC services provided on any given day to a Medicaid beneficiary. This is a cost based, per clinic rate that applies uniformly to all services rendered by a CCBHC and qualified satellite facilities established prior to April 1, 2014. The state has the option of offering Quality Bonus Payments (QBPs) that are to be paid in addition to the PPS rate to any certified clinic that achieves at least the six required measures as shown in Table 3 of the PPS guidance.*

#### Section 2.1.a Components of the CC PPS-1 Rate Methodology

##### *Demonstration Year One (DY1) Rate Data*

*In the box below explain the source(s) of cost and visit data used to determine the DY1 rate. Detail any estimates that the state used to determine allowable cost and the appropriate number of daily visits to include in the rate calculation.*

DY1 rate data was developed from actual financial results from each Certified Community Behavioral Health Center (CCBHC). The clinics used the macro-enabled cost report template provided by Centers for Medicare & Medicaid Services (CMS) to calculate the Prospective Payment System (PPS)-1 rate. The State provided guidance to each organization to capture the most recently audited financial period data, known as the reporting period. Costs were



categorized as Direct CCBHC expenses, Indirect Costs and direct non-CCBHC expenses or unallowable costs. To identify direct costs, the State first defined CCBHC services using the Scope of Services document. Costs associated with providing these services were categorized as direct CCBHC service expenses.

Shared costs were allocated between those categories using the reclassifications tab. Expenses were evaluated to follow Medicaid cost principles by adjusting actual data using the Trial Balance adjustments tab. Examples of adjustments include the removal of bad debt expense, and the adjustment of rent expense from a related party to match depreciation expense. Another example of an adjustment is the cost for care coordination in Behavioral Health Homes (BHH). Four of MN's CCBHCs are also certified as BHH, and will continue to receive separate payment for BHH services. Removal of these costs from the PPS assures that CCBHCs will not receive duplicate payment.

Clinics were instructed to count daily visits as the State elected to use the PPS-1 method. Visits represent a count of the number of days per patient where billable CCBHC services were delivered, regardless of the amount of services provided on any given day. Each day a patient received any number of CCBHC services was counted as one visit.

Anticipated costs were added using the anticipated cost tab and explained using supplemental schedules and narratives. These costs were identified as known changes from the reporting period or as additional expenses needed for the demonstration. Anticipated costs were scrutinized for each clinic. The salaries included for additional full-time employees were compared to those published by the Bureau of Labor Statistics for each personnel type and explanations were required to justify the additional costs. Psychiatrist compensation was compared to data from the Bureau of Labor Statistics to verify salary ranges were appropriate. Other metrics, such as visits per full time equivalent (FTE), actual costs per FTE, and anticipated costs per additional FTE were also analyzed for reasonableness. Anticipated costs were also reviewed to ensure compliance with allowable cost standards. The anticipated costs were then compared to actual costs to determine the impact of growth.

Anticipated visits were added for known growth and projected for growth needed to deliver the services required for the demonstration. These visits were used in conjunction with the actual and anticipated CCBHC costs expected for the demonstration to arrive at the daily cost per visit. We compared the ratio of cost per visit from actual data to anticipated cost per anticipated visit as a reasonableness check.

The Medicare Economic Index (MEI) was utilized to trend the resulting cost per visit forward to the DY1 period.

Each cost report for each CCBHC underwent a formal desk review in which actual results were compared to audited financial statements to ensure accuracy. As part of the desk review process, the CCBHCs were required to describe how direct CCBHC costs were identified when compared to direct non-CCBHC costs and indirect costs. Additionally, indirect cost allocations were scrutinized to follow the guidelines of the cost report. When CCBHCs had indirect rate agreements with cognizant federal agencies, the rate agreement

terms and conditions were used to calculate indirect costs allocable to the PPS rate calculation. Anticipated costs and anticipated visits were compared to actual costs and actual visits for reasonableness, consistency and accuracy. Finally, the MEI factor was recalculated by the review staff to ensure accuracy.

*PPS-1 Rate Updates from DY1 to DY2*

*The DY1 CC PPS-1 rates will be updated for DY2 by (select one):*

- The MEI
- Rebasing CC PPS-1 rate

*If rebasing the DY2 rate to reflect DY1 cost experience, provide in the box below an explanation of the interim payment methodology. Specify how the interim rate plus the DY2 rebased rate will cover the expected cost of care in DY2 and how long the interim payment will be in effect during DY2*

DY2 rates will be based on DY1 plus MEI. After consulting with stakeholders, Minnesota chose to not rebase due to logistical timing issues and concerns about downside risks associated with potential retroactive adjustments back to the beginning of DY2.

Minnesota appreciates the flexibility offered by CMS regarding this issue in the Q&A issued 9/28/16. If actual costs for DY1 are significantly higher or lower than projected costs, Minnesota will re-evaluate the above position. As required by the 9/28/16 Q&A, Minnesota will notify CCBHCs and CMS as soon as possible of any change that deviates from the methodology documented in this application.

***Section 2.1.b CC PPS-1 Quality Bonus Payments (QBPs)***

*When using the CC PPS – 1 method, a state may elect to offer a quality bonus payment (QBP) to any Certified Community Behavioral Health Clinic (CCBHC) that has achieved all of the six required quality measures as shown in Table 3 of the PPS guidance in section 2.1. The state can make a QBP on the basis of additional measures provided in the Prospective Payment System (PPS) Guidance and may propose its own quality measures. Any additional state defined measure must be approved by Centers for Medicare & Medicaid Services (CMS).*

*The state chooses to (select one):*

- Not offer QBP(s)
- Offer QBP(s)

*In the box below provide a list of the quality measures that will be used (in addition to the six*

required measures shown in Table 3 of the PPS guidance) for QBPs. Note any measure that is state-defined and provide a full description of the measure. If additional space is needed, please attach and identify the page that pertains to this section.

The Minnesota Department of Human Services (DHS) will implement the certified clinic (CC) PPS – 1 methodology, which is a fixed daily rate that reflects the expected cost of all CCBHC services provided on any given day to a Medicaid eligible individual. As part of the CC PPS – 1 payment methodology, DHS has opted to offer Quality Bonus Payments (QBPs) in addition to the PPS rate to any certified clinic that achieves six required measures.

#### Required quality measures

Acronym	Measure	Measure Steward
SRA – BH – C	Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	AMA - PCPI
SRA – A	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	AMA - PCPI
SAA – BH	Adherence to Antipsychotics for Individuals with Schizophrenia	NCQA
FUH – BH – C	Follow Up After Hospitalization for Mental Illness (child/adolescent)	NCQA
FUH – BH – A	Follow Up After Hospitalization for Mental Illness (adult)	NCQA
IET – BH	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	NCQA

The State is making a portion of the QBP fund pool available to CCBHCs who meet two additional optional measures (see Table below). None of the additional measures are state – defined and DHS and the CCBHCs will adhere to the *Metrics and Quality Measures for Behavioral Health Clinics Technical Specifications and Resource Manual* for collecting, reporting and calculating the required and optional measures.

DHS and a workgroup comprised of representatives from each of the CCBHCs utilized the following criteria to inform the selection of the two optional measures:

- An assessment of how the source data for the measure(s) would be collected, the extent to which the information was available and if the process for collecting and reporting the data represented significant administrative burden for the CCBHCs.
- The availability of state-specific, regional and/or national benchmark data that could be reviewed to identify an appropriate minimum performance threshold for the measure(s).
- The degree to which the measure(s) aligned with DHS’ goals for the delivery system and furthered the achievement of the following demonstration goals:
  - Provide the most complete scope of services as described in the criteria to individuals eligible for medical assistance under the State Medicaid program; and

- Improve availability of, access to and participation in, CCBHC covered services to individuals eligible for medical assistance under the State Medicaid program.

#### Optional quality measures

Acronym	Measure	Measure Steward
PCR – BH	Plan All-Cause Readmission Rate	NCQA
CDF – BH	Screening for Clinical Depression and Follow – Up Plan	CMS

#### Description of Quality Bonus Payment Methodology

*In the box below describe the CC PPS – 1 QBP methodology, specifying (1) factors that trigger payment, (2) the methodology for making the payment, (3) the amount of the payment, and (4) how often the payment is made to CCBHCs. Also, provide an annual estimate of the amount of QBP by demonstration year (DY) for all CCBHCs, including an estimate of the percentage of QBP payment to payment made through the PPS rate.*

#### **1. What are the factors that trigger payment?**

Each CCBHC must meet all six required measures to qualify for a bonus payment, subject to the conditions described below regarding minimum denominator size.

A minimum of 30 members/visits (i.e., denominator size) for each CCBHC must be present in order for the State to calculate any given measure. For measures with multiple reported rates, the minimum denominator size will need to be met for all rates calculated under the measure (e.g., 7 day and 30 day follow up measures).

All CCBHCs must meet the minimum denominator size for the following measures to qualify for the bonus payment:

- Adult Major Depressive Disorder (MDD): Suicide Risk Assessment
- Adherence to Antipsychotics for Individuals with Schizophrenia

We have analyzed historical data and are confident that all CCBHCs meet the denominator size for the above measures. However, the smaller clinics might not be large enough to meet the minimum denominator size on the other measures and should not be disqualified from bonus payments simply based on their size. If a CCBHC does not meet the minimum denominator size for the remaining quality measures, it will remain eligible for a bonus payment based on its performance for all measures that meet or exceed the minimum denominator size (i.e., 30).

The State will identify a minimum performance threshold during DY 1 for each measure that all CCBHCs must achieve to qualify for a bonus payment. DHS plans to collect and analyze an initial six months of data to inform the identification of the minimum performance level for the SRA – BH – C and SRA – A measures (adult and child suicide risk assessment measures) due to

an absence of state-specific historical performance data and the unavailability of comparable regional or national benchmark data.

When establishing the minimum performance threshold for the remaining measures, DHS will utilize the following approach:

- When available, review applicable statewide and region specific system performance for each measure in prior years.
- Review available regional and national benchmark data for selected measures.
- Consider input from representatives of each CCBHC that have experience with collecting and reporting the measures.

During DY 2, DHS will review the CCBHCs' DY 1 performance for each measure and identify a revised minimum performance level for each measure that will require each CCBHC to incrementally improve performance (e.g., increase of 3 or 5 percentage points) from DY 1 to DY 2. The State plans to review actual performance on the measures during DY 1. Based on that review of DY1 performance, the State will re-evaluate the following DY 2 minimum performance thresholds. See Table below for an example.

CCBHC	Measure	MPT (DY 1)	DY 1 Performance	DY 1 +3% (DY 2)	DY 1 +5% (DY 2)
CCBHC 1	Follow Up (30 days)	60%	62%	65%	67%
CCBHC 2	Follow Up (30 days)	60%	68%	71%	73%
CCBHC 3	Follow Up (30 days)	60%	58%	61%	63%

For measures that have multiple rates (e.g., FUH – BH – C, FUH – BH – A, IET – BH), the CCBHCs must achieve all established minimum performance thresholds for each rate for the measure to be considered met.

## 2. What is the methodology for making the payment?

QBPs are payments in addition to the basic PPS rate and, for purposes of CCBHC QBP reporting and payment, only consumers who are Medicaid beneficiaries, including Title XIX eligible Children's Health Insurance Program beneficiaries, will be counted towards payment.

Each of the six required measures will contribute equally towards the QBP amount. The State has chosen to designate payment for meeting the six required measures as a percentage of the overall QBP fund pool (funded as part of the State Medicaid Forecast) without establishing different payment amounts for each measure. During DY 1, a lump sum payment is available to any CCBHC that meets the minimum performance threshold for all six required measures.

In addition, during DY 1, the State will offer each CCBHC an additional portion of the quality

bonus payment pool based on meeting the following optional measure: Screening for Clinical Depression and Follow – Up Plan (CDF – BH). DY 1 will serve as the initial baseline assessment for the second optional measure (Plan All – Cause Readmission Rate), which will not be tied to a QBP during DY 1.

During DY 2 to qualify for the QBP, the State will require a percentage increase from the DY 1 minimum performance thresholds and will include both optional measures.

**Example:**

During DY 1, a lump sum payment is available to any CCBHC that meets the minimum performance threshold for all six required measures. An additional portion of the QBP is available to any CCBHC that meets all six required measures and the selected optional measure.

During DY 2, a percentage of the overall QBP pool is available to any CCBHC that exceeds the CCBHC’s DY 1 performance level by 3 or 5 percentage points. The two optional measures, if met, will trigger an additional payment based on a pre-determined portion of the overall QBP fund pool.

**3. What is the amount of payment?**

DHS anticipates that five percent of the total CCBHC payments or approximately \$2,500,000 will be available to support the QBP program for each demonstration year. The amount of payment under the QBP program will be disbursed using the following approach: (for this purpose, the term “qualifying CCBHC” refers to a clinic that has met the performance thresholds described above as well as the minimum denominator size described earlier.)

- **During DY 1**, the State will designate 90% of the total QBP fund pool towards achievement of the six required measures.
  - The State will offer a base payment, equal in amount for each qualifying CCBHC, for any CCBHC that meets or exceeds the six required measures. The amount of the base payment pool will be 25% of the QBP funds designated for achieving the six required measures or approximately \$600,000.
  - The State will distribute the remaining 75% of the QBP fund to qualifying CCBHCs based on the proportion of overall member visits during DY 1.
- For the remaining 10% of the QBP fund pool during DY 1, a base payment, equal in the amount for each qualifying CCBHC, will be available to any CCBHC that meets the six required measures and the DY 1 optional measure.
- **During DY 2**, the State will designate 90% of the total QBP fund pool towards achievement of the six required measures.
  - The State will offer a base payment, equal in amount for each qualifying CCBHC, for any CCBHC that meets or exceeds the six required measures. The amount of the base payment pool will be 25% of the QBP funds designated for achieving the six required measures or approximately \$600,000.
  - The State will distribute the remaining 75% of the QBP fund to qualifying CCBHCs based on the proportion of overall member visits during DY 2.
- For the remaining 10% of the QBP fund pool during DY 2, a base payment, equal in the amount for each qualifying CCBHC, will be available to any CCBHC that meets the six

required measures and one or both of the DY 2 optional measures. The fund pool will be split, with 50% of the funds available for each of the two optional measures.

See the example below that illustrates the potential amount of the QBPs to each qualifying CCBHC.

Total CCBHC payments = \$50,000,000  
 Available QBP pool (5%) = \$ 2,500,000

CCBHC	Number of Visits	Percent of Visits	Base QBP for Meeting 6 Required Measures	Share of Remaining Pool Based on % of Visits	Base QBP for Meeting Optional Measure(s)	Total QBP
CCBHC 1	13,000	13%	\$93,750	\$219,375	\$41,666	\$354,791
CCBHC 2	25,000	25%	\$93,750	\$421,875	\$41,666	\$557,291
CCBHC 3	15,000	15%	\$93,750	\$253,125	\$41,666	\$388,541
CCBHC 4	15,000	15%	\$93,750	\$253,125	\$41,666	\$388,541
CCBHC 5	12,000	12%	\$93,750	\$202,500	\$41,666	\$337,916
CCBHC 6	20,000	20%	\$93,750	\$337,500	\$41,666	\$472,916
Total	100,000	100%	\$562,000	\$1,687,500	\$250,000	~\$2,500,000

#### 4. How often the payment is made to CCBHCs?

To allow sufficient time to report and calculate the measures, DHS will make QBPs to the CCBHCs annually. This will help ensure that any data collection issues and/or reporting challenges are addressed and resolved early in the reporting period and will not negatively impact quality bonus payments to the CCBHCs. In addition, for smaller CCBHCs, allowing a full 12 months of data will help ensure that minimum case numbers are met for each measure. The State is planning to produce quarterly data reports for each measure that so that CCBHCs can assess how they are performing on an ongoing basis. This will allow the CCBHCs to analyze clinical work flows, identify, and implement interventions, and engage in a process of continuous quality improvement.

*If Section 2.1 is completed, skip Section 2.2 and continue to Section 3.*

**Section 2.2: CC PPS Alternative (CC PPS-2) NOT/APPLICABLE**

#### **Section 3: Payment to CCBHCs that are FQHCs, Clinics, or Tribal Facilities**

*In some instances, a CCBHC already may participate in the Medicaid program as a Federally Qualified Health Center (FQHC), clinic services provider or Indian Health Service*

*(IHS) facility that receives payment authorized through the Medicaid state plan. In these instances, the state should refer to the guidance for how these Medicaid providers would be paid when a clinic user receives a service authorized under both the state plan and this demonstration.*

- The state will require each certified clinic on its CCBHC cost report to report whether it is dually certified as a FQHC, clinic services provider or IHS facility.*

None of Minnesota's CCBHCs are dually certified as FQHCs, clinic services providers or IHS facilities.

#### ***Section 4: Cost Reporting and Documentation Requirements***

*In order to determine CCBHC PPS rates, states must identify allowable costs necessary to support the provision of services.*

##### ***Section 4.1: Treatment of Select Costs***

*CMS provides additional guidance for the state regarding how to treat select costs, including uncompensated care, telehealth, and interpretation or translation service costs.*

- The state excludes the cost of uncompensated care from its calculation of the CCBHC PPS.*

Costs for providing CCBHC services and the corresponding visits incurred during the reporting period were included as part of PPS rate calculation, regardless of whether the beneficiary was uninsured or underinsured. Bad debt expense related to uninsured, underinsured or uncompensated care, however, was not included in the PPS rate calculation and was either categorized as an unallowable expense on the Trial Balance tab or adjusted out of Direct CCBHC or Indirect expenses pursuant to 45 CFR §75.426. Consequently, neither bad debt expense nor offsetting grant revenue designated for uninsured or underinsured recipients were included in the PPS rate calculation.

##### ***Section 4.2: Cost Report Elements and Data Essentials***

###### ***Cost Reporting***

- The state will use the CMS CCBHC cost report and has attached a sample completed form plus an explanatory narrative (see below) that demonstrates the rate for DY1.*
- The state will use its own cost report and has attached a sample completed form plus an explanatory narrative that demonstrates the rate for DY1.*



Attached is an example of one of the clinic's cost report submissions and the resulting PPS rate, in Microsoft Excel format. The following is an explanatory narrative regarding the overall rate methodology for DY1:

The State has elected to utilize the CMS cost report template issued on January 28, 2016. The State has provided guidance on cost reporting to the six clinics participating in the CCBHC demonstration and has collected cost reports from each of them. The cost reports contain actual costs and visits as experienced by the clinics as well as additional anticipated costs expected to occur during the demonstration year, either from known expenses incurred since the end of the reporting period or additions needed to provide services required for participation in the demonstration. The State and Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, performed desk reviews on each cost report in detail for accuracy and consistency in application of the required components and inclusion of allowable costs for allowable services.

The State elected to use the PPS-1 methodology, which will result in a clinic-specific fixed rate per day that will cover all CCBHC services provided on a given day to Medicaid recipients. The cost reports were utilized to derive the clinic-specific daily rate by calculating the estimated annual allowable costs divided by the estimated annual amount of visits. The estimated annual costs are derived from the cost report actual and anticipated costs, trended forward by the MEI. The estimated annual visits are based on actual experience and projections for increased capacity, adjusted as necessary for changes resulting from the input from the readiness review and needs assessments.

And the following is additional explanatory narrative regarding the specific cost report and rate which are attached:

Northwestern Mental Health submitted their cost report along with supporting documentation, including their calendar year audited financial statements for 2014 and 2015, a crosswalk of grouped accounts mapping to the categories listed in the Trial Balance tab of the cost report, documentation of daily visits, support for adjustments and supplemental information to support their anticipated costs. Minnesota staff and contract staff (Mercer) performed desk review procedures to validate the accuracy of the reported results and to review anticipated costs for reasonableness and accuracy.

The cost report included all of the required information for calculating and supporting the PPS-1 daily rate. The provider information tab included the list of behavioral health professionals, the hours open as a clinic and as a CCBHC. Northwestern Mental Health did not list any satellite facilities.

The trial balance segregated costs for direct CCBHC services according to the CCBHC

service list provided by the state during our stakeholder sessions. Direct costs were assigned as CCBHC services and non-CCBHC services based on the coding provided on the list. The list of CCBHC services is a separate attachment to this application and is titled “Scope of Services.”

Documentation for reclassifications and adjustments was included in each of the respective tabs and reviewed for accuracy. Mercer staff reviewed the documentation for understanding and verified all amounts were accurately transferred to the Trial Balance tab. Reclassifications were primarily for shared resources between CCBHC and non-CCBHC direct costs. Adjustments were primarily for grant revenue received to offset expenses.

Northwestern’s indirect costs were allocated using the percentage of direct costs method under line 11 of the Indirect Cost Allocation tab resulting in 80.8% allocation to CCBHC services. Other indirect costs were allocated by square footage per the allocation descriptions tab.

*Anticipated costs* included additional salaries, benefits, supplies, training, and a reduction to direct non-CCBHC salaries, benefits, and other expenses as resources were redirected to provide CCBHC services. Supporting narratives and expense amounts were reviewed for reasonableness, including comparisons to the Bureau of Labor Statistics published levels for wages. Northwestern provided additional supporting narratives for clarifications of costs upon request.

Northwestern’s daily visits included actual and *anticipated visits* with no visits from DCOs (since Northwestern does not plan to use DCOs). The amount of anticipated visits was tested for reasonableness against actual visits. Actual visits per FTE were at 394.3, whereas anticipated visits were listed at 389.7. The methodology for calculating daily visits was verified to be accurate in that any beneficiary receiving any number of CCBHC services on a particular day was counted only once.

The MEI adjustment was updated by the state and accepted by the clinic as 6.012% leading to a projected **PPS rate of \$239** per CCBHC visit day.

*The attached state-developed cost report template includes following key elements as specified in section 4.2 of the PPS guidance:*

- Provider Information
- Direct and Indirect Cost – Identification
- Direct and Overhead Cost – Allocations
- Number of Visits
- Rate Calculations

### ***Section 5: Managed Care Considerations***

*The statute requires payment of PPS and allows payment to be made FFS and through managed care systems for demonstration services. If the state chooses to include CCBHC service coverage in their managed care agreements, CCBHCs must still receive the actual PPS rates, or their actuarial equivalent. The state has two options for incorporating the CCBHC rate into the managed care payment methodology: (1) fully incorporate the PPS payment into the managed care capitation rate and therefore require the managed care plan to pay the full PPS, or (2) have the managed care plans pay a rate that another provider would receive for a similar service and use a supplemental payment (wraparound) to ensure that total payment is equivalent to CCBHC PPS.*

#### ***Section 5.0.a Managed Care Capitation CCBHC PPS Rate Method***

The PPS methodology selected in Section 2 will apply to services delivered in both managed care payment and FFS.

#### ***Section 5.0.b Building CCBHC PPS Rates into Managed Care Capitation***

*Explain how the state will ensure access to CCBHC services from Managed Care Organizations (MCO), Prepaid Inpatient Health Plans (PIHP), or Prepaid Ambulatory Health Plans (PAHP) through network adequacy requirements.*

Minnesota will amend its MCO contracts to require compliance with Section 223 requirements including access to CCBHC services. Minnesota's MCOs have been active participants and supporters in the CCBHC planning process. The state will monitor compliance but we do not expect this to be a problem. MCOs are required to submit timely and accurate encounter data which will be monitored frequently and used in the PPS wraparound process.

*CMS offers states the option of using either of the following methodologies for incorporating the CCBHC rate into the managed care payment methodology (select one):*

- Fully incorporate the PPS payment into the managed care capitation rate and require the managed care plans to pay the full PPS or its actuarial equivalent.*

*Explain how the state will provide adequate oversight for CCBHCs that receive the actual PPS rates or their actuarial equivalent, including provisions for special populations and outlier payments.*

N/A see below

OR

*Require the managed care plans to pay a rate to the CCBHCs that other providers would receive for similar services then use a supplemental payment (wraparound) to ensure payment to CCBHCs is equal to the PPS.*

*Explain how the state will provide adequate oversight related to reconciling managed care payments with full PPS rates, including provisions for special populations and outlier payments.*

Minnesota will use a uniform wraparound payment methodology for all qualified Medicaid recipients, including fee-for-service (FFS) and managed care. Under this method, the MCOs and the state's FFS system will pay a rate to the CCBHCs that other providers would receive for similar services. The State will then make a supplemental payment (wraparound) to ensure payment to CCBHCs is equal to the PPS. This method will ensure that all CCBHCs receive the full PPS rate plus appropriate Quality Bonus Payments for all qualified recipients. This method will reconcile managed care and FFS payments to CCBHCs with the full PPS rates for covered services to determine whether the minimum payment was achieved. If the minimum payment was not achieved, the state (not the MCO) will make supplemental payments to the CCBHCs to make up the shortfall. This methodology includes ongoing oversight of all managed care payments to CCBHCs and a monthly reconciliation process between the state and the CCBHCs. Minnesota will contract for external expertise to ensure that the reconciliation process meets all required standards. The following is a detailed description of the methodology:

**Payment reconciliation methodology.** Clinics will continue to submit fee-for-service claims to the State MMIS and to MCOs, in the normal manner.<sup>1</sup> Bi-weekly, Minnesota will place a file on the State's secure FTP server, which will contain encounters submitted by the MCOs and fee-for-service claims paid by Minnesota FFS to the CCBHCs. This data will be vetted through the Minnesota claim and encounter system to only include data for members who are eligible for the CCBHC wraparound payment. In addition to the encounter file, a file of members who are veterans will be provided to the contractor for reporting purposes. This file will be provided monthly. The contractor will use the file of members identified as veterans to flag the encounter data. This flag will be used during reporting to identify and summarize CCBHC services used by veterans. (Veterans' status does not affect the payment, but inclusion of this data will ensure that the state can meet federal reporting requirements.)

Upon receiving the encounter data files, the contractor will ensure that control totals match those of the State, validate that all fields are populated as expected and that a reasonable

<sup>1</sup> This time-limited payment process mitigates the re-programming burden on the State's legacy MMIS and MCO claims-payment systems in order to meet the CCBHC timelines and reconciles traditional payments with PPS rates, using methodology developed by a contractor. Upon permanent enactment of CCBHC in Minnesota, PPS methodology will be fully implemented in the State payment system.

number of records exist. If the data appears to be incomplete, the contractor will work with the State to ensure that the data is complete. The contractor will then run a standardized set of validation metrics on the data to include code and code accuracy checks, volume comparisons to previous cycles, reasonableness checks and lag triangles.

If the data appears to be complete and accurate within reasonable parameters, the contractor will load the data for reconciliation processing. The reconciliation process will look at each member's dates of service, flag the first eligible PPS service received on a date-of-service, ignore additional eligible services received on the same date, and enter a PPS payment obligation for the eligible service. The process will then calculate the number of days that the member was eligible for the CCBHC PPS payment and the total PPS payment obligation due for that member. Monthly, the process will calculate the difference between total fee-for-service claims and MCO encounters versus total PPS payment obligations to determine any supplemental (wraparound) payment due to the CCBHC. In instances where there are retroactive eligibility changes or encounters that were adjusted (changed) or voided, the process will take those instances into account and include them. It is possible for the member's final PPS wraparound amount in a specific month to be a negative dollar amount due to changes and retroactivity.

*Explain the frequency and timing of the wraparound payment used by the state:*

Wraparound payments will be made monthly, based on biweekly extracts from the state's fee-for-service and MCO claims database. If additional claims and/or corrections come in for the same recipient for the same day, the wraparound calculation will be updated each month back to the beginning of the demonstration.

### ***Section 5.0.c PIHP and PAHP Coverage Areas in Managed Care States***

- The state contracts with a PIHP or PAHP and intends to use these delivery systems as part of CCHBC service delivery.*

*Describe which managed care plans will be responsible for providing CCBHC services and what services provided in other managed care plans may duplicate the CCBHC services.*

Minnesota does not have PIHPs or PAHPs. Minnesota contracts with managed care organizations (MCOs), all of which cover behavioral health services and will be required to cover CCBHC services. Under the wraparound payment methodology, MCOs will pay a rate to the CCBHCs that other providers would receive for similar services. These MCO payments will be factored into the determination of the supplemental wraparound payment.

*Explain the methodology for removing services that duplicate CCBHC demonstration services*

*from the managed care plans not responsible for the CCBHC services, how managed care capitation rates will be changed, the timing/process for determining that the new managed care rates will be actuarially sound, and how the state will ensure no duplication of expenses.*

All of Minnesota's managed care plans will be responsible for all CCBHC services. Under the wraparound methodology described above, the state will pay a wraparound supplemental payment directly to the CCBHCs to make up the difference between the MCO's payment and the PPS. Since the state will make the supplemental payment directly to the CCBHCs, little or no impact is expected on MCO capitation rates. We will work with actuaries prior to implementation of the demonstration to assure that managed care rates continue to be actuarially sound. This will include a review of any potential duplication of responsibilities between the MCOs and the CCBHCs and appropriate adjustments in managed care rates.

Minnesota is also working with its CCBHCs and MCOs to administratively delineate and coordinate any overlapping responsibilities, particularly relating to care coordination. Most of Minnesota's CCBHCs are also certified as behavioral health homes (BHH). In order to prevent any duplication of payment to the CCBHCs:

- The cost of BHH services has been excluded from the PPS encounter rate
- Any payments received by the CCBHC for non-BHH care coordination (or for any other services that are included in the PPS) will be subtracted out as part of the wraparound payment methodology.

*If a state chooses not to include all demonstration services under one contractor, define the delineation of services between contractors. If this delineation will require a change to managed care capitation rates, explain how rates will be affected, the timing and process for determining that the new managed care rates will be actuarially sound, and how the state will ensure non-duplication of payments.*

N/A

#### ***Section 5.0.d Data Reporting and Managed Care Contract Requirements***

*Describe the data reporting policies and processes, including specific data deliverables to be reported by each entity, collection of data, timing of reporting, and contract language for data reporting.*

Managed care data is collected from the MCOs via the MMIS claim system in X12 formats. Per the MCO contract, claims are sent within 30 days of adjudication. Approximately 70 edits have been customized to scrutinize this data. The claims data is migrated to the data warehouse where it resides alongside FFS claims data, eligibility data, provider data and numerous reference tables. MN's MCO contracts include about 4 pages of technical specifications relating to data reporting.

#### ***Section 5.0.e Identification of Expenditures Eligible for Enhanced Federal Matching***

**Percentage (FMAP)**

*Describe the process whereby the state will ensure proper claiming of enhanced FMAP for CCBHC services by identifying the portion of the capitation payment(s) applicable to the new adult group rate cells and the existing managed care population associated with CCBHC services.*

Minnesota's MCO encounter claims include the actual amount paid by the MCO. Claims eligible for CCBHC enhanced match will be identified by a combination of recipient eligibility, procedure code and certified provider, with a CCBHC modifier wherever necessary. The state's claim for enhanced match will be based on the MCO's actual payment plus the wraparound payment described above.

**Funding Questions: Section 223 Behavioral Health Demonstration**

*The questions below should be answered relative to all payments made to CCBHCs reimbursed pursuant to Section 223 of P.L. 113-93 Protecting Access to Medicare Act of 2014 and the methodology described in the state's application to participate in the demonstration program.*

*CMS requests the following information about the source(s) of the non-federal share of payment made for demonstration services.*

*1. Section 1902(a)(2) stipulates that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan.*

- Describe how the non-federal share of each type of Medicaid payment (e.g., basic PPS rate, outlier payment and quality bonus payments) is funded.*

The non-federal share for Medicaid payments for CCBHC services (PPS rate) and for quality bonus payments will come from general fund appropriations from the legislature to the Medicaid agency.

- Describe whether the state share is from appropriations from the legislature to the Medicaid agency, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share.*

The 2016 Minnesota Legislature appropriated \$7.8 million in additional general fund appropriations to the Medicaid agency to fully fund the projected state share of Medicaid payments to CCBHCs. This is an entitlement appropriation which can be exceeded if actual utilization is higher than expected.

Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either through an IGT or CPE. In this case, please identify the agency to which the funds are appropriated.

- *If any of the non-federal share of payment is being provided using IGTs or CPEs, fully describe the matching arrangement including when the state agency receives the transferred amounts from the local governmental entity transferring the funds.*

N/A – see above

- *If certified public expenditures (CPEs) are used, describe the methodology used by the state to verify that the total expenditures being certified are eligible for federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or intergovernmental transfers (IGTs), please provide the following:*
  - A complete list of the names of entities transferring or certifying funds*
  - The operational nature of the entity (state, county, city, other)*
  - The total amounts transferred or certified by each entity*
  - Whether the certifying or transferring entity has general taxing authority*
  - Whether the certifying or transferring entity received appropriations (identify level of appropriations)*
  - A cost report for CMS approval for any CPE-funded payment(s)*

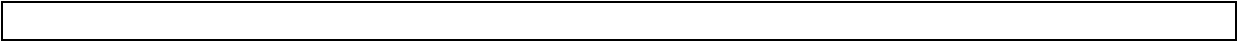
N/A – see above

2. *Do CCBHC providers receive and retain the total Medicaid expenditures claimed by the state for demonstration services (includes basic PPS and enhanced payments) or is any portion of the payments returned to the state, local governmental entity, or any other intermediary organization?*

*If providers are required to return any portion of payments, provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the state (e.g., general fund, medical services account, etc.).*

Providers affected by this demonstration will receive the total computable Medicaid payment. The state does not monitor how providers use their payment, and therefore cannot assert that they will “retain” that funding. However, providers will not return any portion of their payment to the state or local government.





## Minnesota SUD Services by ASAM Level of Care

ASAM Level of Care	Service	Service Definition	Expenditure Authority in Minnesota
0.5	Early Intervention	One to one counseling and screening with at-risk individuals, motivational interventions and educational programs for groups such as DUI offenders; SBIRT	State Plan (for SBIRT only)
1	Outpatient Service	Counseling services up to 9 hrs per week- adults; fewer than 6 hrs per week for adolescents when determined to be medically necessary and in accordance with an individualized treatment plan.	State Plan (including CCDTF)
1	Opioid Treatment Program	Counseling services coordinated with medication assisted treatment delivered in an Opioid Treatment Program (OTP) when determined to be medically necessary and in accordance with an individualized treatment plan..	State Plan (including CCDTF)
1	Office-Based Opioid Treatment	Counseling services coordinated with medication assisted treatment delivered in a physician's office when determined to be medically necessary and in accordance with an individualized treatment plan. Counseling services could be delivered at a separate location.	State Plan (including CCDTF)
2.1	Intensive Outpatient Service	Counseling services delivered from a minimum of 9 hrs per week to a maximum of 19 hours per week for adults; and a minimum of 6 hrs per week to a maximum of 19 hours per week for adolescents when determined to be medically necessary and in accordance with an individualized treatment plan.	State Plan (including CCDTF)
2.5	Partial Hospitalization	Structured programming of 20 hrs or more of clinically intensive services per week for adults when determined to be medically necessary and in accordance with an individualized treatment plan; adolescents usually receive services during school hrs. Level 2.5 partial hospitalization programs typically have direct access to psychiatric, medical, and laboratory services.	State Plan (including CCDTF)
3.1	Clinically Managed Low-Intensity Residential Services	Supportive living environments (SLE) with 24-hour staff and close integration with clinical services provided when determined to be medically necessary and in accordance with an individualized treatment plan. Program services of 5 or more hours of services weekly may be offered in a (usually) free-standing, appropriately licensed facility located in a community setting.	State Plan (including CCDTF)

ASAM Level of Care	Service	Service Definition	Expenditure Authority in Minnesota
3.3	Clinically Managed Population-Specific High Intensity Residential Services	Clinically managed therapeutic rehabilitation facilities for adults with cognitive impairment including developmental delay or traumatic brain injury that provides rehabilitation services to recipients with an SUD when determined to be medically necessary and in accordance with an individualized treatment plan. High intensity clinical services are provided in a manner to meet the functional limitations of patients with cognitive impairment so significant and the resulting level of functional impairment is so great that outpatient motivational strategies and/or relapse prevention strategies are not feasible or effective. Staffed by credentialed addiction professionals, physicians/physician extenders, credentialed mental health professionals.	State Plan (including CCDTF)
3.5	Clinically Managed High Intensity Residential Services	Clinically managed therapeutic community or residential treatment facilities providing high intensity services for recipients with an SUD when determined to be medically necessary and in accordance with an individualized treatment plan. Staffed by licensed/credentialed clinical staff, including licensed addiction professionals, licensed social workers, licensed professional counselors, physicians/physician extenders, and credentialed mental health professionals.	State Plan (including CCDTF)
3.7	Medically Monitored Intensive Inpatient Services	Medically monitored inpatient services provided in a freestanding residential facility or inpatient unit of an acute care hospital or psychiatric unit when determined to be medically necessary and in accordance with an individualized treatment plan. Includes 24-hour clinical supervision including physicians, nurses, addiction counselors, and behavioral health specialists.	State Plan (including CCDTF)
4	Medically Managed Intensive Inpatient Services	Acute care general or psychiatric hospital setting, with 24/7 medical management and nursing supervision, and counseling services (16 hours per day). Managed by addiction specialist physician with interdisciplinary team of credentialed clinical staff knowledgeable of biopsychosocial dimensions of addictions.	State Plan (including CCDTF)

ASAM Level of Care	Service	Service Definition	Expenditure Authority in Minnesota
1 WM	Ambulatory Withdrawal Management without Extended On-Site Monitoring	Ambulatory withdrawal management without extended on-site monitoring. May include specialized psychological and psychiatric consultation and supervision.	State Plan only
2 WM	Ambulatory Withdrawal Management with Extended On-Site Monitoring	Ambulatory withdrawal management with extended on-site monitoring with clinical (medical) consultation and supervision. May include specialized psychological and psychiatric consultation and supervision.	State Plan only
3.2 WM	Clinically Managed Residential Withdrawal Management	Moderate Withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery	Will be added to State Plan in 2019
3.7 WM	Medically Managed Inpatient Withdrawal Management	Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete withdrawal management without medical, nursing monitoring	Will be added to State Plan in 2019

ASAM Standards of Care Comparison Table

ASAM Standards of Care	Minnesota's standards of care in law, rule, or practice	Alignment with ASAM standards
<b>I. Assessment and Diagnosis</b>		
Standard I.1 Comprehensive Assessment	Comprehensive Assessment and Assessment Summary under Minnesota Statutes, section 245G.05	Comprehensive assessments, diagnoses and referrals are completed for all patients by behavioral health clinicians or other health practitioners, as appropriate to their scope of practice
Standard I.2 Monitoring Diagnostic Procedures	Comprehensive Assessment and Assessment Summary under Minnesota Statutes, section 245G.05	Data from diagnostic procedures is collected and monitored by behavioral health clinicians, nurses, or other health practitioners as appropriate to their scope of practice.
Standard I.3 Making the Diagnosis	Comprehensive Assessment and Assessment Summary under Minnesota Statutes, section 245G.05	Diagnoses are made by behavioral health clinicians, nurses, or other health practitioners as appropriate to their scope of practice.
<b>II. Withdrawal Management</b>		
Standard II.1 Assessing Withdrawal Management Needs	Detoxification program under Minnesota Rules, Chapter 9530 (Rule 32)  Withdrawal management to be implemented under Minnesota Statutes, section 245F	Withdrawal management services provided under the SUD waiver will closely align with ASAM standards
Standard II.2 Providing Intoxication/Withdrawal Medication Interventions	Detoxification program under Minnesota Rules, Chapter 9530 (Rule 32)  Withdrawal management to be implemented under Minnesota Statutes, section , 245F	Withdrawal management services provided under the SUD waiver will closely align with ASAM standards
Standard II.3 Assuring Intoxication/Withdrawal Psychosocial Interventions	Detoxification program under Minnesota Rules, Chapter 9530 (Rule 32)  Withdrawal management to be implemented under Minnesota Statutes, section , 245F	Withdrawal management programs will include care coordination services. Early implementation of withdrawal management services under the SUD waiver will inform the state on optimal practices in anticipation of state-wide rollout of withdrawal management services in 2019
<b>III. Treatment Planning</b>		

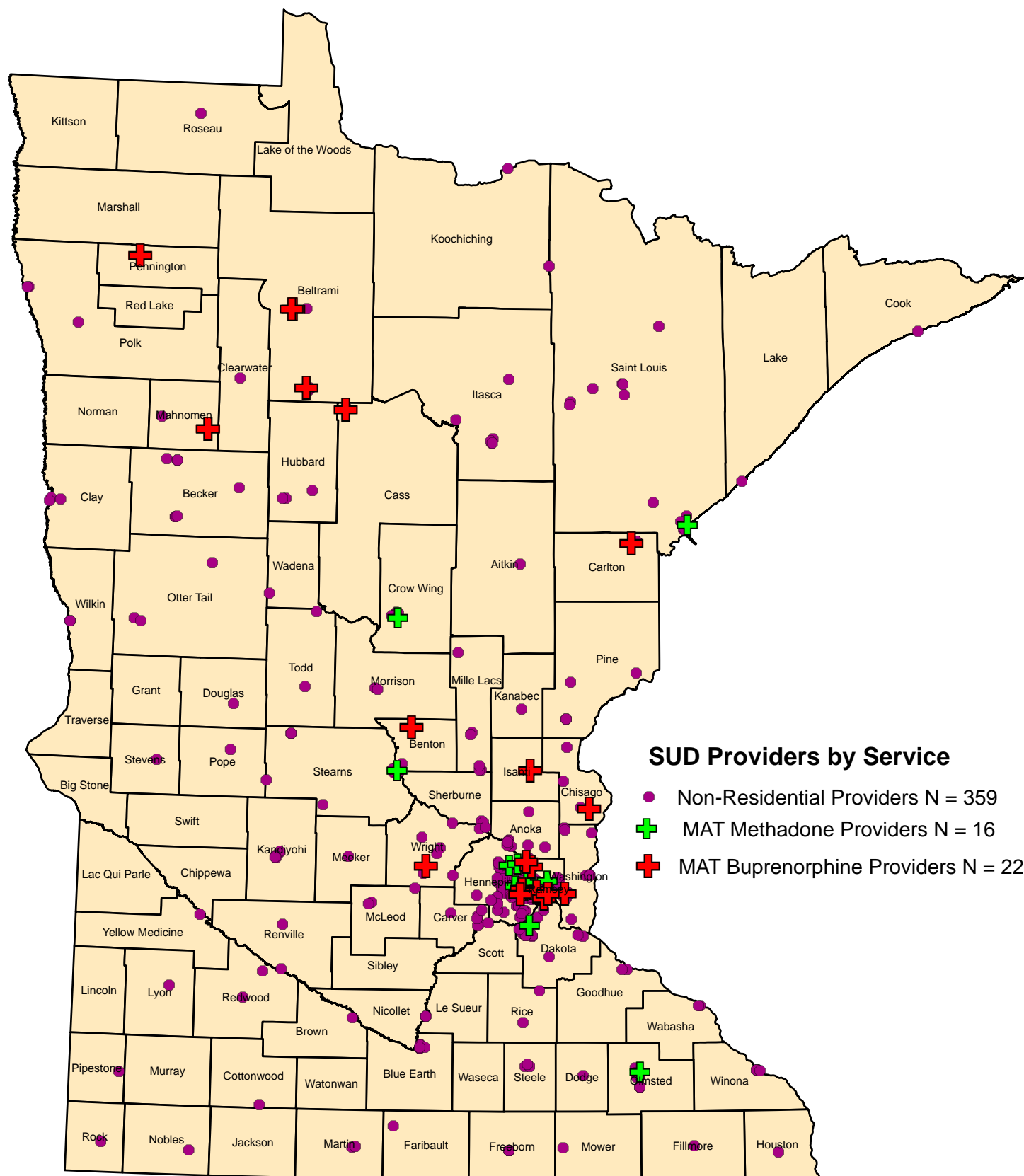
<b>ASAM Standards of Care</b>	<b>Minnesota's standards of care in law, rule, or practice</b>	<b>Alignment with ASAM standards</b>
Standard III.1 Coordinating Medical Care	Comprehensive Assessment and Assessment Summary under Minnesota Statutes, section 245G.05 Individual Treatment Plan under Minnesota Statutes, section 245G.06 Medical Services under Minnesota Statutes, section 245G.08	Treatment planning is coordinated by SUD program counselors in consultation with other health care practitioners
Standard III.2 Providing Therapeutic Alternatives	Comprehensive Assessment and Assessment Summary under Minnesota Statutes, section 245G.05 Individual Treatment Plan under Minnesota Statutes, section 245G.06 Medical Services under Minnesota Statutes, section 245G.08	Psychosocial and psychopharmacological therapies are coordinated by SUD program counselors, nursing and prescribing staff, and other health care practitioners
Standard III.3 Evaluating Safety	Initial Services Plan under Minnesota Statutes, section 245G.04 Individual Treatment Plan under Minnesota Statutes, section 245G.06	Treatment planning is coordinated by SUD program counselors in consultation with other health care practitioners
Standard III.4 Addressing Comorbidity	Comprehensive Assessment and Assessment Summary under Minnesota Statutes, section 245G.05 Individual Treatment Plan under Minnesota Statutes, section 245G.06 Medical Services under Minnesota Statutes, section 245G.08	Treatment planning is coordinated by SUD program counselors in consultation with mental health staff and other health care practitioners
Standard III.5 Involving Social Support Networks	Comprehensive Assessment and Assessment Summary under Minnesota Statutes, section 245G.05 Individual Treatment Plan under Minnesota Statutes, section 245G.06 Treatment Services under Minnesota Statutes 245G.07	Treatment planning is coordinated by SUD program counselors in consultation with other health care practitioners

ASAM Standards of Care	Minnesota's standards of care in law, rule, or practice	Alignment with ASAM standards
Standard III.6 Documenting Clinical Decisions	Comprehensive Assessment and Assessment Summary under Minnesota Statutes, section 245G.05 Individual Treatment Plan under Minnesota Statutes, section 245G.06 Medical Services under Minnesota Statutes, section 245G.08 Client Records under Minnesota Statutes, section 245G.09	Treatment planning and documentation is coordinated by SUD program counselors in consultation with other health care practitioners
<b>IV. Treatment Management</b>		
Standard IV.1 Assuring Quality of Care	Individual Treatment Plan under Minnesota Statutes, section 245G.06 Medical Services under Minnesota Statutes, section 245G.08	Treatment management is coordinated by SUD program counselors in consultation with other health care practitioners
Standard IV.2 Determining Clinical Progress	Individual Treatment Plan under Minnesota Statutes, section 245G.06	Treatment management is coordinated by SUD program counselors in consultation with other health care practitioners
Standard IV.3 Assuring Support Service Referral	Individual Treatment Plan under Minnesota Statutes, section 245G.06 Treatment Services under Minnesota Statutes 245G.07	Treatment management is coordinated by SUD program counselors in consultation with other health care practitioners
<b>V. Care Transitions and Care Coordination</b>		
Standard V.1 Coordinating Treatment and Confidentiality	Individual Treatment Plan under Minnesota Statutes, section 245G.06	Addiction care and confidentiality is coordinated by SUD program counselors in consultation with other health care practitioners

<b>ASAM Standards of Care</b>	<b>Minnesota's standards of care in law, rule, or practice</b>	<b>Alignment with ASAM standards</b>
Standard V.2 Assuring Quality in Transitions	Individual Treatment Plan under Minnesota Statutes, section 245G.06 Treatment Services under Minnesota Statutes, section 245G.07	Care transitions are coordinated by SUD program counselors in consultation with other health practitioners
Standard V.3 Sharing Information and Protecting Privacy	Individual Treatment Plan under Minnesota Statutes, section 245G.06 Treatment Services under Minnesota Statutes, section 245G.07	Sharing of treatment information is coordinated by SUD program counselors in consultation with other health practitioners to assure proper authorizations for release of information and confidentiality during care transitions.
Standard V.4 Providing Referral	Individual Treatment Plan under Minnesota Statutes, section 245G.06 Treatment Services under Minnesota Statutes, section 245G.07	Referrals are conducted by SUD program counselors in consultation with other health care practitioners
<b>VI. Continuing Care Management</b>		
Standard VI.1 Assuring Continuity in Addiction Care	Comprehensive Assessment and Assessment Summary under Minnesota Statutes, section 245G.05 Individual Treatment Plan under Minnesota Statutes, section 245G.06 Treatment Services under Minnesota Statutes 245G.07	Discharge planning is coordinated by SUD program counselors in consultation with treating medical practitioners

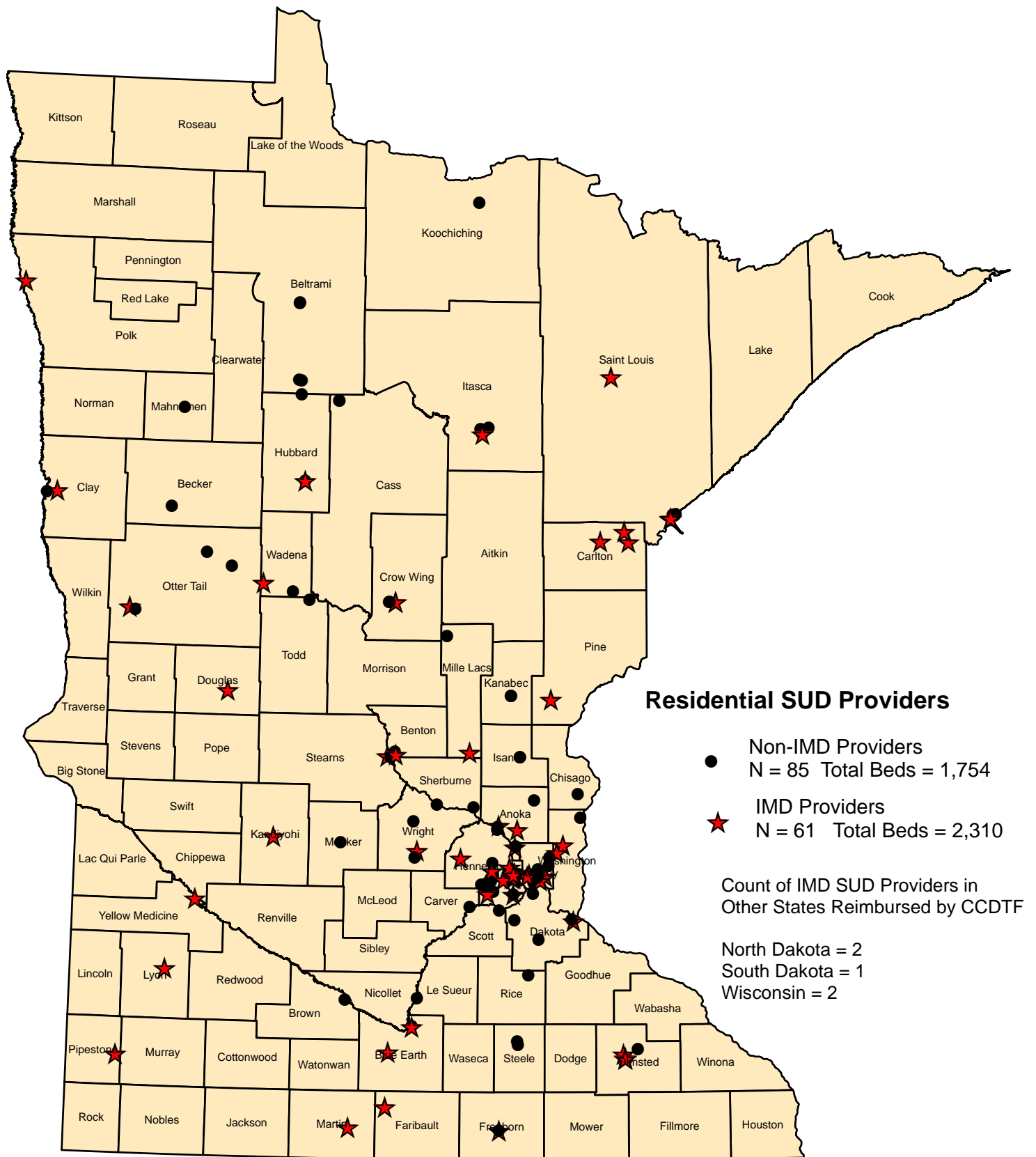


# Substance Use Disorder Treatment Providers



Source: Minnesota Department of Human Services, ADAD, DAANES (12/23/2017)

# Residential SUD Treatment Providers



Source: Minnesota Department of Human Services, ADAD, DAANES (12/23/2017)



# Federal health care waivers

Federal waivers allow states to test new ways to deliver and pay for health care services. Changes to the state's Medicaid and Children's Health Insurance Program often require waivers approved by the federal Centers for Medicare & Medicaid Services (CMS) to continue receiving federal Medicaid funding. The following are waivers that the Minnesota Department of Human Services (DHS) has applied for or received.

## Section 1115 waivers

- **Substance use disorder system reform waiver request**  
DHS submitted a substance use disorder (SUD) section 1115 demonstration waiver application March 15, 2018, for CMS review and approval. This demonstration project is an important component of the state's larger effort to address the opioid crisis as well as transform the health care delivery system for Medicaid recipients who need substance use disorder treatment and services.

DHS held an initial 30-day public comment period on the waiver request through March 13, 2018. All written comments received during the public comment period were included in the March 15, 2018, waiver application. In addition, DHS held public hearings to provide stakeholders and other interested persons the opportunity to comment on the waiver request:

- Thursday, Feb. 22, 2018  
10 a.m.  
Metropolitan Mosquito Control District  
2099 University Ave. W.  
St. Paul, MN 55104
- Friday, Feb. 23, 2018  
1:30 p.m.  
Department of Human Services, Elmer L. Andersen Human Services Building  
Room 2380  
540 Cedar St.  
St. Paul, MN 55101

## New request for public comment

On March 28, 2018, CMS requested that DHS publish a new request for public comment to clarify certain elements of the waiver proposal. The description below includes these clarifications about the project's financing, goals and objectives. The proposal itself remains unchanged.

DHS invites public comment on the proposed demonstration through May 10, 2018. Comments received will be posted on the DHS website. Written comments may be submitted to [dhs.waiver.comments@state.mn.us](mailto:dhs.waiver.comments@state.mn.us) (<mailto:dhs.waiver.comments@state.mn.us>) or:

Jan Kooistra  
Minnesota Department of Human Services  
P.O. Box 64983  
St. Paul, Minnesota 55164-0983

Please submit comments in Microsoft Word files or as text within the body of your email so DHS may make the comments accessible to people with disabilities. If you want to provide a signed copy of your comments, you may submit a second copy of them as a PDF.

DHS plans to resubmit the waiver request titled "[Minnesota Substance Use System Reform](#)" (PDF) ([//dhs/assets/sud-system-reform-waiver-request-draft\\_tcm1053-326540.pdf](#)) following this second 30-day comment period. To request a paper copy of the waiver request, please contact Sara Lent at 651-431-2836.

## Description of the proposal

### Overview

State law directs DHS to seek federal waiver authority to receive Medicaid matching funds for residential programs that have been determined as Institutions for Mental Disease (IMDs) to ensure continued access to this level of care for individuals with the most intensive treatment needs. Accordingly, the state proposes a five-year demonstration project that will test the impact of evidence-based provider referral arrangements and practices on health outcomes for Medicaid enrollees with substance use conditions.

Under this new demonstration, provider referral networks will be designed to provide Medicaid enrollees access to each of the levels of care for SUD treatment, as well as community mental health services. Consistent with guidance from CMS to state Medicaid directors, the levels of care will be modeled after the levels of care recommended by the [American Society of Addiction Medicine](#) (<http://asamcontinuum.org/about/>) for treating addictive, substance-related and co-occurring conditions.

Providers seeking to participate in this demonstration will verify to the department that they have, or will have, established the necessary partnerships or referral arrangements with other SUD providers to provide all levels of care for enrollees during the waiver period. In place of the state's existing process for assessment and placement under [Rule 25](#) (<https://mn.gov/dhs/partners-and-providers/policies-procedures/alcohol-drug-other-addictions/>), participating providers will be required to assess and record their Medicaid patients' treatment needs based on an evidence-based assessment tool called the [ASAM Six Dimensions of Multidimensional Assessment](#) (<https://www.asam.org/resources/the-asam-criteria>). All providers participating in this demonstration will also be required to apply at least three of the four evidence-based practices that were recently identified as cost effective by the Minnesota Management and Budget agency when applied to adults receiving SUD treatment.

The state intends to implement the first phase of the demonstration with interested SUD providers July 1, 2018. In the second year of the waiver, the state proposes to integrate community mental health services into the demonstration by permitting each of the state's six Certified Community Behavioral Health Clinics to apply to participate in the project.

### Demonstration Goals and Objectives

The proposed SUD reform waiver demonstration is designed to support the following goals and objectives:

- Improve patient access and quality of care through timely initiation and engagement in treatment for SUD.
- Improve patient quality of care through adherence to treatment for SUD over time.
- Improve health outcomes for patients through a reduction in the rate of deaths due to opioids.
- Improve health outcomes for patients through a reduction in the utilization of emergency department and inpatient hospital settings for SUD treatment.
- Improve access to care for physical health conditions among beneficiaries through coordination of care between physical and behavioral health providers treating Medicaid beneficiaries with a SUD diagnosis.

This demonstration will build on the state's efforts to transform its SUD delivery system to improve access to appropriate treatment and greater integration of SUD services with the broader health care system, including community mental health providers with the inclusion of the Certified Community Behavioral Health Clinic model. Over time, the state expects that these referral networks or partnerships that follow ASAM criteria will lead to better health outcomes for Medicaid enrollees, including those in need of the most intensive services in residential settings.

## Delivery system

Minnesota currently uses fee-for-service and managed care systems as specified under its state plan for delivering SUD services, both of which currently operate statewide. The only difference in the demonstration project will be for enrollees receiving assessments and services for treatment through the federal model for the Certified Community Behavioral Health Clinics program. The state intends to maintain the cost-based payment model currently permitted by federal law for the Certified Community Behavioral Health Clinics model.

## Eligibility

The state will use the same standards and methodologies to determine Medicaid eligibility for all populations in the demonstration project as used in the state plan. The state expects that all enrollees affected under the demonstration would be otherwise eligible for Medicaid, and that any enrollees eligible and enrolled in Medicaid seeking or receiving services from a participating provider would be included in this demonstration's population.

## Benefits and cost-sharing

Other than the differences described below, the benefits for Medicaid enrollees participating in this demonstration will be the same as those for all other enrollees under the Medicaid state plan. The benefits provided under the demonstration will differ from those provided under the state plan in two ways:

1. Participating providers that are not IMDs may bill for withdrawal management as a Medicaid-covered service under this waiver, which will not be permissible under the state plan before CMS approves of this state plan benefit in Minnesota on July 1, 2019.
2. Participating IMD providers may bill for withdrawal management as a Medicaid-covered service during the five-year waiver period.

The cost-sharing requirements under this demonstration will not differ from those provided under the Medicaid state plan.

## Enrollment and expenditures

Following are the state's estimates of the expected increase in annual enrollment and expenditures under the demonstration. Please note that more than 80 percent of the increase in Medicaid enrollee months shown below represents months of eligibility already covered in Medicaid at 100 percent state expense.

## Estimates of enrollee months during demonstration

	Demonstration year 1	Demonstration year 2	Demonstration year 3	Demonstration year 4	Demonstration year 5
<b>Fee-for-service IMD resident months</b>	4,178	4,333	4,493	4,660	4,832
<b>Managed care IMD residential months</b>	14,443	14,624	14,807	14,992	15,179
<b>State-funded IMD resident months become added Medicaid enrollee months</b>	18,622	18,957	19,300	19,651	20,011
<b>New withdrawal management service adds withdrawal management enrollee months</b>	3,443	3,570	3,702	3,839	3,982
<b>Total added Medicaid enrollee months</b>	22,065	22,527	23,003	23,491	23,993
<b>Total added Medicaid average enrollees (months/12)</b>	1,839	1,877	1,917	1,958	1,999

## Estimates of costs during demonstration

	Demonstration year 1	Demonstration year 2	Demonstration year 3	Demonstration year 4	Demonstration year 5
<b>Costs for fee-for-service IMD resident months</b>	\$22,027,628	\$23,528,060	\$25,133,833	\$26,844,242	\$28,675,813

<b>Costs for managed care IMD resident months</b>	\$11,395,051	\$11,883,636	\$12,393,168	\$12,924,525	\$13,478,614
<b>State-funded IMD costs become added Medicaid costs</b>	\$33,425,293	\$35,414,363	\$37,526,555	\$39,769,742	\$42,152,282
<b>New withdrawal management service costs</b>	\$18,152,494	\$19,388,866	\$20,709,427	\$22,119,942	\$23,626,551
<b>Total added Medicaid costs</b>	\$51,575,173	\$54,800,562	\$58,236,428	\$61,888,709	\$65,780,978

Under the demonstration the state will receive federal matching funds for withdrawal management services and SUD services provided to Medicaid beneficiaries in participating IMDs.

## Evaluation plan

Through this demonstration, the state will test the impact of ASAM-based referral networks on enrollee access to services. The state will also evaluate the impact over time of the application of ASAM recommendations on quality of care and health outcomes. After the first year of the demonstration, the state will also assess the impact of integrating community mental health care providers into an ASAM-based provider referral network with SUD providers and other health care professionals as needed. Refer to Attachment B1 of the waiver application for the evaluation plan, including questions, metrics and data for testing its hypotheses related to SUD outcomes.

## Waiver and expenditure authorities

Under the authority of section 1115 of the Social Security Act, the state is requesting the following waiver and spending authorities in order to implement the SUD system reform demonstration:

- **Statewide uniformity:** To the extent necessary, to permit the State to operate the demonstration on a less than statewide-basis to the geographic area served by the participating providers in the pilot project.
- **Comparability:** To the extent necessary, to permit the State to include withdrawal management as a Medicaid-covered benefit for demonstration enrollees only before it's approved in the State Medicaid Plan for all enrollees.
- **IMD spending authority:** To the extent necessary, to allow the state to operate its section 1115 demonstration and to provide federal funding to cover services otherwise ineligible for federal financial participation when furnished to Medicaid enrollees in facilities participating in this demonstration that meet the federal definition of an Institution for Mental Disease.
- **Certified Community Behavioral Health Clinics spending authority:** To the extent necessary, to allow the state to operate its section 1115 demonstration and to provide federal funding to

cover services through a cost-based payment structure when furnished to Medicaid enrollees in clinics participating in this demonstration that meet the federal definition of a Certified Community Behavioral Health Clinics under section 223 of the Protecting Access to Medicare Act, which is currently administered by the Substance Abuse and Mental Health Services Administration.

## CMS public comment period

CMS will hold a federal comment period following DHS' submission of the SUD system reform waiver request. At that time, you may submit comments directly to CMS by going to [www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html](http://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html) (<http://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html>) and entering Minnesota in the search box.

## Medicaid waivers email list

Receive free one-way email notification when new information is available about Medicaid waivers by signing up for the Medicaid waivers email list. Click [Subscriptions \(/dhs/general-public/publications-forms-resources/email-subscriptions/index.jsp\)](http://dhs/general-public/publications-forms-resources/email-subscriptions/index.jsp) and select Medicaid waiver from the list of topics.

Subscribers will receive emails when DHS is seeking public comment on items that will be submitted for federal approval, when requests for federal authority are submitted to the federal government, and when waiver requests have been approved or denied.

- [+](#) Prepaid Medical Assistance Project Plus (PMAP+) waiver
- [+](#) Minnesota Family Planning Program (MFPP) waiver
- [+](#) Reform 2020 waiver
- [+](#) Indian Health Board (IHB) of Minneapolis waiver
- [+](#) Spousal deeming waiver

## Section 1915(b) waivers

- [+](#) Minnesota Senior Care Plus (MSC+) waiver
- [+](#) Consolidated Chemical Dependency Treatment Fund (CCDTF) waiver
- [+](#) Case Management waiver
- [+](#) CFSS Consultation and Financial Management Services waiver

## Sign up for email updates

- [+](#) Medicaid waivers

## CMS website

- [+](#) Information on CMS website

Updated: 2018-04-20



**Attachment J**

Public Comments and DHS Response to Public Comments

Hennepin County Health and Human Services Division  
Substance Use Disorder (SUD) system reform section 1115 Medicaid waiver  
March 1, 2018

Hennepin County fully supports the Minnesota Department of Human Services' (DHS) application for an 1115b Waiver through the Centers for Medicare and Medicaid (CMS). This waiver would allow for exceptions to the federal Institution for Mental Disease (IMD) exclusion for medically necessary SUD treatment. We believe this waiver would assist in modernizing Minnesota's addiction care system through: the use of ASAM criteria as a multi-dimensional assessment tool; permitting direct access to SUD treatment services; providing mechanisms for direct reimbursement of credentialed professionals; reimbursement for peer support and care coordination services; the implementation of withdrawal management services; attention to preventive care, and; the development of new services that align with treating substance use as a chronic disease of the brain.

Hennepin County serves as the SUD placement authority for low income individuals in Minneapolis and surrounding communities, determining eligibility and placement needs for our Medicaid population. In 2017, Hennepin County authorized and placed approximately 13,000 low income individuals in SUD treatment. There are currently 85 licensed SUD providers in Hennepin County alone that serve this population, several of which are designated as IMDs. Of the 13,000 individuals referred to treatment, approximately 3,200 were referred to IMD settings in 2017. As a result of SUD reform in Minnesota, including the potential for obtaining the 1115b waiver, Hennepin County seeks to work with DHS to redefine traditional county roles and align our function with direct access requirements.

Currently, withdrawal management ("Detox") services are funded exclusively by counties. With approval from CMS to add withdrawal management services to the Minnesota Medicaid benefit-set (for participating demonstration project sites), Hennepin County can more effectively address addiction and the opioid epidemic currently impacting our communities. Medicaid funding for ASAM levels 3.2 & 3.7 would allow for enhanced service delivery to safely manage detoxification and withdrawal from opioids and other substances, while preventing admissions to emergency departments and other high-cost crisis and medical services.

With Hennepin County's extensive provider network, we are well positioned to offer the full continuum of services as defined in ASAM. Hennepin County is also well positioned to further develop and integrate addiction services with other behavioral and physical health care systems. Finally, Hennepin County offers its assistance to the state of Minnesota to develop and implement utilization reviews, ensuring clinically intensive services are medically necessary and lengths of stay appropriate.

**m** DEPARTMENT OF  
HUMAN SERVICES

May 4, 2018

Bob Rohret  
Hennepin County  
300 South 6<sup>th</sup> Street, MC 140  
Minneapolis, MN 55487

Dear Mr. Rohret:

Thank you for your correspondence dated March 1, 2018 in response to the state's request for comments on the waiver application supporting reform for Minnesota's substance use disorder system.

If approved by the Centers for Medicare & Medicaid Services (CMS), this waiver will allow the state to evaluate the impact of evidence-based provider referral arrangements and practices on access to high quality, clinically appropriate treatment.


Thank you for your support for the goals of this demonstration. We also appreciate your feedback regarding Hennepin County's role in supporting the objectives of this waiver and Minnesota's broader system reform initiative.

We look forward to working with Hennepin County and our other partners to develop a more integrated and coordinated delivery system that, over time, will lead to better health outcomes for Medicaid beneficiaries with substance use conditions.

Your comments were included in the waiver application submitted to CMS. The Minnesota Department of Human Services will inform stakeholders when the waiver request has been approved or denied by CMS through its web site and email lists.

Thank you again for your comments.

Sincerely,



Marie Zimmerman  
Medicaid Director

From: Linda Muldoon <muldo005@umn.edu>  
Sent: Friday, March 02, 2018 2:04 PM  
To: MN\_DHS\_Waiver\_Comments  
Subject: substance abuse reform waiver

I am strongly in favor of Minnesota applying for a waiver from the Federal government from the IMD exclusion--the law restricting the size of facilities from which Medicaid recipients may receive treatment. HHS Secretary Azar has signaled that all states have to do is ask. This will speed up the process by which Medicaid recipients can receive treatment and open more options for better treatment programs. My opinion is informed by my long years as a mental health provider and by my experience as the parent of a substance abuser/addict.

--

Linda Muldoon

**Kooistra, Jan M (DHS)**

---

**From:** MN\_DHS\_Waiver\_Comments  
**Sent:** Wednesday, May 09, 2018 9:43 AM  
**To:** 'Linda Muldoon'  
**Subject:** RE: substance abuse reform waiver

Dear Ms. Muldoon,

Thank you for your email correspondence dated March 2, 2018 in response to the Minnesota Department of Human Services' request for comments on the waiver application supporting reform for Minnesota's substance use disorder system.

If approved by the Centers for Medicare & Medicaid Services (CMS), this waiver demonstration will build on the state's broader reform efforts to develop a more integrated and coordinated delivery system that, over time, will lead to better health outcomes for Medicaid beneficiaries with substance use conditions, including those in need of the most intensive residential service settings.

Thank you for your support of the state's request to waive the IMD exclusion for SUD treatment in residential settings. The waiver will be instrumental in promoting timely access and an expanded scope of treatment options for individuals with the most intensive treatment needs.

Your comments were included in the waiver application submitted to CMS. The Minnesota Department of Human Services will inform stakeholders when the waiver request has been approved or denied by CMS through its web site and email lists.

Thank you again for your comments.

Sincerely,

Jan Kooistra

**Jan Kooistra**  
Federal Relations | Health Care Administration

**Minnesota Department of Human Services**  
540 Cedar Street  
St. Paul, MN 55155  
651-431-2188  
[mn.gov/dhs](http://mn.gov/dhs)





DEPARTMENT OF HEALTH & HUMAN SERVICES  
Indian Health Service  
522 Minnesota Ave., NW  
Bemidji, Minnesota, 56601

March 9, 2018

RE: Substance Use Disorder (SUD) System Reform 1115 Medicaid Waiver Request

Ms Zimmerman,

Please accept the below comments for consideration in response to the Minnesota Substance Use Disorder Reform 1115 Waiver Demonstration Request for comment.

The Bemidji Area Indian Health Service (IHS) applauds the state of MN for pursuing expanded demonstration waiver authority to provide holistic care approaches to improve recovery outcomes for patients with diagnosed Opioid Use Disorders (OUD). We appreciate inclusion of the American Indian data surrounding maternal opioid use and perinatal infant opioid exposure in your background data and additionally offer the staggering age-adjusted disparity rate ratio of deaths due to drug poisoning for our population exceeding **five times** compared to whites. The Bemidji Area IHS has heard in numerous listening sessions with the Minnesota tribes the critical need to expand access to reimbursement models for culturally appropriate treatment practices within our Tribal communities and this is an important first step. The proposed demonstration waiver, while specifically mentioning the American Indian opioid related morbidity and mortality data, fails to include viable reimbursement mechanisms to directly support cultural practices and delivery of traditional medicine approaches to create sustainable models to impact prevention and treatment strategies surrounding the opioid epidemic for tribal communities.

The below represent the Bemidji Area IHS Federal concerns with the proposed demonstration waiver:

1. Lack of recognition of cultural based practices and traditional medicine approaches and over-reliance on evidence-based services related to substance use disorder treatment in 12-step facilitation therapy models: These models have not been adequately studied in tribal populations for opioid use disorders. Additionally, these models may not be widely accepted in tribal communities.
2. Opioid withdrawal management services in the outpatient setting: IHS requests additional consideration to create models that could increase access to withdrawal management services in Tribal communities. The IHS requests specific consideration to use this waiver to evaluate the feasibility of offering reimbursement for protocol driven withdrawal approaches delivered by trained physician extenders (pharmacists and nurses) to assist with managing withdrawal in an outpatient setting (if appropriate based upon ASAM placement criteria).
3. Access to care and services in rural areas: IHS recognizes the need for comprehensive approaches to SUD treatment across all ASAM levels; however, the current demonstration waiver unnecessarily restricts access to IMD waivers for tribes under this current proposed model. This could contribute to further health disparities. Additionally, the IHS requests consideration to establish a reimbursement mechanism for supportive recovery housing, Tribal adolescent group homes, peer recovery coach services, as well as other recovery support services in tribal communities.

4. Verification of Relationships via written agreements or MOUs: the IHS seeks interpretation of this standard to be fulfilled if an existing payment relationship is established with an IHS Purchased Referred Care provider.
5. Inpatient/residential treatment services within IHS Hospital facilities: the IHS requests consideration to create a demonstration model where IHS Hospital facilities could partner with tribal Chemical Dependency and Behavioral Health programs to expand access to inpatient/residential treatment for both FFS and managed care patients where each specific care provider (i.e. NPI number) could seek reimbursement for the elements of services provided.
6. Managed Care Payments for SUD treatments at the OMB All Inclusive Rate (AIR): IHS specifically requests consideration to identify the OMB AIR for IMD, Tribal adolescent group homes, and withdrawal management services furnished by Federal and Tribal IHS providers participating under this waiver.
7. Care Provided Outside of the Four Walls: the IHS requests additional specific language to identify an alternate payment methodology at the OMB AIR for treatment of emotional, behavioral, and cognitive conditions furnished outside of the 'facility four-walls' to support SUD care delivery under the five care levels within schools and jail settings for American Indian populations.

Thank you for your consideration. Please let us know if you desire a meeting to discuss the request.

Sincerely,

Antonio Guimaraes, MD  
Chief Medical Officer, Bemidji Area Indian Health Service

for

Keith Longie  
Director, Bemidji Area Indian Health Service



May 4, 2018

Antonio M. Guimaraes, Chief Medical Officer  
Bemidji Area Indian Health Service  
522 Minnesota Ave., NW  
Bemidji, MN 56601

Dear Dr. Guimaraes:

Thank you for your correspondence received on March 12, 2018 in response to the state's request for comments on the waiver application supporting reform for Minnesota's substance use disorder system.

If approved by the Centers for Medicare & Medicaid Services (CMS), this waiver demonstration will build on the state's broader reform efforts to develop a more integrated and coordinated delivery system that, over time, will lead to better health outcomes for Medicaid beneficiaries with substance use conditions, including those in need of the most intensive residential service settings.

Thank you for your expressed support of the state's efforts, through this waiver, to improve recovery outcomes for patients with opioid use disorders. We appreciate your feedback about the need to continue to expand access to services that support culturally appropriate treatment practices and traditional medicine. We also appreciate your comments on the need to develop care models and reimbursement mechanisms that increase access to withdrawal management and other recovery support services in tribal communities. We look forward to continued discussion on these topics.

Your comments will be included in the waiver application submitted to CMS. The Minnesota Department of Human Services will inform stakeholders when the waiver request has been approved or denied by CMS through its web site and email lists.

Thank you again for your comments.

Sincerely,



Marie Zimmerman  
Medicaid Director



HealthPartners  
8170 33rd Avenue South  
Bloomington, MN 55425

healthpartners.com

Mailing Address:  
PO Box 1309  
Minneapolis, MN 55440-1309



March 12, 2018

Marie Zimmerman  
Medicaid Director  
Minnesota Department of Human Services  
P.O. Box 64983  
St. Paul, Minnesota 55164-0983

**Re: Minnesota Substance Use Disorder System Reform, Section 1115 Waiver Demonstration Request**

Dear Ms. Zimmerman:

Thank you for the opportunity to review the proposed Section 1115 Waiver Demonstration Request. We appreciate the Department of Human Services' continued focus on exploring ways to improve the state's substance use disorder treatment system. We support the waiver's goal to expand access to those with substance use disorders and broaden the continuum of care, filling in gaps in the service delivery system.

Founded 60 years ago, HealthPartners provides comprehensive medical, dental, and behavioral health treatment services to more than one million patients in Minnesota and western Wisconsin. Our experience in managing the healthcare for more than 1.5 million members in Minnesota and western Wisconsin informs our belief that reform must be centered around the patient's needs. Patients with the most serious mental illness or substance use conditions, or both, experience care along a continuum from preventive to outpatient or home care to step down care (such as IRTS) to crisis care to emergency room to inpatient hospitalization to residential treatment. Patients along this continuum, especially those who experience episodic exacerbation of longstanding serious mental health and substance use problems. Gaps along this continuum, in access to care, payment, or coverage, interrupts the course of treatment and adversely affects outcomes.

HealthPartners considers those programs now classified as Institutions for Mental Diseases (IMDs) as vital providers of care along the continuum and supports the department's work in this area, especially the proposal to allow for exceptions to federal IMD exclusion for substance use disorder treatment in a residential setting. We believe that DHS' waiver request could provide critical funding for patients who would benefit from residential treatment. While a significant step in the right direction, we believe it can be improved as outlined in the following sections.

## **I. Expand the Provider Network**

As part of the program's description, DHS states that as a condition of participation providers will need to prove that they have referral networks that address the full ASAM-continuum of care. As noted in the application, the ASAM continuum extends from early intervention to medically managed intensive inpatient services, with a parallel withdrawal management continuum. The waiver specifies that networks must have "signed agreements, such as memoranda of understanding, with other SUD or health care providers in other parts of the state" in order to ensure that patients have sufficient access to care. The department intends on testing whether these arrangements improve the substance use disorder outcomes for patients.

We appreciate, value, and support the use of the standardized criteria established by ASAM. However, we are concerned that very few providers will be able to develop this continuum or establish relationships with other providers in order to offer a full spectrum of services across the ASAM continuum. This is especially true in rural parts of the state and for detoxification services in general. Additionally, some levels of care are underdeveloped in MN (e.g., ASAM levels 2.5, 3.3, 3.7, and 4.0) and, in most instances, very expensive to establish. Therefore, we are concerned that the proposal will result in very few if any organizations/partnerships being able to fulfill the intent of the proposal. We believe that a proposal that emphasizes access to and movement across the existing continuum, flexibly accommodating those with more medically compromised conditions without having to have access to all ASAM levels of care, would be a more realistic proposal given the current limitations in the system of care in MN.

We believe that the inclusion of care coordination is vital to helping those with substance use disorders access services and, in particular, direct patients to appropriate alternative care when gaps in the service continuum exist. Thus, we fully support this aspect of the DHS proposal. However, in order to successfully recruit and retain employees who assume the role of care coordinators, compensation for this service must be in keeping with knowledge, skills, and abilities required for the position. We propose that DHS reconsider the rate for payment for this service as published in the State Register (Volume 42, number 34, Feb. 20, 2018). In particular we note that the rate of compensation for this service is lower than that of peer-recovery support services, a service that we believe requires fewer technical and professional skills.

## **II. Support Comprehensive Access for Treatment at IMDs**

While outside the scope of substance use disorders, we are in a historic moment where there is a renewed focus on mental health treatment and IMDs, which is why we urge DHS to ask CMS to lift the exclusion for all IMD services. As stated in a letter recently signed by a coalition of 39 state attorneys generals, the original purpose of the prohibition was to discourage the "inhumane and ineffective state-run asylums", which is no longer the pressing

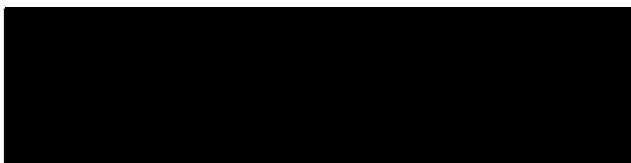
concern it was in 1965.<sup>1</sup> In addition, we recommend that the department reviews the policy arguments in Alaska's Behavioral Health 1115 waiver that seeks funding for all services provided to individuals residing in IMD facilities as an example.<sup>2</sup>

Furthermore, quite often an individual's substance use disorder cannot be effectively treated without consideration of the patient's other health factors. One area where this is particularly evident is with eating disorders. Research finds that up to half of those with eating disorders also use alcohol or drugs. A patient's relapse from an eating disorder can negatively affect their substance use disorder, making recovery more difficult.<sup>3</sup> Correspondingly, care coordination between addiction specialists in addition to dietitians, doctors, and psychologists is quite often essential for the long-term success of patients.

Ensuring Medicaid beneficiaries have access to a full spectrum of treatment and providers is the basis for strong substance use disorder reform in the state. Given the federal administration's encouraging guidance and statements towards revising their 1960s-era policy, we think that the moment is right for DHS to seize a unique opportunity to support the state's mental health providers and patients in need of intensive care.

Thank you for the opportunity to provide these comments. We hope that they are helpful to you as you collect information and potentially develop any additional proposals. We welcome the opportunity to answer any of your questions on our comments and look forward to continuing to be engaged on future substance use disorder reform.

Sincerely,



Donna Zimmerman  
Sr. Vice President, Government & Community Relations

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<sup>1</sup> <http://www.ohioattorneygeneral.gov/Files/Briefing-Room/News-Releases/Policy-and-Legislation/Final-NAAG-Letter-Road-to-Recovery-Support.aspx>

<sup>2</sup> [http://dhss.alaska.gov/HealthyAlaska/Documents/AK1115\\_Draft\\_Application-11-2017.pdf](http://dhss.alaska.gov/HealthyAlaska/Documents/AK1115_Draft_Application-11-2017.pdf)  
<http://dhss.alaska.gov/dbh/Documents/PDF/1115/1115-Behavioral-Health-Demonstration-Waiver.pdf>

<sup>3</sup> <https://store.samhsa.gov/shin/content/SMA10-4617/SMA10-4617.pdf>

**m** DEPARTMENT OF  
HUMAN SERVICES

May 4, 2018

Donna Zimmerman  
HealthPartners  
8170 33<sup>rd</sup> Avenue South  
Bloomington, MN 55425

Dear Ms. Zimmerman:

Thank you for your correspondence dated March 12, 2018 in response to the state's request for comments on the waiver application supporting reform for Minnesota's substance use disorder system.

If approved by the Centers for Medicare & Medicaid Services (CMS), this waiver demonstration will build on the state's broader reform efforts to develop a more integrated and coordinated delivery system that, over time, will lead to better health outcomes for Medicaid beneficiaries with substance use conditions.

Thank you for your general support of the demonstration goals and your support of the state's request to waive the IMD exclusion for SUD treatment in residential settings. The IMD exclusion waiver will be instrumental in promoting timely access and an expanded scope of treatment options for individuals with the most intensive treatment needs.

Your letter also expresses concern that participating providers will have difficulty establishing the necessary partnerships or referral arrangements with other providers to offer a full continuum of care, particularly in rural parts of the state and for certain types of services. We share your concern that all levels of care may not be readily available within all provider networks initially established under the demonstration. We plan to use this demonstration to gain a better understanding of all levels of care and their availability throughout the state, which will inform strategies to address gaps in the continuum of care.

We appreciate your feedback that the payment rate for care coordination is not in keeping with the knowledge, skills, and abilities required for the position. The payment rate for care coordination is outside the scope of this waiver request. You also asserted that the IMD exclusion should be lifted across all providers. This is also beyond our authorization in state law.

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Page 2 - Ms. Donna Zimmerman

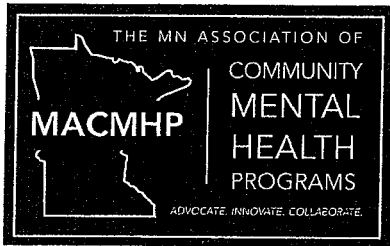
Your comments were included in the waiver application submitted to CMS. The Minnesota Department of Human Services will inform stakeholders when the waiver request has been approved or denied by CMS through its web site and email lists.

Thank you again for your comments.

Sincerely,



Marie Zimmerman  
Medicaid Director



# Minnesota Association of Community

PO Box 40027 | St. Paul, MN 55104  
651-571-0515

Marie Zimmerman  
Medicaid Director  
Minnesota Department of Human Services  
P.O. Box 64983  
St. Paul, Minnesota 55164-0983  
March 13, 2018

Dear Director Zimmerman

Thank you for this opportunity to offer our comments to the State of Minnesota 1115 Substance Use Disorder Waiver Request.

## **Minnesota Community Mental Health Programs' Perspective**

The Minnesota Association of Community Mental Health Programs (MACMHP) is the state's leading association for Community Mental Health Programs, representing 32 community-based mental health providers and agencies across the state. Collectively, we serve over 100,000 Minnesota families, children and adults. Our mission is to serve *all* who come to us seeking mental and chemical health services, regardless of their insurance status, ability to pay or where they live. As *Essential Community Providers*, we are critical to the behavioral health safety net. We serve primarily culturally diverse, low-income, uninsured and public healthcare program insured Minnesotans, who cannot access services elsewhere. Community Mental Health Programs provide wrap-around and community-based services to very complex and vulnerable patients, with love and coordinated care.

### State of Minnesota 1115 Substance Use Disorder Waiver Request -

MACMHP supports this 1115 Substance Use Disorder Waiver request of the State of Minnesota. Representing the majority of Minnesota's Certified Community Behavioral Health Clinics (CCBHC), as well as several member community mental health centers and programs offering substance use disorder treatment programs, MACMHP believes this waiver provides Minnesota the path to evolve our SUD system by establishing new provider delivery systems modeled after the American Society of Addiction Medicine (ASAM) levels and continuum of care. We believe this will increase quality of and access to desperately needed SUD treatments.

### *Model Structure -*

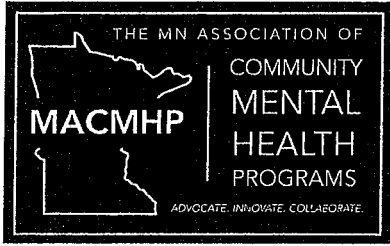
As we understand the waiver request, the first year of the waiver, July 1, 2018, the state will establish provider networks with the ASAM continuum of care.

In the second year of the waiver, July 1, 2019, the state proposes to integrate community mental health services into the demonstration by permitting each of the six CCBHCs to participate and maintain their existing model and payment structures. The intent is for CCBHCs client populations to have access to each of the levels of ASAM care, in addition to their own required practices. *MACMHP is encouraged by CCBHCs' ability to fulfill requirements for the ASAM criteria through Memorandums of Understanding (MOU) to build out networks.* This reflects acknowledgment by the state of a current lack of certain ASAM level providers across the state. This also reflects understanding that building the systems internally to provide all levels of ASAM criteria would be a hardship for many providers.

### *Authorities -*

MACMHP supports the following authorities that state is requesting under the waiver:

- State-wideness and uniformity to permit the state to operate the demonstration less than statewide in a pilot project.
- Comparability to include withdrawal management as a Medicaid-covered benefit for demonstration beneficiaries prior to its approval in State Medicaid Plan.



# Minnesota Association of Community

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- IMD expenditure authority to provider federal funding to cover services, otherwise ineligible for federal financial participation, when provided to beneficiaries in federal Institutions for Mental Disease (IMD).
- Providing extension for payment in Minnesota's CCBHC demonstration.

### *Evaluation –*

The waiver request states CCBHCs will continue using the CCBHC Evaluation Plan for the duration of the waiver. *We urge flexibility in evaluation, allowing the state to add new measures that appropriately reflect Minnesota's changing needs and evolving activities of the work.*

### *Funding and Payment –*

Under the new ASAM treatment services, our CCBHCs are required to comply with the ASAM services requirements, including Six Dimensions of the Multidimensional Assessment. However, our CCBHCs' payment structure does not include the additional ASAM services. We encourage the state consider options for including these new services to the payment model.

MACMHP thanks you for this opportunity to provide you with our comments. Please do not hesitate to contact me regarding these comments and general information on community mental health programs.

Respectfully Submitted



Jin Lee Palen,  
Executive Director  
Minnesota Association of Community Mental Health Program



May 4, 2018

Jin Lee Palen  
Minnesota Association of Community Mental Health Programs  
PO Box 40027  
St. Paul, MN 55104

Dear Ms. Palen:

Thank you for your correspondence dated March 13, 2018 in response to the state's request for comments on the waiver application supporting reform for Minnesota's substance use disorder system.


If approved by the Centers for Medicare & Medicaid Services (CMS), this waiver will allow the state to evaluate the impact of evidence-based provider referral arrangements and practices on access to high quality, clinically appropriate treatment.

Thank you for your support for the goals of this demonstration. We appreciate your feedback regarding the demonstration evaluation design and implementation. The evaluation plan for the SUD waiver is due 180 days after approval of the demonstration and will provide for flexibility to modify or increase measures as needed. We appreciate your recommendation that we include new treatment services under the demonstration in the Certified Community Behavioral Health Clinics payment model to accommodate any additional costs.

Your comments were included in the waiver application submitted to CMS. The Minnesota Department of Human Services will inform stakeholders when the waiver request has been approved or denied by CMS through its web site and email lists.

Thank you again for your comments.

Sincerely,



Marie Zimmerman  
Medicaid Director



**Kooistra, Jan M (DHS)**

---

**From:** Leah Lundgren <leah.lundgren@co.mcleod.mn.us>  
**Sent:** Thursday, April 12, 2018 12:31 PM  
**To:** MN\_DHS\_Waiver\_Comments  
**Subject:** Public comment

▶ **Chemical health comprehensive assessments: County assessor certification process.** Current law requires persons conducting comprehensive assessments to be licensed alcohol and drug counselors (LADC) by 2020. Many counties currently employ staff who are not LADCs to conduct chemical use assessments. Due to the significant shortage of LADCs, counties are very concerned about access to services if individuals are not able to have an assessment done by an LADC in a timely manner. ~~MACSSA recommends providing for a certification process for county staff so that counties continue to provide this service if they choose~~ and promote timely access to treatment. Requiring an LADC for county staff will likely result in many counties no longer providing this service.

*Leah M. Lundgren*

Social Services Supervisor  
McLeod Social Service Center  
1805 Ford Ave North Suite 100  
Glencoe, MN 55336  
phone: (320) 864-1431  
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[leah.lundgren@co.mcleod.mn.us](mailto:leah.lundgren@co.mcleod.mn.us)

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**m** DEPARTMENT OF  
HUMAN SERVICES

May 4, 2018

Leah M. Lundgren  
McLeod Social Service Center  
1805 Ford Avenue North, Suite 100  
Glencoe, MN 55336

Dear Ms. Lundgren:

Thank you for your correspondence dated April 12, 2018 in response to the state's request for comments on the waiver application supporting reform for Minnesota's substance use disorder system.

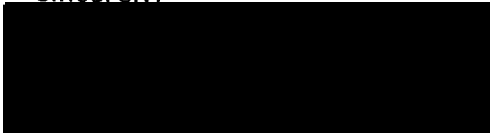
If approved by the Centers for Medicare & Medicaid Services (CMS), this waiver demonstration will build on the state's broader reform efforts to develop a more integrated and coordinated delivery system that, over time, will lead to better health outcomes for Medicaid beneficiaries with substance use conditions.

We appreciate your feedback regarding the requirement that comprehensive assessments be conducted by Licensed Alcohol and Drug Counselors (LADC) and your concerns about timely access to treatment. The Alcohol and Drug Abuse Division also shares your priority of ensuring timely access to SUD services. Direct access under the new reform requires a comprehensive assessment instead of the Rule 25 assessment, and this can be done by LADCs or by qualified staff whose individual licensure provides the scope of practice to do a comprehensive assessment. We are currently exploring all options, including legislation, to support timely access during the two-year transition period.

Your comments will be included in the waiver application submitted to CMS. The Minnesota Department of Human Services will inform stakeholders when the waiver request has been approved or denied by CMS through its web site and email lists.

Thank you again for your comments.

Sincerely,



Jan Kooistra

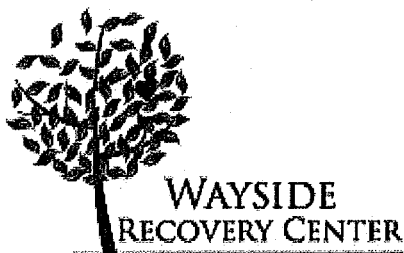
## Kooistra, Jan M (DHS)

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**From:** Jessie Everts <Jessie.Everts@waysiderc.org>  
**Sent:** Wednesday, April 18, 2018 3:45 PM  
**To:** MN\_DHS\_Waiver\_Comments  
**Subject:** Fw: CCDTF e-Memo: Comment period open for substance use disorder system reform waiver application  
**Attachments:** 1115 Waiver application comments - Wayside 2018.docx

Please find attached my comments/questions on the 1115 waiver application, and let me know if you have or need any further information.

Thanks, Jessie



JESSIE C EVERTS, PHD LMFT  
Vice President of Clinical Programs

 651-242-5543  
 [www.waysiderecovery.org](http://www.waysiderecovery.org)  
 2356 University Ave W, Suite 210,  
St. Paul, MN 55114



Empowering women to recover sobriety, identity, home, family and community by providing treatment, housing and supportive services.

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**From:** Minnesota Department of Human Services <Minnesota\_DHS@public.govdelivery.com>  
**Sent:** Thursday, April 12, 2018 10:46 AM  
**To:** Karina Forrest-Perkins  
**Subject:** CCDTF e-Memo: Comment period open for substance use disorder system reform waiver application

1115 Waiver application – Jessie comments

Proposing 5-year demonstration project to show efficacy of “evidence-based referral networks and models.” p. 5

**Q: What is an “evidence-based referral network”? What are the criteria for evidence of a referral network? MOUs? Will this be established prior to or in year one of implementation? Is there any measure of efficacy or capacity of the referral network?**

“Providers seeking to participate in this demonstration will verify to the Department that they have, or will have, established the necessary partnerships or referral arrangements with other SUD providers to provide all levels of care for beneficiaries during the waiver period...Verification of such relationships may include signed agreements, such as memoranda of understanding, with other SUD or health care providers in other parts of the state to ensure Medicaid beneficiaries have access to each of the recommended levels of care for SUD treatment.” P. 6

**Q: There is no mention of IMDs being a necessary part of the referral network in this section. The danger is that larger hospital-based or MAT providers partner with smaller, non-IMD settings for residential treatment, in hopes of avoiding the payment issue, and the smaller residential programs don’t actually have the capacity to offer enough of the care needed for the referring population. Do MOUs need to address the capacity to take referrals from a partner agency?**

“All providers participating in this demonstration will also be required to apply at least three of the four evidence based practices listed below that were recently identified as cost-effective (i.e. as producing overall savings) by the Minnesota Management and Budget agency when applied to adults receiving SUD treatment.” P. 7

**Q: The four evidence-based practices are limited to 12-step Facilitation Therapy, Brief cognitive behavioral intervention, Motivational Interviewing, and Contingency Management. Are these really the only options for MI/CD, complex populations? We use so many more evidence-based practices that take into account the mental health needs of our population. 12-step facilitation is no longer a relevant intervention in our modality, so our options are further limited.**

“To implement this demonstration, the Department will take a phased-in approach, with the first year of the waiver (July 1, 2018 to June 30, 2019) concentrated on building the capacity of interested SUD providers across the state to build ASAM-based referral networks. As of the date of this application, 14 Minnesota SUD provider agencies have expressed interest in applying to participate in this demonstration.” P. 7

**Q: What happens to IMDs who do not want to participate or who are not selected by a CCBHC for partnership?**

“In the second year of the waiver (July 1, 2019 to June 30, 2020), the state proposes to integrate community mental health services into the demonstration by permitting each of the state’s six Certified Community Behavioral Health Clinics (CCBHCs), to apply to participate in the project and maintain their existing model and payment structure as a CCBHC in accordance with the Excellence in Mental Health Act... The intent is to require interested CCBHCs to demonstrate that Medicaid beneficiaries will have

access to each of the ASAM-recommended levels of care in addition to their other required practices under this SUD reform.” P.7

Q: This proposal seems heavily focused on coordinating care between CCBHCs and IMDs – is there any incentive for CCBHCs to need to have MOUs with IMDs? Or are we putting the fate of (especially smaller) IMDs in the hands of CCBHCs to decide whether there is any value in partnering with us?

“If approved, this waiver would allow for federal Medicaid matching funds for the following services when provided to Medicaid beneficiaries participating in the demonstration: a) **SUD services provided to Medicaid beneficiaries residing in participating IMDs for up to two nonconsecutive stays of 30 days or less, within a one-year period**; b) Withdrawal management services (i.e. ASAM 3.2 and 3.7) provided by participating providers during waiver-year one, prior to full state plan implementation of this benefit on July 1, 2019; c) Withdrawal management services provided by participating IMD providers (i.e. ASAM 3.2 and 3.7) during each year of the waiver period; and d) Services provided through the CCBHC model with additional ASAM referral networks that meet the qualifications of this SUD reform demonstration. (While the state is able to expand CCBHCs statewide under federal law with federal Medicaid funding, it is proposing a more incremental approach over time through this waiver, which will allow the state to further evaluate, support, and build capacity for future implementation state-wide).” P. 8-9

Q: Does this further inhibit longer-term facilities like Wayside, where clients stay longer than 30 days? Does this mean that our services will no longer be eligible for the county match that is currently offered for stays beyond 15 days?