NORC at the University of Chicago

REPORT

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Mid-Point Assessment: Minnesota Substance Use Disorder System Reform Section 1115(a) Demonstration Project

Presented by:
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Presented to:
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General Background Information

Introduction

On May 31, 2016, the governor of Minnesota signed Minn. Stat. § 254B.15 that directed the commissioner of the Minnesota Department of Human Services to design a reform of Minnesota's Substance Use Disorder (SUD) treatment system in order to ensure a full continuum of care is available for individuals with SUDs.[1] In fulfilling this statute under the authority of Minnesota Statutes, section 256B.0759[2], the Minnesota Substance Use Disorder System Reform Section 1115(a) Demonstration Project (hereinafter referred to as "the Demonstration") from the Minnesota Department of Human Services (MN DHS) Behavioral Health Division was approved by the Centers for Medicare & Medicaid Services (CMS) on July 22, 2020.The Demonstration supports access to a full continuum of care with a focus on ensuring that individuals are matched to an appropriate level of care. With Minnesota's American Society of Addiction Medicine (ASAM) levels of care requirements published in October 2020 and the monitoring protocol approved on January 5, 2021, Minnesota officially began the rollout of training and technical assistance to participating providers on January 14, 2021.

This Mid-Point Assessment documents progress since implementation of the Demonstration in July 2020. It draws on the Demonstration monitoring metrics and input from providers and Medicaid and Demonstration project staff at MN DHS. Some providers were involved in the evolution of Minnesota's approach, working with the MN DHS Behavioral Health Division, their professional association, and the legislature to expand resources for SUD treatment and coordination. As the state continued to refine its legislative approach, MN DHS was involved in the development of systems and processes to support enrollment, service integration and delivery, and monitoring. These perspectives on the first years of the Demonstration will highlight the significant changes underway after over three decades of delivering services through a 1915(b) waiver that relied on Minnesota's state-funded system of county and tribal-based placing for treatment.[3]

The state of Minnesota has contracted with NORC at the University of Chicago (NORC) to conduct an independent evaluation of the Demonstration. This Mid-Point Assessment report is part of the overall evaluation. NORC is an objective, non-partisan research institution that delivers reliable data and rigorous analysis to guide critical programmatic, business, and policy decisions. NORC is conducting an independent mixed-method evaluation for MN DHS of the Demonstration, informed by NORC's experience developing and implementing rigorous qualitative and quantitative data collection and analytic approaches.

Demonstration Policy Goals

Minnesota is pursuing a multi-agency strategy to make SUD treatment more accessible and integrated with the larger health care system. More specifically, the Demonstration is structured around progress towards the following six milestones:

1. Access to critical level of care for SUDs
2. Use of evidence-based SUD-specific patient placement criteria
3. Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications
4. Sufficient provider capacity at each level of care, including medication assisted treatment (MAT)
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and opioid use disorder (OUD)
6. Improved care coordination and transitions between levels of care

In 2019, the legislature expanded the SUD treatment services covered under the state plan to include comprehensive assessment, treatment coordination, peer recovery, and support services and residential withdrawal management.[i] The state plan includes coverage of outpatient services (i.e., treatment coordination and peer support), counseling, withdrawal management, intensive levels of care in residential and inpatient settings, and MAT. A state plan amendment to cover screening, brief intervention, and referral to treatment (SBIRT) was approved by CMS in October 2019. MAT was previously provided in conjunction with outpatient and residential treatment services. The use of all U.S. Food & Drug Administration (FDA) approved MAT medications for the use of treating OUD are supported and encouraged by Minnesota DHS and will be expanded under the Demonstration. In 2020, the state approved a 15 percent rate increase for the treatment portion of residential services and a 10 percent rate increase for outpatient services delivered through the Demonstration.[4]

In addition to the rate increase, the adoption of the ASAM levels of care provides a framework for Minnesota's SUD continuum of care. Beginning in the early 1990s, the ASAM developed, validated, and refined a six-dimension model to assess the level and intensity of treatment needed for a given individual at a specific moment in time.[5] These dimensions include: 1) acute intoxication and potential for withdrawal, 2) biomedical conditions, complications, and past history, 3) emotional, behavioral, and cognitive conditions, 4) readiness to change, 5) relapse, continued use, or continued problems, and 6) recovery and living environment. Based on measures within each of these dimensions and in combination, applying the ASAM criteria results in a clinical recommendation for treatment services ranging from early intervention (at the low end of the scale) to medically managed intensive inpatient services (at the high end).

[i] Support services include services to help people overcome personal and environmental obstacles to recovery, assist the newly recovering person into the recovery community, and serve as a personal guide and mentor toward the achievement of goals. See Minnesota Department of Human Services. (2019). Minnesota Substance Use Disorder Section 1115 Waiver Implementation Plan (DRAFT). Submitted to the Centers for Medicare & Medicaid Services on September 27, 2019.

Before the start of the Demonstration, Minnesota implemented evidence-based placement criteria that was based on ASAM six-dimension model. To meet the goal of fully aligning the Minnesota Medicaid SUD care system with the ASAM levels of care, Minnesota is using a mix of the Minnesota Substance Use Disorder System Reform Section 1115(a) Demonstration Project, pilot programs, licensing reforms, and other regulatory tools to establish a comprehensive continuum of care.[ii]

Demonstration Overview

The Demonstration will test new ways to strengthen the state's behavioral health care system by improving access to treatment for the ASAM critical levels of care through the Demonstration.[6] The action items described in the Implementation Plan aim to strengthen the state's behavioral health care system by improving access to the ASAM levels of care. It will do this through:

- implementing new federal Medicaid funding opportunities for SUD services provided to patients within intensive residential settings (i.e., Institutions for Mental Diseases, or IMDs) that have established referral arrangements with other SUD providers to create a continuum of care network
- increasing the use of evidence-based placement assessment criteria and matching individual risk with the appropriate ASAM level of care to ensure beneficiaries receive the treatment they need; and
- establishing a network of providers interested in providing the comprehensive continuum of ASAM levels of care to individuals in need of SUD treatment

Providers that participate in the Demonstration are required to establish and maintain formal patient referral arrangements to ensure access to the ASAM critical levels of care defined by the state. Providers must implement at least three of the four evidence-backed practices identified by the Minnesota Management and Budget agency as being cost-effective. These include 12-step facilitation therapy, brief cognitive behavioral therapy, motivational interviewing to enhance treatment engagement, and contingency management. These practices produce a net benefit of between $4.70 (12-step facilitation therapy) and $16.10 (motivational interviewing), according to a cost-benefit analysis conducted by Minnesota Management and Budget.[7]

Providers also have access to training and technical assistance on the ASAM criteria and the program modifications needed to assure that service delivery models align with these standards. Payment rates for participating providers are increased to support their transition to the ASAM-based standards.

[ii]For more details on the ASAM Continuum of Care, please see https://edocs.dhs.state.mn.us/lfserver/Public/DHS-7326-ENG

Spring 2021 Legislative Changes

In 2021, the Minnesota legislature passed additional changes that affect the Demonstration. Key among these was the mandatory participation of licensed residential SUD and withdrawal management providers. These changes included:[8]

- Requiring mandatory enrollment for 245G licensed residential SUD providers and licensed 245F withdrawal management providers by January 2024, including out of state SUD and withdrawal management providers receiving payment through the Minnesota Health Care Program (MHCP) for eligible recipients.
- Enhancing the rate for outpatient treatment services, medication-assisted therapy, and adolescent treatment programs from 10 percent to 20 percent.
- Enhancing the rate for residential treatment services from 15 percent to 25 percent.
- Clarifying the base pay rate for medium intensity residential program participation.
- Requiring public posting of data and outcome measures.
- Requiring MN DHS to seek federal approval for extension of the Demonstration.
- Requiring MN DHS to convene an evaluation work group for the Demonstration.

> "So to go from selected residential to mandated residential doesn't necessarily change stuff. It just makes the volume bigger. And so because you have a bigger volume, obviously the networks [will] grow as well, it's a much greater volume that we have to deal with, with a finite time to do it. And then you throw, you know, COVID on top of it, and it's an exciting time…"
>
> - MN DHS staff

As originally designed, the Demonstration was a voluntary program for a smaller group of providers among the state's 400 plus SUD provider organizations. However, the 2021 legislative mandate for all residential and withdrawal management providers to participate was a shift from the initial limited participation of key segments of the SUD/OUD treatment continuum.

To ensure the success of SUD system reform, the 2021 Legislature implemented changes that resulted in a shift to the mandatory statewide program for all residential and withdrawal management providers through the legislative process.

Impact of the COVID-19 pandemic on Demonstration implementation

Minnesota had just begun implementing its demonstration when the COVID-19 pandemic emerged in March of 2020.[iii] During this time, the state was focused on provider enrollment and training and policy alignment. As the state described in their quarterly Medicaid Section 1115 SUD Demonstrations Monitoring Reports, and as the data illustrates, the state experienced a twofold increase in SUD diagnoses and demands for services during the public health emergency, coupled with significant barriers to accessing treatment and an overall reduction in healthcare seeking behavior. The state also experienced resource and state staffing shortages throughout the COVID-19 pandemic. State staff reported in the quarterly Monitoring Report – Part B reports and interviews that while there was initial progress made on direct access and billing system changes, there was a slowdown in implementation as Minnesota IT (MNIT) Services did not have the capacity to support all the necessary systems changes. These resource shortages were due to reprioritization of resources related to Covid-19 priorities that affected the projects, such as changes in timelines and deliverables, adjustments in scope, delays, and budgetary adjustments[9]. MN DHS was able to overcome some of the resource shortages, as they implemented the new "direct access" to treatment and billing process for SUD services.[iv]

Similar to other employers throughout the country, the state faced several significant barriers: a hiring freeze, staff shortages and turnover as a result of the pandemic. This shortage created administrative burden and delays in implementing milestones. For example, under the Demonstration, to implement Milestone 3 (*Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities*) the state created and filled a fulltime Standards of Care position to manage the Demonstration participant provider enrollment process, provide technical assistance and training on ASAM, review residential level of care standards, and manage the contract for conducting utilization management (UM). During this time, the state filled a vacant position for the Behavioral Health Director, and several new roles were added to the Demonstration team in addition to the Standards of Care position: data specialist, communication specialist, supervisor for the Demonstration staff. The goal was for the Demonstration staff team ~~was~~ to be fully staffed by December 8, 2021.

[iii] The Center for Disease Control and Prevention cites that the World Health Organization declared COVID-19 a global pandemic on March 11, 2020.

[iv] Direct access refers to eligible members' ability to select the SUD provider who they want to receive services from, including assessment and treatments.

Methodology

Data Sources

NORC used five data sources to assess Minnesota's progress toward meeting the Demonstration milestones at Mid-Point (Exhibit 1). This assessment included a comprehensive document review as well as key informant interviews and focus groups conducted in August through September of 2021. Data sources also included the required quantitative monitoring metrics and additional process measures.

Exhibit 1. Data Sources for the Mid-Point Assessment

Data source	Description
Minnesota Substance Use Disorder System Reform Section 1115(a) Demonstration Project Monitoring Reports	The state, with guidance from CMS, identified monitoring metrics that provide insight into progress of the Demonstration. Critical metrics are those that have clear directionality, direct alignment with milestones, and are most directly responsive to Demonstration activities. The data for these reports are the claims for services and the MN DHS provider enrollment database.
Baseline PCA conducted by Independent Evaluator	A baseline assessment of the number of providers, health professional types, and services offered by the state as well as its capacity to treat SUD clients at the assessment point.
Key Informant Interviews	Key informant interviews held with MN DHS to understand their experiences and perspectives on implementation of the Demonstration.
Provider Focus Groups	Focus groups held with SUD providers to understand their experiences and perspectives on implementation of the Demonstration.
Process Measures	Administrative data provided by Minnesota that demonstrate the state's progress toward the established action items.

Analytic Methods

Quantitative Methodology

Methods for analyzing monitoring metrics. MN DHS provided NORC with quarterly and annual monitoring metric report data from Demonstration year one quarter two (10/01/2019), through year three quarter one (09/30/2021). The evaluation team reviewed the data to determine the first (earliest) and most recent result for each metric. Only 5 of the 19 metrics had data for more than two time points, as most metrics did not have data until the post-implementation phase (07/22/2020), and data lag by a quarter.[v] We then calculated the absolute and relative change for each metric, per CMS guidance, shown below:

- Absolute Change = value of metric at mid-point - value of metric at baseline
- Percent Change = (value of metric at mid-point - value of metric at baseline)/value of metric at baseline

We observed extensive variation across subgroups for certain measures; therefore, to better assess milestone progress, we conducted a stratified analysis of absolute and percent change for Demonstration sub-populations, e.g., age or OUD status, and for which there were sufficient monitoring data (≥11 events). Next, for the five metrics with three time points, we conducted linear regression analysis to understand any trend in the change over time, indicating continued movement towards or away from the target. The Demonstration's Monitoring Protocol includes 18 metrics in addition to the 19 critical metrics selected by CMS to inform the state on implementation progress. Next, since the overall milestone risk assessment is based on progress towards each milestone, not each metric, we examined five additional monitoring metrics that had sufficient data to help provide further insight on progress towards milestones. Finally, since there are no critical metrics identified for Milestone 3 (use of nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications), we assessed milestone progress based on administrative data and interviews with MN DHS staff.

Methods for provider availability assessment. NORC used the pre-existing baseline PCA as part of this assessment. The baseline PCA was completed using claims and encounter data for SUD services at provider organizations and from MAT prescribers (individual NPIs). These were used to create counts of each type of provider organization and counts of clients and services for each type of provider organization and service (Exhibits 2 and 3). For the baseline PCA, NORC also obtained data on the number of health professionals, such as Licensed Practical Nurse and Licensed Professional Clinical Counselors, Alcohol and Drug Counselors, etc. (HP workforce data) from the Minnesota Department of Health, Health Care Workforce Data & Analysis Unit, and linked the HP workforce data to enrollment

[v] The SUD DY1Q1 reporting period is not listed because metrics data are reported with a one-quarter lag. Implementation date is when the state could begin federal financial participation for services provided to individuals in institutions for mental disease.

data to determine the ratio of enrollees per health professional. NORC also used Minnesota's Drug and Alcohol Abuse Normative Evaluation System (DAANES) data to count the number of detoxification providers, and to create an enrollee-to-detoxification provider ratio.

Exhibit 2 shows how the types of services were classified and provides a brief description of each one.

Exhibit 2. Types of Services in Claims Data

Types of Services	Description
Assessment	A clinical encounter to provide a diagnosis and recommendations for the intensity and setting of treatment needed and any supportive services.
MAT: Any Buprenorphine	A prescription for buprenorphine, with or without naloxone.
MAT: Methadone	Methadone administered at a facility.
MAT: Naltrexone	A prescription for naltrexone.
MAT: Other Services	Counseling and behavioral health interventions provided alongside of medication for treating OUD.
Outpatient Treatment (group and individual)	Includes behavioral strategies to help motivate people to stay engaged in drug treatment, cope with drug cravings, teach ways to avoid drugs and prevent relapse, and help individuals deal with relapse if it occurs.[10]
Peer Support	Former or current SUD clients who have been successful in the recovery process and can provide shared understanding and empowerment, to help clients become and stay engaged in the recovery process and reduce the likelihood of relapse.
Residential	Facilities that provide intensive therapeutic services and clinical supervision and monitoring by trained staff to individuals seeking treatment.
Treatment Coordination	A treatment service involving the deliberate, collaborative planning of SUD services with the client and other professionals involved in the client's care.[11]
Withdrawal management	Care of patients who are experiencing withdrawal symptoms as a result of ceasing or reducing use of their drug of dependence.

Exhibit 3 below shows the types of providers and examples of the provider names from the claims/encounter data.

Exhibit 3. Types of provider organizations and examples by name

Types of Providers	Example
Hospital	Hennepin County Medical Center, UMMC Fairview, St Cloud Hospital
Community Mental Health Center	Hiawatha Valley Mental Health Center, Winona
Chemical Health	Includes residential and outpatient treatment providers that are licensed in Minnesota by MN DHS.).[12] Center for Alcohol and Drug Treatment, Park Avenue Center, Valhalla Place, Alliance Clinic.
Indian Health Service Program	Lower Sioux Health Care Center, Ne-Ia-Shing Clinic
Physician Group	Duluth Family Medicine Clinic, Allina Health Cambridge Clinic
Outpatient Claims for Methadone	Specialized Treatment Services Inc, Valhalla Place LLC
Consolidated Provider Organization	Associated Clinic of Psychology, Hennepin County Medical Center
Home and Community Based	Day Training & Habilitation Centers (DT&H); housing support supplemental services; home care nurses (RN and LPN); Home Health agencies (HHA); Moving Home Minnesota (MHM) Personal care assistant (PCA); Waiver and Alternative Care (AC)
Other	Federally Qualified Health Centers, Rural Health Clinics, Nurse Practitioners, Other (United Community Services), Bill Entity For Physician Services (Recovering Hope Treatment Center, COR Counseling & Psychiatric Services)

Source: Medicaid claims and encounter data, July 1, 2018 to June 30, 2019.

Action Items. For each milestone identified by CMS and Minnesota's corresponding action items, a group of process indicators were identified to measure progress. There are 26 action items that the state identified to achieve the Demonstration's milestones. The process indicators are the metrics for each action item. NORC used the data provided by MN DHS to identify the action items that have been completed or are currently open (see **Exhibit 4**). For example, indicators include information such as a report from the Question Log or data on searches of the Minnesota Prescription Monitoring Program (MNPMP) data. Exhibit 4 illustrates how NORC used the indicators and data to show progress on each milestone's action items.

Exhibit 4. Example Milestone, Action Item, and Process Indicator Mapping

Action Item	Process Indicator	Description
5.3 Increase the use of MNPMP by providers and pharmacists	Prescribers and Delegates: • In 2020, there was an increase of 9.6% in the number of providers and 4.1% provider delegates. • In 2020, there was an increase of 12.1% in the number of provider searches.	The Bureau of Pharmacy reports MNPMP data on the unique number of physicians, pharmacists, and their delegates who searched the database and the total number of searches per month. The most recent data available was for calendar year 2020. These data can be used to document increases and trends over time.
	Pharmacist/Dispensers and Delegates: • In 2020, there was an increase of 11.5% in the number of pharmacist/dispensers and 10% pharmacist delegates. • In 2020, there was an increase of 11.4% in the number of pharmacist/dispenser searches.	The Bureau of Pharmacy reports MNPMP data on the unique number of physicians, pharmacists, and their delegates who searched the database and the total number of searches per month. The most recent data available was for calendar year 2020. These data can be used to document increases and trends over time.

Focus Groups and Key Informant Interviews. Qualitative data collection was conducted to gather stakeholder feedback and to understand the state's approach to implementation. The objective was to learn about their experiences and perspectives on implementation of the Demonstration. Focus groups were held with most Demonstration enrolled providers as of June 2021. Several groups of MN DHS staff participated in either individual or small group interviews. A total of four focus groups with enrolled providers were conducted, and the focus groups were organized by the different ASAM levels of care offered by the providers. Throughout the analysis, NORC incorporated MN DHS perspectives on each milestone to understand the ongoing efforts to complete each milestone and assist MN's SUD providers throughout the Demonstration. Protocols for the focus groups and interviews were structured to collect standard information to track implementation progress and document stakeholder perceptions in line with the goals and milestones of the Demonstration (see Attachment B). Exhibit 5 summarizes the objectives of the focus groups and informant interviews by respondent type.

Exhibit 5. Respondent Type & Knowledge Objectives

Respondent Type	Knowledge Objectives
Providers	• Knowledge of new Demonstration-related benefits • Perceptions about the extent to which SUD treatment coverage standards align with the ASAM criteria • Perceptions about appropriate staffing at different ASAM levels of care • Perceptions of gaps in provider capacity and ways to address those gaps • Perceptions about patient placement criteria for clinically managed residential services and medically managed inpatient services • Adequacy of reimbursement rates for new SUD treatment services • Key challenges and facilitators of implementation
MN DHS	• Key policy or administrative challenges in implementing the Demonstration, underlying causes, and mitigation strategies • Key achievements from the state's perspective, and the underlying drivers of success • Perceptions about support and technical assistance from CMS

NORC employed a theme-based approach to analyzing qualitative data from focus groups and interviews. NVivo software was used to code the focus groups and informant interviews transcripts.[vi] The approach that NORC took for coding included developing and defining analytic categories based on research questions and the domains of focus; operationalizing the research question in the codebook, which provides clear and concise guidelines for categorizing all qualitative data collected; and refining the codebook as needed to ensure strong inter-coder reliability and accuracy of applying codes.

Assessment of Overall Risk of Not Meeting Milestones

In order to quantify and subsequently categorize the risk associated with not meeting each milestone, NORC used an established rubric that is unique to each data source type. The considerations and guidance in **Exhibit 6** were used to classify each milestone as either low, medium, or high risk.

In order to quantify and then subsequently categorize the risk associated with failing to meet each milestone, NORC used an established rubric that is unique to each type of data included in the assessment source type. The considerations and guidance in **Exhibit 7** were used to classify each milestone as either low, medium, or high risk.

[vi] QSR International Pty Ltd. (2020) NVivo (released in March 2020).

Exhibit 6. Overall Risk of Not Meeting Milestone

Data source	Considerations	Low	Medium	High
Critical metrics (required)	For each metric associated with the milestone, is the state moving in the direction of the state's annual goal and overall Demonstration target?	All or nearly all (e.g., more than 75 percent) of the critical metrics trending in the expected direction	Some (e.g., 25-75 percent) of the critical metrics and other monitoring metrics trending in the expected direction	Few (e.g., less than 25 percent) of the critical metrics and other monitoring metrics trending in the expected direction
Implementation plan action items	Has the state completed each action item associated with the milestone as scheduled to date?	All or nearly all (e.g., more than 75 percent) of the action items completed	Some (e.g., 25-75 percent) of the action items completed	Few (e.g., less than 25 percent) of the action items completed
Stakeholder feedback	Did key stakeholders identify risks related to meeting the milestone?	Few stakeholders identified risks; risks can be easily addressed within the planned timeframe	Multiple stakeholders identified risks that may cause challenges meeting milestone	Stakeholders identified significant risks that may cause challenges meeting milestone
Provider availability assessment data	Does the state have or expect to have adequate provider availability at critical levels of care?	Availability is adequate	Availability is not yet adequate but is moving in expected direction	Availability is not yet adequate and not moving in expected direction

Limitations

Time and Implementation. The progress that can be reported at the time of this Mid-Point Assessment is limited by the time elapsed since the implementation and uptake of the Demonstration by providers. Providers continued to enroll in the Demonstration through the final quarter of Year 2, (4/1/2021-6/30/2021), and will continue to do so. In addition, the state is working on a 2022 legislative proposal that will ensure progress on implementing requirements for outpatient SUD levels of care (1.0 Outpatient and 2.1 Intensive Outpatient).

Data Availability. The availability of quantitative data for some critical metrics does not cover sufficient quarters to determine directionality of change. The Demonstration is early in its implementation, therefore, a number of critical metrics are only reported in two quarterly monitoring reports. In addition, claims for early intervention services and follow-up after treatment were not fully captured since

providers were not fully trained on the new billing process for SUD services. MNIT was able to deploy the claims coding process for residential services delivered by Demonstration providers in December 2020. As some of these metrics may both increase and decrease periodically by nature, using only two time-points may not represent the true trends of these metrics.

Qualitative data. Our qualitative data included many stakeholder viewpoints, but data collection was limited in time and scope. We could not survey all providers or state staff currently involved in the Demonstration. Findings from our focus groups may reflect some selection bias on the part of providers who were motivated to participate in the demonstration. Providers who participated in the focus groups for the mid-point assessment enrolled voluntarily in the Demonstration and may have been more likely to express favorable views than providers who would enroll subsequently under the legislative mandate. Their views may not be generalizable to all providers participating in the Demonstration.

Findings

This section describes findings and recommendations from NORC's independent assessment of progress related to the Demonstration's monitoring metrics and action items, as well as the response from the state to those findings.

Monitoring Metrics

Exhibit 7 below shows the baseline and the most recent data, as of Demonstration Year 3, for the 19 metrics CMS identified as critical indicators for the Mid-Point Assessment for five of the SUD Demonstration milestones. Detailed specifications and more information on data sources can be found in Attachment C. Risk assessment is only required for each milestone, not each metric. Therefore, following the presentation of data from all sources (quarterly reports narratives and monitoring metrics, stakeholder interviews, and focus groups) we summarize milestone risk assessment (see Exhibit 7). Overall, the state made progress on five metrics, experienced a lack of progress on ten metrics, and there was insufficient data for four metrics. Importantly, progress was made on three metrics critical to the treatment of OUD, for which there has been an increase in the need for services in Minnesota (and nationwide).

The state saw an increase in several measures of SUD service utilization, which may reflect the expansion of services to meet the increased need for treatment as a result of the pandemic.[13,14] The increase in withdrawal management (Milestone 1) services may also reflect the overall increase in newly diagnosed need for SUD services. Withdrawal management is necessary for people who are determined to be dependent on drugs, and is an important first step before a patient begins psychosocial treatment.[15] Similarly, the increase in residential and inpatient services may reflect the rise in need for the services, following the onset of the pandemic in Demonstration Year 1 Quarter 3.

Thus, while the COVID pandemic created additional barriers to care seeking behaviors, the need for services increased, and the increased use of services indicates sufficient access. This is especially so for MAT, as beneficiaries sought prescriptions in lieu of in person services.

Based on NORC's assessment of the key factors presented in Exhibit 7, we assess the risk for the state not meeting Milestones #1 and #2 as low. For Milestones #4-6 between 25-75 percent of the critical metrics and other monitoring metrics are trending in the expected direction and we therefore assessed them as at medium risk of the state not meeting these milestones. A few important caveats for those Milestones assessed at medium risk:

- For Milestone 4, the observed reduction in providers may not accurately reflect the available number of prescribers of buprenorphine (i.e., the number of beneficiaries on MAT increased). This is due to the claims-based metrics reflecting provider organizations, rather than individual prescribers (See discussion below).
- The absolute changes in the metrics used for Milestone 5 (apart from overdose death rates) and Milestone 6 are very minimal.

Exhibit 7. Findings from Mid-Point Assessment of Monitoring Metrics

			Monitoring metric rate or count							
Milestone	**Metric #**	**Metric Name**	**At baseline**	**At mid-point**	**Absolute change**	**Percent change**	**State's target**	**Directionality at mid-point**	**Progress (Yes/No)**	**Milestone risk assessment**
#1 Access to critical levels of care for OUD and other SUD	7	Early Intervention	1.0	4.0	3	300	Maintain or increase	Insufficient data*	--	Low
	8	Outpatient Services	22,026.7	23,705.7	1,679	7.6	Maintain or increase	Increase	Yes	
	9	Intensive Outpatient and Partial Hospitalization Services	NA	NA	NA	NA	NA	NA	--	
	10	Residential and Inpatient Services	2,362.7	2,694	331.3	14.0	Maintain or decrease	Increase	No	
	11	Withdrawal Management	396.7	449	52.3	13.2	Maintain or decrease	Increase	No	
	12	Medication-Assisted Treatment	11,292.7	12,966.7	1,674	14.8	Maintain or increase	Increase	Yes	
	22	Continuity of Pharmacotherapy for Opioid Use Disorder	45.3	48.6	3.2	7.1	Increase	Increase	Yes	
#2 Use of evidence-based, SUD-specific patient placement criteria	5	Medicaid Beneficiaries Treated in an IMD for SUD	14,407.0	15,547.0	1,140.0	7.9	Maintain or increase	Increase	Yes	Low
	36	Average Length of Stay in IMDs	39.8	32.3	-7.5	-18.8	o more than 30 days	Decrease	Yes	
#4 Sufficient provider capacity	13	Provider Availability	454.0	438.0	-16	-3.5	Maintain or increase	Decrease	No	Medium

			Monitoring metric rate or count							
Milestone	**Metric #**	**Metric Name**	**At baseline**	**At mid-point**	**Absolute change**	**Percent change**	**State's target**	**Directionality at mid-point**	**Progress (Yes/No)**	**Milestone risk assessment**
at each level of care	14	Provider Availability – MAT	20.0	18.0	-2.0	-10.0	Maintain or increase	Decrease	No	
#5 Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD	18	Use of Opioids at High Dosage in Persons Without Cancer (NQF #2940)	6.9	7.5	0.7	10.1	Decrease	Insufficient data*	--	Medium
	21	Concurrent Use of Opioids and Benzodiazepines (NQF #3175)	15.8	15.1	-0.6	-4.1	Decrease	Decrease	Yes	
	23	Emergency Department Utilization for SUD per 1,000 Medicaid Beneficiaries	4.3	4	-0.3	-8.1	Maintain or decrease	Insufficient data*	--	
	27	Overdose death rate per 100,000 Medicaid Beneficiaries	38.4	48.9	10.5	27.3	Decrease	Increase	No	
#6 Improved care coordination and transitions	15	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (NQF #0004)	39.9	39.5	-0.4	-1.0	Increase	Decrease	No	Medium

			Monitoring metric rate or count							
Milestone	**Metric #**	**Metric Name**	**At baseline**	**At mid-point**	**Absolute change**	**Percent change**	**State's target**	**Directionality at mid-point**	**Progress (Yes/No)**	**Milestone risk assessment**
between levels of care.	17(1)	Follow-up after Emergency Department Visit for Alcohol or Other Drug Dependence (NQF #2605)	27.3	26.8	-0.6	-2.1	Increase	Decrease	No	
	17(2)	Follow-up after Emergency Department Visit for Mental Illness (NQF #2605)	60.4	59.4	-1	-1.6	Increase	Decrease	No	
	25	Readmissions Among Beneficiaries with SUD	12.1	12.8	0.7	5.8	Decrease	Increase	No	

Notes: There are no critical metrics for Milestone 3 so therefore it is not included in the table above. Insufficient data is indicated where there were less than 11 events in the first or last quarter of data used in the calculation. NA= MN DHS did not have data for this measure as of the assessment period. The baseline and midpoint values are the quarterly average from the three months in the respective quarters. NQF=National Quality Forum, SUD = substance use disorder.

Given the changes in policies around prescribing MAT, care-seeking behaviors, the need for services brought about by the pandemic, as well as the rise in fentanyl-related opioid overdose deaths, we examined changes in metrics across beneficiary subpopulations to understand how different groups sought treatment services, and where overdose deaths were occurring. Progress on each core metric by subgroup (where sufficient data (N>11) were available) is shown in **Exhibit 8**. We find that MAT increased largely among youth and the working age population, and declined for those over age 65. This may reflect divergent trends in the need for OUD services among these groups. In contrast, there was progress on increasing outpatient services, residential, and inpatient services for seniors, but a decline in these services for youth, possibly reflecting reluctance among youth to enter facilities for treatment. Nearly all overdose deaths occurred among the working age population.

Exhibit 8. Select Monitoring Metrics, by Subgroup

Measure	Medication-Assisted Treatment (MAT)		Outpatient Services		ED visits for SUD		Residential and Inpatient Services		Overdose Deaths (rate)		Overdose Deaths (Count)	
For subgroups where N >11, for 8 observation periods	**Absolute change (N)**	**Relative Change (%)**	**Absolute change (N)**	**Relative Change (%)**	**Absolute change (N)**	**Relative Change (%)**	**Absolute change (N)**	**Relative Change (%)**	**Abs. change (Percentage point)**	**Relative Change (%)**	**Absolute change (N)**	**Relative Change (%)**
Under age 18	14.3	37.7	-91.7	-15.2	-15.7	-18.7	-21.7	-35.0	N<11	*N<11*	*N<11*	*N<11*
18-64	1771.7	16.2	1606.7	7.7	306.3	6.5	329.3	14.5	0.2	*30.1*	*156.0*	*27.1*
65+	-112.0	-33.6	164.0	32.2	23.0	13.0	23.7	96.0	0.0	*0.0*	*0.0*	*0.0*
Dual Eligible	-460.0	-46.1	229.0	8.3	N/A	N/A	42.7	23.8	N/A	*N/A*	*N/A*	*N/A*
Medicaid-only	2134.0	20.7	1450.0	7.5	N/A	N/A	288.7	13.2	N/A	*N/A*	*N/A*	*N/A*
Beneficiaries with OUD Overall	593.7	6.5	1475.0	18.6	240.7	17.6	231.7	30.1	1.5	*20.1*	*37.0*	*32.8*

Notes: N/A= MN DHS does not report this measure for this subgroup. *N<11: data were insufficient to calculate percent change.* MAT = medicated-assisted treatment. ED = emergency department.

Although the absolute and relative percentage change can be calculated for 15 of the metrics, we could only measure a trend for three. We used linear regression to examine change over time for these three metrics, and report the coefficient and associated p-value (see **Exhibit 9**). The coefficient is estimated average number of services each quarter. As described above, this is because there was not enough time prior to the mid-point assessment for the state to make observable progress. Additionally, the delayed implementation and staffing shortages, as described above and in the findings from stakeholder discussions, resulted in data availability limitations for the monitoring metrics. We did find significant ($p<.05$) sustained progress on the provision of MAT, a small but significant increase in residential and inpatient services, and no significant linear change in outpatient services. We will revisit the trend analysis in the Interim Evaluation Report in June 2023.

Exhibit 9. Select Monitoring Metrics, Trend Analyses

Metric #	Milestone	Metric Name	P-value	Coeff.
8	1	Outpatient Services	0.301	212.6
10	1	Residential and Inpatient Services	0.010	35.9
12	1	Medication-Assisted Treatment (MAT)	0.000	245.6

Note: Trends in early intervention services are excluded due to the low frequency in each quarter (N=4).

In addition to the 19 critical metrics, we analyzed data for four additional monitoring metrics with sufficient data to further assess milestone progress (**Exhibit 10**). The state was able to diagnose and initiate SUD treatment for more beneficiaries. The state continued to expand provider capacity through Project Extension for Community Healthcare Outcomes (ECHO), an important instrument of the Demonstration. Project ECHO increases provider preparedness to treat OUD through knowledge sharing and improving provider capacity to deliver high quality of services.[vii] Minnesota is using Project ECHO to educate and engage a range of provider environments and professionals about MAT, from the prescribers to social service staff, to licensed alcohol and drug abuse counselors and clinic administrators.

[vii] Project ECHO a collaborative model of medical education and care management that helps clinicians provide high quality care to patients wherever they live. Experts use video-conferencing technology to train, advise, and support primary care providers, The project has been widely used to train providers to delivery specialty treatment in rural and underserved areas for a variety of conditions. It was developed by developed by Dr. Sanjeev Arora, at the University of New Mexico Health Sciences Center. See https://hsc.unm.edu/echo/.

Exhibit 10. Additional metrics to support milestone progress

Metric #	Supporting Milestone #	Metric Name	At baseline	At mid-point	Absolute change	Percent change	Overall Demonstration Target	Direction at mid-point	Progress
2	1	Medicaid Beneficiaries with Newly Initiated SUD Treatment/Diagnosis	5,333	5,630	296.7	5.6	Increase	Increase	Yes
32	6	Access to Preventive/ Ambulatory Health Services for Adult Medicaid Beneficiaries with SUD	93.8	92.4	-1.4	-1.5	Increase	Decrease	No
NA	5	Number of training sessions providers held on pain management through Project ECHO	16	21	5	31.2	Increase	Increase	Yes
NA	4	Number of training sessions providers held on OUD Treatment through Project ECHO	56	65	9	16.1	Increase	Increase	Yes

Implementation Plan Action Items

In addition to the metrics reported in the monitoring reports, Minnesota has also addressed or begun to address the actions items from the state's Minnesota Substance Use Disorder Section 1115 Waiver Implementation Plan (Implementation Plan) described below in Exhibit 11. The status of each action item is either noted as completed, ongoing, or suspended. Action items noted as completed were either accomplished by the Implementation Plan date of completion or have the necessary systems and staffing in place to support ongoing implementation throughout the Demonstration. Action items noted as ongoing (1.4, 3.5 and 5.1) were in process or intended by Minnesota in the Implementation Plan to be ongoing activities across the Demonstration period. Overall, there are 27 total action items and:

- 23 action items are completed,
- 3 action items are ongoing, and
- 1 action item is suspended.

Some action items assist the state in progress towards multiple Demonstration milestones, such as implementing training and technical assistance for providers. Specifically, 7 of 26 action items are repeated across several different milestones. In the section below, process indicators for these action items apply to each of the milestones and are reported for the corresponding ones. Relevant stakeholder input is reported where it is most aligned with the milestone goal.

Exhibit 11 Findings from Mid-Point Assessment of Implementation Plan Action Items

Number	Action Item Description	Date to be Completed	Status
1.1	Implement training and technical assistance to align providers with ASAM-based standards	July 2020; ongoing	Completed
1.2	Publish ASAM-based service standards and staffing requirements in MHCP provider manual	October 2020	Completed
1.3	Target for providers to reach ASAM-based compliance	June 2021	Completed
1.4	Begin state plan coverage of intensive outpatient treatment	January 2022	Ongoing
2.1	Begin process of updating managed care organization (MCO) contracts to define participating providers	December 2019	Completed
2.2	Implement training and technical assistance to align providers with ASAM-based standards	July 2020; ongoing	Completed
2.3	Update MCO contracts to align utilization management practices with ASAM-based placement criteria	September 2020	Completed
2.4	Begin utilization management process that includes an independent utilization review process for residential placements	July 2021	Completed

Number	Action Item Description	Date to be Completed	Status
2.5	Communicate changes to providers	Ongoing	Completed
3.1	Providers electing to participate provide verification of formal referral arrangements to ensure access to each of the ASAM levels of care	January 2020; ongoing	Completed
3.2	Implement training and technical assistance to align providers with ASAM-based standards	July 2020; ongoing	Completed
3.3	Update MCO contracts to reflect residential provider requirement changes	September 2020	Completed
3.4	Publish ASAM-based service standards and staffing requirements in MHCP provider manual	October 2020	Completed
3.5	Develop residential treatment provider review process and initiate ongoing monitoring process	June 2021	Ongoing
3.6	Communicate changes to providers	Ongoing	Completed
4.1	Providers electing to participate provide verification of agreement to submit pertinent data for assessment measures	January 2020; ongoing	Completed
4.2	Assess provider capacity at critical levels of care and plan a response to address gaps where identified, including for MAT	Within 12 months of approval	Completed *
4.3	Baseline measurements collected for provider capacity assessment	July 2020	Completed
5.1	Continue to support the use of the MNPMP when prescribing, and the use of the Prescribing Guidelines	December 2020; ongoing	Ongoing
5.2	Identify opportunities for expanding MNPMP functionality and use	Ongoing	Suspended
5.3	Increase the use of MNPMP by providers and pharmacists	Ongoing	Completed
6.1	Providers electing to participate provide verification of formal referral arrangements to ensure access to each of the ASAM levels of care	January 2020; ongoing	Completed
6.2	Implement training and technical assistance to align providers with ASAM-based standards.	July 2020; ongoing	Completed
6.3	Update MCO contracts to reflect any necessary residential provider requirement changes	September 2020	Completed
6.4	Publish ASAM-based service standards and staffing requirements in MHCP provider manual	October 2020	Completed
6.5	Develop residential treatment provider review process and initiate ongoing monitoring process	June 2021	Completed
6.6	Communicate changes to providers	Ongoing	Completed

Notes: *MN DHS has reviewed the completed Provider Capacity Assessment, is aware of the data limitations, and has stated that it will put a plan in place to improve the situation.

In the sections below, NORC provides assessment on progress towards each milestone, integrating information from the relevant monitoring metrics, action items, process indicators, key informant interviews, focus groups and other available data. Based on the state's implementation under the recent legislative mandate, some progress has been made towards all milestones and many action items have been achieved. One exception is Action Item 5.2 to identify opportunities for expanding MNPMP functionality and use. While the state continued to promote use of the MNPMP, due to other priorities and resource constraints, expansion of the MNPMP was not pursued. However, the action item remained in the Implementation Plan at the time of the Mid-Point Assessment.

Progress towards Milestone 1: Access to Critical Levels of Care for OUD and Other SUDs

Milestone 1 focuses on ensuring that patients with OUD or other SUDs have access to all critical levels of care from outpatient, intensive outpatient services, and MAT, including medications as well as counseling and other services, to intensive levels of care in residential and inpatient settings and medically supervised withdrawal management. Beginning with training and technical assistance, under Milestone 1 Minnesota will establish systems and processes to deliver all ASAM levels of care.

At the outset, the Implementation Plan established that the state Medicaid plan provided coverage for, and therefore access to, all levels of care except Early Intervention (.5). The state also established June 2021 as the target date for providers to come into ASAM-based compliance except for Level 2.1 Intensive Outpatient Services (IOP) which had a January 2022 target date. The Implementation Plan notes that access to the ASAM standard for Ambulatory Withdrawal Management with Extended On-Site Monitoring (2-WM) was scheduled to occur through the state's Certified Community Behavioral Health Clinics (CCBHC) although funding for these clinics was extended through another program and they did not become part of the Demonstration.

Implementation Plan Action Items

The state identified four action items needed to achieve Milestone 1 (Exhibit 12 below).

Exhibit 12. Milestone 1: Access to Critical Levels of Care for OUD and Other SUDs

Action Item	Process Indicator	Description
1.1 Implement training and technical assistance to align providers with ASAM-based standards	**Training:** • 6 Webinars • 1 Public Comment • 6 Sessions of Enhanced Professional Learning (EPL) series • 862 Providers participated in ASAM trainings	Minnesota offers ongoing trainings to providers regarding the ASAM criteria. MN DHS reported the number and types of training and provider attendance from November 2020 – September 2021.
	Technical Assistance: • 28 office hours conducted • 432 questions asked by providers via Question Log • 133 Providers in attendance of office hours	Minnesota offers technical assistance to providers. MN DHS reported the number and types of technical assistance and provider attendance from November 2020 – September 2021.
1.2 Publish ASAM-based service standards and staffing requirements in MHCP provider manual	Published the MHCP provider manual	Minnesota published the initial ASAM-based service standards and staffing requirements in the MHCP provider manual online in October 2020 and there are ongoing updates.
1.3 Target for providers to reach ASAM-based compliance	Provider enrollment requirement	When enrolling in the Demonstration, providers sign a Provider Agreement form agreeing to be compliant with the Demonstration.
1.4 Begin state plan coverage of intensive outpatient treatment	Start date of plan coverage of Intensive Outpatient Treatment	Legislation is pending for ASAM level of care 2.1 Intensive Outpatient Treatment

Minnesota has achieved three of the four action items and action item 1.1**,** Implement training and technical assistance to align providers with ASAM-based standards, and 1.4, Begin state plan coverage of intensive outpatient treatment are ongoing. The state reported that providers attest to being ASAM compliant upon enrollment in the Demonstration. Currently, enrollment is continuing through June 2022 under the new legislative mandatory

participation. Stakeholder input on training and ASAM compliance is provided below and input on technical assistance is provided under Milestone 2.

Stakeholder Input

Most providers reported that they have attended training or sought technical assistance since the implementation of the Demonstration. MN DHS reported that the first of seven training sessions was offered in November 2020 with 137 individuals attending. Training was offered in January, April (two sessions), May, June and September 2021. Attendance ranged from 53 to 198 individuals. In order to facilitate the training webinars, Demonstration staff collaborated with different divisions and partners within MN DHS. Most of the ASAM trainings have been provided by external vendors that specialize in SUD technical assistance. Exhibit 13 provides an overview of the training sessions that were offered.

Exhibit 13. Overview of Training Sessions

Type	Description
ASAM criteria webinar	Initial MN training webinar to introduce and familiarize SUD providers with the ASAM criteria.
Enhanced professional learning series	A six-month long web-based course of monthly sessions through the Natl Frontier and Rural Telehealth Education Center and the Great Lakes Addiction Technology and Transfer Center regarding ASAM integration that was only open to residential providers, including topics such as Navigating Levels of Care.
ASAM live session	Training session held for SUD providers to address their questions (e.g., clinical questions related to ASAM criteria).
Kepro Utilization Management Trainings	Training webinars designed to review the ASAM criteria and instruct enrolled providers on how to submit cases for utilization review.

Some providers reported challenges getting the necessary information from the trainings. Providers shared constructive feedback on the ASAM-based trainings, indicating that they did not find the original trainings clear or tailored to their needs. Others reported that training sessions elicited more questions than answers. *"…it was just [that] the training on the ASAM was just so big that I don't know [that] people got the option to ask a lot of questions or get a lot of that feedback."* Providers' specific concerns were that the trainings focused on MAT not ASAM criteria generally or that the ASAM criteria were discussed generally as opposed

> The biggest need now is to continue the work of collaborating with our providers in the state…making sure that they feel supported…supporting them to start thinking through the Medicaid lens… most importantly, like the oversight of substance use disorder services are concerned… we have providers from our rural areas, as well as we have providers from our BIPOC [Black, Indigenous, and People of Color] communities [that need to be] really well supported because they do not have infrastructure, like our big, huge providers.
>
> - MN DHS staff

to their context within the Demonstration. Given these challenges, several providers created internal staff training at their facilities on the ASAM criteria. While the state offered approximately a dozen sessions, most providers relied on informal information sharing to prepare themselves to participate in the Demonstration. MN DHS acknowledged that the transition is difficult and that they would like to be able to provide more online, on demand training for providers.

As part of the Demonstration the state is establishing a new utilization management (UM) system and it is being provided through a contract with Kepro, formerly known as the Keystone Peer Review Organization. Kepro is an independent UM organization that is hired to train providers and conduct UM reviews. For the first year, Kepro's focus will be on training, explaining ASAM criteria to ensure providers understand the process. Training is offered several times a month and will be extended, based on demand and frequently asked questions by providers. Regarding the trainings on UM, many providers felt that they were too high-level, were provided too close to the implementation date, and did not allow adequate time for providers to ask questions about a new and complicated billing process. MN continues to offer Kepro training webinars to provide ongoing support and ensure providers entering the Demonstration understand the requirements.

Most providers already delivered care consistent with the ASAM criteria as they were required to by commercial payers. The Demonstration requires that participating providers transition to using ASAM criteria from the ASAM-like criteria established in the Minnesota Matrix, the Rule 25 Assessment tool used to determine clinical eligibility for treatment.[16] The Minnesota Matrix was developed in partnership with ASAM. According to one provider: *"we've worked with commercial insurances and had to utilize ASAM prior to the 1115 waiver, but this just aligns our consolidated funding funds, PMAP [Prepaid Medical Assistance Project]—just the whole—under one versus the Minnesota Matrix versus ASAM."* Nonetheless, the stricter requirements under the Demonstration required providers to change some practices, such as offering MAT, and managing client assessment and placement (see text box). This was accompanied by the move to direct client access for SUD services across all DHS programs so Demonstration providers also experienced an increase in the number of assessments they had to perform using the new criteria.

> And the expectation now [is] that the provider themselves evaluate the individual, determine whether they're [in] the appropriate setting for the care that the person needs, apply ASAM criteria to that person presenting issues, and either admit or refer. And so this is a switch for them. They've been essentially handed clients in a lot of cases rather than having to do the assessment and referral or acceptance. And so that's [going to]be a change in their practice, and they're [going to] have to adjust to the idea that not everybody that shows up is appropriate for the services that they provide.
>
> Demonstration Provider

Reflecting on this change, however, one provider saw these requirements and changes as a positive because the organization was developing better relationships with their referring partners. *"I think some of the partnering processes with other agencies outside of our levels*

of care, I think, [it] will be a useful tool to help us be more intentional with working with other providers outside of what we can provide ourselves."

Progress towards Milestone 2: Use of Evidence-Based, SUD-Specific Placement Criteria

Milestone 2 focuses on aligning the ASAM patient placement criteria with the ASAM levels of care and developing a comprehensive, independent utilization review process. The five action items address the essential steps in the implementation of integrated SUD/OUD treatment starting with coordination with MCOs and providing training and technical assistance to the establishment of the new UM system provided by Kepro and regular, ongoing communication with providers. MN DHS also contracted with eight early adopter Demonstration providers to share insights with the state during implementation regarding operations and information needs.

Implementation Plan Action Items

The state identified five action items needed to achieve Milestone 2 (Exhibit 14 below).

Exhibit 14. Milestone 2: Use of Evidence-Based, SUD-Specific Placement Criteria

Action Item	Process Indicator	Description
2.1 Begin process of updating MCO contracts to define participating providers	8 MCO contracts updated	Minnesota has updated MCO contracts to define participating providers.
2.2 Implement training and technical assistance to align providers with ASAM-based standards	**Training:** • 6 Webinars • 1 Public Comment • 6 Sessions of Enhanced Professional Learning (EPL) series • 862 Providers participated in ASAM trainings	Minnesota offers ongoing trainings to providers regarding the ASAM criteria. MN DHS reported the number and types of training and provider attendance from November 2020 – September 2021.
	Technical Assistance: • 28 office hours conducted • 432 questions asked by providers via Question Log • 133 Providers in attendance of office hours	Minnesota offers technical assistance to providers. MN DHS reported the number and types of technical assistance and provider attendance from November 2020 – September 2021.

Action Item	Process Indicator	Description
2.3 Update MCO contracts to align utilization management practices with ASAM-based placement criteria	8 MCO contracts updated	Minnesota has updated MCO contracts to align utilization management practices with ASAM-based placement criteria.
2.4 Begin utilization management process that includes an independent utilization review process for residential placements	MN DHS executed the Kepro contract for utilization management on February 2, 2021 and the utilization management process was implemented on July 1, 2021	Start date of the contract with the utilization management contractor and start of the utilization management process.
2.5 Communicate changes to providers	See action item 2.2	Training and technical assistance represent targeted and ongoing communication with providers regarding changes occurring to implement the Demonstration.
	MN DHS reports making 157 web updates related to the Demonstration and disseminated 15 eMemos to providers	MN DHS' website serves as the primary communication channel/mechanism for informing providers about the Demonstration and training and TA opportunities. Changes are ongoing and the state uses website metrics data to track changes related to the Demonstration.

The actions needed to achieve Milestone 2 relate to updating MCO contracts, ASAM-based standards training and technical assistance for providers, initiating the UM process, and communicating with providers. These actions also relate to achieving Milestones 3 and 6. Stakeholder input on MCO contract updates, technical assistance, UM and communication are provided below and address these areas of Milestones 3 and 6.

Stakeholder Input

MN DHS updated the contracts of all eight Medicaid MCOs to reflect new requirements under the Demonstration. Because SUD provider contracts with MCOs were based on the state rates, the PMAPs would also reimburse providers at the increased outpatient rates. At the time of the Mid-Point Assessment, providers were receiving adjustments to their reimbursement and communicating with the MCOs about billing under the Demonstration. Providers reported receiving payments for calendar year 2021 as well as contract language from several different MCOs. However, consistent with reports from MN DHS that training was ongoing, providers reported that some MCO billing staff were not fully aware of the contract changes. Some providers expressed concern that MCOs were

not already reimbursing them at the new rates and/or were unaware of the requirement when the provider contacted them.

MN DHS is providing varying types of technical assistance to SUD providers. As shown in Exhibit 15 below, MN DHS is offering several mechanisms to connect with providers, including an electronic mailbox for the Demonstration and virtual office hours. Almost 150 attendees had participated in 28 office hour sessions as of September 2021. MN DHS reported that the use of the different types of technical assistance by providers varies. For example, the number of emails sent to the mailbox varies per week, sometimes as many as 20 or as low as five. To date, the state has received almost 500 email inquiries regarding enrollment, service delivery, and UM. In the Spring of 2021 following the initial trainings on ASAM, MN DHS scheduled regular office hours for providers. Attendance in virtual office hours varies by the week and typically consists of up to 15 providers.

Exhibit 15. Overview of Technical Assistance

Type of Technical Assistance	Description
Virtual Office Hours	Facilitated Q&A sessions where SUD providers can discuss enrollment and clinical questions. The office hours started twice per week at the beginning of the Demonstration and are now once per week, rotating Tuesdays and Thursdays.
Webinars	Topics of the webinars are based on frequently asked questions by providers. They are held as needed. Some of the webinars have covered standards and MAT policy, public comment, and billing overview.
Mailbox	Emails with questions about the Demonstration are sent by SUD providers. Providers can send questions about the Demonstration here, and then they are funneled through channels in DHS to get a response. If a question cannot be answered during virtual office hours, then the providers are directed to the Mailbox.
One-on-one meetings	Providers can attend one-on-one meetings with DHS if they have specific concerns for their facility. Most of these sessions are held with adolescent providers due to the alignment of the adolescent treatment system and ASAM.

Some providers reported challenges getting the information they needed through the state's technical assistance. Regarding technical assistance, some providers noted the lag time in receiving answers back from the Demonstration mailbox operated by MN DHS, noting that it can take days to weeks to receive a response. Some providers said they reach out to the larger provider community seeking answers and expressed concerns that they were burdening other providers to address their questions. *"I signed up for every single one [virtual office hours], and always had a series of questions afterward, and then had to wait, submit those into the web page where you submit your questions."* Some providers valued the state's willingness to listen to the provider community and incorporate feedback while

others felt that the state was not adequately prepared when the Demonstration was implemented.

MN DHS acknowledges the need to increase opportunities for technical assistance for providers. MN DHS has explored hiring more staff and making shifts within the department so additional staff can help with technical assistance. There were discussions about technical assistance with the Minnesota Association of Resources for Recovery and Chemical Health (MARRCH) a professional association of addiction treatment professionals and organizations during the 2021 Legislative Session. MARRCH requested additional technical assistance. In response the state acknowledged that there was room for improvement and communicated to providers what steps it was taking to fill gaps and increase capacity.

In response to the request for additional guidance, MN DHS scheduled regular office hours for providers starting in April 2021, including twice weekly in May and June. Providers reported attending these sessions and asking specific questions about the Demonstration. While they welcomed the opportunity for technical assistance, providers described some frustration with the office hour processes including the lag time to get a response to follow-up questions and in some cases, there was not enough time for all attendees to ask their questions.

Providers made a range of suggestions to improve available training and assistance. Additional resources that providers suggested could be beneficial to ensuring the future success of the Demonstration included, for example,

- providing a dedicated MN DHS team for training,
- a hotline or call center for providers to address questions, ensure the provider/facility is compliant, and share best practices from other facilities, and
- providing additional training on aligning ASAM with the former Minnesota Matrix standards.

Providers described challenges in patient placement and cited the difference between the ASAM criteria and Minnesota Matrix. As indicated in Milestone #1, Minnesota is working to align the state's current patient placement criteria in the Minnesota Matrix with the ASAM levels of care. ASAM-based training has been offered to SUD providers who enrolled initially during the voluntary program. Some providers described how they implemented their own training sessions within their facilities to ensure staff knew the ASAM criteria and how to admit patients based on the ASAM patient placement criteria. One challenge for providers was the change in the number of hours authorized for treatment under ASAM. One provider indicated that additional technical assistance from MN

> "I'd say, with assessment and placement, the biggest issue that we have right now is that the Minnesota Matrix requires that our patients for residential treatment have a score of at least a four or just need a four in dimension four, five, or six for residential. But the waiver requires a score of four in at least two of those dimensions, so there's a conflict between those two residential requirements."
>
> Demonstration Provider

DHS on the evidence-based approach and transitioning from the old model to the new one was needed.

MN DHS implemented the new UM process administered by Kepro in July 2021 with a year long trial period. At the initial implementation of Kepro MN DHS gave providers one year of field practice before Kepro would begin making determinations on whether cases met medical necessity. During the initial year technical assistance will help providers learn how to submit documentation. The first year will also involve the implementation of UM policies and procedures, setting expectations, and creating a year-long field training for providers. Kepro also reaches out to providers via phone or mail whenever they need more information. One state administrator reported, "*We've gotten really good feedback from providers that Kepro is proactive in reaching out and saying, 'This is—there's an easier way. Try it this way*.'"

The Demonstration's UM process as instituted by Kepro was unanticipated and challenging for enrolled providers. Some providers were not expecting the amount of required data entry as part of the UM process, such as entering every patient into the system. One provider indicated that they expected UM would be more like a routine compliance check. Other challenges mentioned by providers included not having the staffing bandwidth or data entry knowledge to complete the tasks. One provider also mentioned the potential financial burden, given the staffing needs and time for data entry, "*At some point, the cost may outweigh the benefit for the 10 or 15 percent [reimbursement increase], and so do providers say, 'You know, I don't want to do this anymore?'*"

MN DHS communication under the Demonstration was extensive, a noted change from past communication practices. Discussing the positive experience they had when providers and the implementation team at DHS discussed the Demonstration, one provider expressed their gratitude for the collaborative experience. However, providers also reported that communication across the Demonstration has not always been coordinated. This was especially true when the work with Kepro began. *"I don't think they communicated across multiple formats in the way that they could [have] leading up to this."* MN DHS used eMemos as the primary vehicle for communicating with providers and keeping them informed about developments and sent 15 demonstration-related eMemos from February – October 2021. MN DHS acknowledged the importance of communicating with smaller providers, many of whom will enroll into the Demonstration due to the legislative mandate.

> It's the first time in 24 years that I have ever been involved with DHS where there was back and forth communication. We weren't watching them do a webinar and not be able to ask questions or talk during it. [The discussion] was a wonderful experience, I think. Because it allowed all of us who were going through the same thing to discuss and maybe come up with ideas and solutions on how to better manage the program itself. So, I give kudos to the implementation team for doing that, because it was real—I think that was more helpful than anything.
>
> Provider

Progress towards Milestone 3: Use of Nationally-Recognized SUD-Specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

Milestone 3 focuses on implementing residential treatment provider qualifications that meet the ASAM criteria standards or other nationally recognized, evidence-based SUD-specific program standards. These qualifications must be incorporated into written guidance such as licensure requirements, policy manuals, and managed care contracts, and the state must establish a process to review residential treatment provider compliance with the standards. This milestone also requires that residential treatment facilities offer MAT onsite or facilitate access to MAT offsite.

While Milestone 3 is focused on residential treatment, Minnesota has identified action items for achieving these changes, including several previously reported items, such as implementing training and technical assistance, updating MCO contracts, and communicating with providers. In the Implementation Plan, MN DHS described plans for meeting Milestone 3, including reviewing current residential treatment facility requirements against the ASAM residential levels of care to define enhanced expectations for residential treatment facilities and publishing them in the provider manual by October 2020. To review compliance with the standards, the state described a planned requirement for providers to submit an enrollment checklist for the Demonstration identifying any standards their programs do not currently meet and their plans for implementing the enhanced standards by June 30, 2021. MN DHS also planned to pursue legislation in 2021 clarifying the agency's oversight authority for the new standards beginning in July 2021. Finally, the state described its process for implementing a new provision in agreement with all participating providers requiring that MAT be offered as part of the continuum of care and that providers have within their networks at least one medical professional with prescribing authority.

Milestone 3 is affected by the passage during the spring 2021 legislative session of Minnesota Laws 2021, First Special Session, Chapter 7, Article 11, Sections 18-23. The law requires that residential treatment programs licensed by DHS in accordance with Minnesota Statutes, section 245G.21 and that receive payment through MHCP enroll as a Demonstration provider and meet provider standards requirements by January 1, 2024. As noted above, DHS is now working to educate and support residential providers statewide as they enter the Demonstration, meeting with rural providers and expanding transition support.

Implementation Plan Action Items

MN DHS identified six action items needed to achieve Milestone 3 (Exhibit 16 below).

Exhibit 16. Milestone 3: Use of Nationally-Recognized SUD-Specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

Action Item	Process Indicator	Description
3.1 Providers electing to participate provide verification of formal referral arrangements to ensure access to each of the ASAM levels of care (LOC)	22 unique providers with 86 locations	Providers complete the Provider Referral Arrangement Agreement (PRAA) to enroll and agree to ensure access to each ASAM LOC.
3.2 Implement training and technical assistance to align providers with ASAM-based standards	**Training:** • 6 Webinars • 1 Public Comment • 6 Sessions of Enhanced Professional Learning (EPL) series • 862 Providers participated in ASAM trainings	Minnesota offers ongoing trainings to providers regarding the ASAM criteria. MN DHS reported the number and types of training and provider attendance from November 2020 – September 2021.
	Technical Assistance: • 28 office hours conducted • 432 questions asked by providers via Question Log • 133 Providers in attendance of office hours	Minnesota offers technical assistance to providers. MN DHS reported the number and types of technical assistance and provider attendance from November 2020 – September 2021.
3.3 Update MCO contracts to reflect residential provider requirement changes	8 MCO contracts updated	Minnesota has updated MCO contracts to align utilization management practices with ASAM-based placement criteria
3.4 Publish ASAM-based service standards and staffing requirements in MHCP provider manual	Published the MHCP provider manual	Minnesota published the ASAM-based service standards and staffing requirements in the MHCP provider manual online in October 2020 and there are ongoing updates.
3.5 Develop residential treatment provider review process and initiate ongoing monitoring process	8 MCO contracts updated and Kepro implemented utilization management on July 1, 2021.	Minnesota has updated MCO contracts to cover residential treatment and provider utilization reviews are now ongoing through Kepro.
3.6 Communicate changes to providers	See action item 3.2	Training and technical assistance represent targeted and ongoing communication with providers

Action Item	Process Indicator	Description
		regarding changes occurring to implement the Demonstration.
	MN DHS reports making 157 web updates related to the Demonstration and disseminated 15 eMemos to providers.	MN DHS' website serves as the primary communication channel/mechanism for informing providers about the Demonstration and training and TA opportunities. Changes are ongoing and the state uses website metrics data to track changes related to the Demonstration.

The actions needed to achieve Milestone 3 relate to updating MCO contracts, ASAM-based standards training and technical assistance for providers, reviewing and monitoring residential treatment providers, and communicating with providers. These actions also relate to achieving Milestones 2 and 6. In addition, action item 3.1 relates to action item 1.3 discussed above. Stakeholder input on MCO contract updates, technical assistance, utilization management and communication were reported above under Milestone 2. Input on the referral arrangements and provider manuals is discussed below.

Stakeholder Input

MN DHS' Demonstration website lists approved locations and approved providers and available levels of care, supporting providers' new referral arrangement requirements.

Providers reported that they had not observed a significant change to their existing referral and care coordination practices due to the Demonstration. Some providers reported that the requirements were beneficial in promoting more intentional coordination and follow-up. Providers also said that the focus on referrals served as a catalyst for improving the tailoring of treatment plans to move away from "cookie cutter" options. However, several providers described the required referral arrangements as burdensome. For example, one provider reported that they had to begin paying a monthly stipend to get a written commitment from the medical and mental health providers to whom they refer patients, even though their referral process and those providers' process for seeing patients did not otherwise change. Providers also noted challenges with meeting the required timeframes for setting up follow-up consults (24 hours for mental health and 72 hours for physical health) due to availability and responsiveness of other providers. Additionally, providers do not want to cause disruption to any existing care plans by referring a patient to an available provider that differs from their established provider.

> It was already part of responsible practice to coordinate with, you know, when you can, with medical providers, mental health providers if they're not engaged in the level of care.
>
> - Provider

Progress towards Milestone 4: Sufficient Provider Capacity at Critical Levels of Care Including for Medication-Assisted Treatment for Opioid Use Disorder

Milestone 4 focuses on having the state complete a statewide assessment of the availability of providers enrolled in Medicaid, including those who are accepting new patients at the different ASAM levels of care and those who are offering MAT.

The first action item was to establish the data sharing requirements and verification of agreement with enrolled providers to submit data for monitoring and evaluating the Demonstration. This process is still ongoing, as providers continue to enroll in the Demonstration. The second two action items were to determine measures for the baseline PCA and conduct the assessment, and review gaps identified by the assessment. The draft PCA was submitted by NORC to MN DHS in December 2020.

Implementation Plan Action Items

The state identified three action items needed to achieve Milestone 4 (Exhibit 17 below).

Exhibit 17. Milestone 4: Sufficient Provider Capacity at Critical Levels of Care Including for Medication-Assisted Treatment for Opioid Use Disorder

Action Item	Process Indicator	Description
4.1 Providers electing to participate provide verification of agreement to submit pertinent data for assessment measures	22 unique providers with 86 approved locations*	Provider Screening and Enrollment (PSE) data reports enrolled providers and verifies agreement to submit pertinent data for assessment measures.
4.2 Assess provider capacity at critical levels of care and plan a response to address gaps where identified, including for MAT	Analysis and report on access to MAT in Minnesota and Baseline Provider Capacity Assessment in Minnesota completed	Minnesota conducted two provider capacity assessments using claims and encounter data. The analysis of provider distribution and access to MAT was completed in December 2020 and the overall provider capacity assessment in June 2020. The reports were not yet public at the time of the Mid-Point Assessment.
4.3 Baseline measurements collected for provider capacity assessment	Baseline Provider Capacity Assessment completed but not yet published	Minnesota completed a baseline provider capacity assessment in June 2020. The report was not yet public at the time of the Mid-Point Assessment.

*As of September 2021 when the mid-point assessment was completed. The count reported in September 2021 excluded Meridian St Anthony, which was approved but had not completed enrollment by the time the data were obtained for this Assessment. Please see https://mn.gov/dhs/partners-and-providers/policies-procedures/alcohol-drug-other-addictions/1115-sud/ for the current list of approved and enrolled locations.

Stakeholder Input

Both MN DHS and providers noted that workforce shortages pose a barrier to implementation of the Demonstration. In addition to providing additional assessments and facilitating care coordination through peer recovery support specialists, providers who entered the Demonstration were already strained by workforce shortages. One provider described staffing challenges at their organization, "*I have lost at least a dozen [LADC] Licensed Alcohol and Drug Counselors over the last three months, all of whom had master's degrees and went to work in mental health because the paperwork and the requirements of working in mental health aren't even close to what they have in SUD services. Workforce is a huge issue*." At the same time, some enrolled providers reported some success in meeting their requirements for 24-hour coverage for nursing and mental health care through onsite staff or referrals. In addition, the COVID-19 pandemic created additional stress and strain on all staff from administrators to providers.

Progress towards Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

Milestone 5 focuses on leveraging the state's regulatory power to address opioid use and OUD. For opioid abuse, this is accomplished by implementing additional opiate prescribing guidelines and other preventive interventions, specifically state expansion, coverage of, and access to naloxone for overdose reversal. As noted above, the second strategy to increase utilization and improve the functionality of the state's prescription drug monitoring programs was not pursued.

Minnesota describes its MNPMP as a new tool for prescribers and pharmacists to assist in managing patient care. It contains information provided by Minnesota licensed pharmacies and prescriber dispensers. Pharmacies and prescribers who dispense from their office submit prescription data to the MNPMP system for all Schedules II, III, IV and V controlled substances, butalbital and gabapentin dispensed in or into Minnesota.[viii]

The Implementation Plan included a specific goal for prescribers in the state, that by December 2020, opioid prescribers over predetermined prescribing thresholds will be required to use and document use of the MNPMP as part of the prescribing improvement program.

[viii] Information on the Minnesota Prescription Monitoring Program was accessed at https://pmp.pharmacy.state.mn.us/.

Implementation Plan Action Items

The state identified three action items needed to achieve Milestone 5 (Exhibit 18 below).

Exhibit 18. Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

Action Item	Process Indicator	Description
5.1 Continue to support the use of the MNPMP when prescribing, and the use of the Prescribing Guidelines	In 2020,10,945 unique provider prescribers searched the MNPMP and an additional 2,146 unique provider delegates[ix] In 2020, 3,666 unique pharmacist/dispenser searched the MNPMP and an additional 165 unique pharmacist delegates In 2020, 1,928,696 provider searches were completed and 1,049,320 pharmacist/dispenser searches.	Minnesota supports the use of MNPMP by opioid prescribers. The Bureau of Pharmacy reports MNPMP data on the unique number of physicians, pharmacists, and their delegates who searched the database and the total number of searches per month. The most recent data available was for calendar year 2020.
5.2 Identify opportunities for expanding MNPMP functionality and use	Not applicable	Not applicable
5.3 Increase the use of MNPMP by providers and pharmacists	**Prescribers and Delegates:** • In 2020, there was an increase of 9.6% in the number of providers and 4.1% provider delegates • In 2020, there was an increase of 12.1% in the number of provider searches	The Bureau of Pharmacy reports MNPMP data on the unique number of physicians, pharmacists, and their delegates who searched the database and the total number of searches per month. The most recent data available was for calendar year 2020. These data can be used to document increases and trends over time.
	Pharmacist/Dispensers and Delegates: • In 2020, there was an increase of 11.5% in the number of pharmacist/dispensers and 10% pharmacist delegates • In 2020, there was an increase of 11.4% in the number of pharmacist/dispenser searches	The Bureau of Pharmacy reports MNPMP data on the unique number of physicians, pharmacists, and their delegates who searched the database and the total number of searches per month. The most recent data available was for calendar year 2020. These data can be used to document increases and trends over time.

[ix] The Bureau of Pharmacy notes that Prescriber and Pharmacist/Dispensers may be counted as Delegates if they also searched directly and utilized a delegate to search on their behalf. Therefore, the data on unique searchers cannot be summed.

Minnesota identified three action items to advance access to comprehensive OUD treatment, including increasing access to MAT. The action items were focused on leveraging the state's prescription monitoring program and improving its functionality. The Bureau of Pharmacy reports increases in utilization during the 2020 calendar year with over three million searches being conducted.

Stakeholder Input

Providers indicated that they currently use the MNPMP and that searches for a patient's prescription history have increased under the Demonstration. MNPMP is a useful tool as more providers deliver MAT. Providers reported that it is beneficial as they can see patients' history of controlled substance use. However, another group of treatment providers reported that they do not usually prescribe controlled substances for their patients in treatment programs, so they have not been impacted by the use of MNPMP. One provider added that disruptions in service delivery due to COVID had limited their use of the MNPMP system.

> Providers are reporting back that it's useful to them, so that they get the history that they were looking for. You know, sometimes people will come in and they're not always truthful about what they're being prescribed and how much. So, we'll get people that don't have the prescriptions at all, so it's been very useful.
>
> - Provider

Achievement of Milestone 5 in Minnesota is also related to the history of SUD treatment in the state and the importance of the Minnesota Model that relies on a philosophy of abstinence only. One provider reported that the biggest change has been that their program was built on abstinence, *"It's a very big culture change for our organization, and I have some staff that are doing fine and some that are not."* As a result, the implementation of the Demonstration and adoption of ASAM-criteria required some providers to re-evaluate their core philosophy and missions when serving individuals with SUD/OUD.

Providers offered mixed perspectives on the use of MAT and their practice for using this treatment in their facilities. Providers discussed some reservations with using MAT for OUD, given the history of the Minnesota Model and the stance of some providers regarding abstinence. Other providers discussed the benefits that they have seen with its use. One provider stated that they will use Suboxone for MAT at their facility but not methadone. They discussed that there was some pushback by MARRCH regarding the use of methadone for MAT at facilities. Most providers stated that there has not been a change in the expansion or capacity of MAT for OUD and client access to MAT at their facility, as they are continuing the same practice prior to the Demonstration. They noted the availability of resources and referrals for MAT within the Minneapolis area and the challenge of resources in rural areas of Minnesota. Others reported a change in culture and practices. One provider reported that they began partnering with a 24-hour on-call prescriber.

MN DHS acknowledged the ongoing discussion with providers regarding MAT policy. There was resistance by some providers to use medications, such as methadone and

Suboxone for MAT. After discussion with interested members of the legislature regarding MAT and providers' participation, especially those providers who were reluctant to support the use of MAT, a plan was developed for those providers to refer patients to other facilities that do offer MAT. MN DHS also provided education regarding the benefit of MAT and how the lack of MAT can exacerbate racial disparities. DHS held a workshop that consisted of health care administration, community, and support administration to review the current Opioid Treatment Program (OTP) model.

Progress towards Milestone 6: Improved Care Coordination and Transitions between Levels of Care

Milestone 6 focuses on implementing policies to ensure that residential and inpatient facilities link patients, especially those with OUD, with community-based services and supports following facility stays.

In the Implementation Plan, MN DHS described its process to establish requirements for participating SUD providers, which it anticipated publishing by October 2020. The Implementation Plan notes that the guidance would emphasize treatment coordination to support transitions between levels of care and would require participating providers to have referral agreements demonstrating that residential providers can coordinate care within all ASAM levels of care. Providers would also be required to offer peer recovery support services. These care coordination requirements would be subject to oversight through the state's UM reviews.

Implementation Plan Action Items

The state identified six action items needed to achieve Milestone 6 (Exhibit 19 below).

Exhibit 19. Milestone 6: Improved Care Coordination and Transitions between Levels of Care

Action Item	Process Indicator	Description
6.1 Providers electing to participate provide verification of formal referral arrangements to ensure access to each of the ASAM levels of care	22 unique providers with 86 locations	To be enrolled, providers complete the Provider Referral Arrangement Agreement (PRAA) and agree to ensure access to each ASAM LOC.
6.2 Implement training and technical assistance to align providers with ASAM-based standards	**Training:** • 6 Webinars • 1 Public Comment • 6 Sessions of Enhanced Professional Learning (EPL) series	Minnesota offers ongoing trainings to providers regarding the ASAM criteria. MN DHS reported the number and types of training and provider attendance from

Action Item	Process Indicator	Description
	• 862 Providers participated in ASAM trainings	November 2020 – September 2021.
	Technical Assistance: • 28 office hours conducted • 432 questions asked by providers via Question Log • 133 Providers in attendance of office hours	Minnesota offers technical assistance to providers. MN DHS reported the number and types of technical assistance and provider attendance from November 2020 – September 2021.
6.3 Update MCO contracts to reflect any necessary residential provider requirement changes	8 MCO contracts updated	Minnesota has updated MCO contracts to cover residential treatment provider requirements.
6.4 Publish ASAM-based service standards and staffing requirements in MHCP provider manual	Published the MHCP provider manual	Minnesota published the ASAM-based service standards and staffing requirements in the MHCP provider manual online in October 2020 and there are ongoing updates.
6.5 Develop residential treatment provider review process and initiate ongoing monitoring process	8 MCO contracts updated and Kepro implemented utilization management on July 1, 2021.	Minnesota has updated MCO contracts to cover residential treatment and provider utilization reviews are now ongoing through Kepro.
6.6 Communicate changes to providers	See action item 6.2	Training and technical assistance represent targeted and ongoing communication with providers regarding changes occurring to implement the Demonstration.
	MN DHS reports making 157 web updates related to the Demonstration and disseminated 15 eMemos to providers.	MN DHS' website serves as the primary communication channel/mechanism for informing providers about the Demonstration and training and TA opportunities. Changes are ongoing and the state uses website metrics data to track changes related to the Demonstration.

The actions needed for Minnesota to achieve Milestone 6 consist of six action items identified previously for Milestones 1, 2, and 3. They address establishing referral arrangements, providing training and technical assistance for providers, reviewing and monitoring residential treatment providers, and communicating with providers. Taken

together, these action items result in coordinated care for SUD/OUD patients. Stakeholder input on care coordination is discussed below.

Stakeholder Input

Per MN DHS, one of the state's motivations for pursuing the Demonstration was to provide patients with the right level of care at the right time. MN DHS reported providing technical assistance to enrolled providers about medical consultations and referrals, based on the new requirement to refer patients to physical health providers. Regarding mental health, enrolled providers were able to leverage existing relationships with psychiatrists and mental health clinics, including a Certified Community Behavioral Health Clinic (CCBHC), but under the Demonstration the referral must be completed within 24 hours.

Providers are required to have a patient or program outreach plan that explains how outreach to the community for awareness of their services will occur and documents what types of relationships the provider has established to build out ancillary services such as housing and urgent care. According to MN DHS, the outreach plan requirement was discussed with providers during office hours.

Some providers believed improved care coordination through the Demonstration could result in improved outcomes for patients. Some providers mentioned their ongoing efforts to build direct partnerships and referrals with other organizations for services like residential and psychiatric care. One explained, "*I like working with other organizations. I think it strengthens our field. I also—you know, I think this will be a good move for client care. I think clients will benefit. I hope it improves outcomes, just having different levels of care and, you know, requiring those levels, especially step-downs and things like that. I think the outcomes should increase.*"

Provider Availability Assessment

Since the start of the Demonstration, MN DHS has enrolled 22 providers with 86 locations, although we cannot determine the full-time equivalent personnel available, per the preceding discussion on the payment system in Minnesota. Following the formal PCA completed in December 2021, MN DHS has recognized the need to develop a system to track data more easily on individual SUD providers within the participating organizations and to report whether a participating SUD facility accepted new Medicaid clients.

MN DHS has increased the availability of services through other initiatives, including training and guidelines, and policies related to telehealth reimbursement that complement the Demonstration. In March of 2020, through an emergency waiver in response to the COVID-19 pandemic, the Commissioner sought to modify its SPA and obtained approval from CMS to do so in April 2020; the modifications included expanding access to mental

health and SUD treatment until further amended.[x] These changes allow for assessments for SUD services to be conducted via telephone or other electronic means and expanded the types of providers eligible to provide services. Prior to this wavier, audio-only was not allowed, and audio-only technology for medications for OUD has the support of the American Psychological Association as an effective means of engaging clients in treatment.[17] Allowing nurse practitioners and physician assistants is particularly important for expanding access to buprenorphine and have shown to be responsible for a majority of the buprenorphine prescription growth among patients with Medicaid and individuals living in rural areas where access to treatment is lacking.[18,19,20] Below we list specific ways that the waiver will affect care delivery, and although these include provisions that will affect not only SUD services, they are a valuable means to expand access to them.[21] These include:

- allow for the originating site to be the patient's home;
- allows for telephonic delivery for all providers who have a telemedicine agreement in place;
- lifts the requirement that the first telemedicine visit occur after a patient-provider relationship is established in-person and face-to-face
- lifts the cap on the number of telemedicine visits per week (previously capped at three);
- allow for required encounters for targeted case management may be conducted by telephone or other electronic means;
- allow the following types of rehabilitative providers to provide services via telehealth, including via telephone: alcohol and drug counselors, alcohol and drug counselor temps, recovery peers, student interns, mental health certified peer specialists, mental health certified family peer specialists, and adult rehabilitation mental health workers, and mental health behavioral aides operating in Children's Therapeutic Services and Supports programs;
- allow for federally qualified health clinics (FQHCs), rural health clinics (RHCs), and Indian Health Service (IHS) and 638 providers that are providing services eligible for an encounter payment, to provide services via telehealth, including telephone, as if they were in-person encounters;
- allow group therapy to be provided via telehealth, including via telephone.

In addition, the state made progress on policies to expedite credentialing of mental health providers to deliver telehealth services, including implementing the federal policies around buprenorphine prescribing. The SPA amendment also allows for 90-day refills without prior authorization for certain maintenance drugs. While the emergency waiver has ended the Behavioral Health Department intends to put the waiver this into legislation so that they can continue the telehealth services after the current waiver expires in June of 2023. The state will complete a study on telehealth services (per legislative mandate) in January of 2023 that will inform policy decisions ahead of the June 2023 expiration date.

[x] State Plan Amendments (SPA) #20-0003 and #20-0004. Approved April 20, 2020

In the next section, NORC discusses overall progress to the capacity building activities around MAT prescribing that are described under Milestone 5, including provider educational and training activities and the use of State Opioid Response (SOR) Grant funds to expand training. Part of the SOR Grant funds Project ECHO. The Project ECHO program began before the Demonstration in 2017 with three hubs and has grown to five as of 2021. The state conducted a formal evaluation of the program in 2020. During the evaluation study period, January 1, 2018 to June 30, 2020, the project had trained 1,070 individual Medicaid providers eligible for DATA waivers (physician assistants, nurse practitioners, and certified nurse specialists). Evaluation results showed that training increased the number of providers who obtained a DATA-waiver by 17 percent and importantly increased the *active use* of DATA-waivers (i.e., prescribing buprenorphine). Through this process, Minnesota is working to expand access to MAT and improve quality of services across the state.

Assessment of Overall Risk of Not Meeting Milestones

Exhibit 20 shows the summary assessment for each metric. We find low risk for half of the milestones, and there is insufficient data to determine any linear trends for all metrics used to assess the milestones. For Milestone 1, providers are performing SBIRT for early intervention and outpatient services. However, they need more training on billing. With regard to Action Item 1.4, issues remain regarding the provision of outpatient care beyond 19 hours. The state is working on a legislative proposal to expand the 19-hour cap to facilitate the transition from the Minnesota Matrix to ASAM in the coming years. For Milestone 4, the number of providers included in the monitoring metrics may underestimate the count of available prescribers of buprenorphine. This is because the claims-based metric reflects the counts of locations, rather than individual prescribers at locations. The absolute changes in the metrics used for Milestone 5 (apart from overdose death rates) and 6 are very minimal. Those small changes in the metrics coupled with the progress the state made in the completion of its action items resulted in an assessment of medium risk for the state failing to meet Milestones 5 and 6. The state continues to implement many initiatives to increase access to SUD.

The state is aware that overall provider capacity has been affected by workforce shortages and challenges created by the pandemic. For examples, SUD providers in Minnesota discussed their experiences of staffing shortages during the COVID-19 pandemic that resulted in administrative burden and challenges related to meeting requirements of the Demonstration. The increase noted for service utilization metrics (i.e., outpatient, inpatient, and withdrawal management services) may be in response to elevated need related to the COVID-19 pandemic. The increase in all-drug overdose and opioid overdose mortality is true of nationwide trends in overdoses, mostly driven by easier access to more lethal drugs. In 2020, preventable deaths by drug overdose increased by 27 percent amongst Minnesotans[22]. This is an increase from 792 deaths in 2019 to 1,008 deaths in 2020.[23] These numbers are consistent with the national trends. Although the true impact that the

pandemic played on preventable deaths by drug overdose cannot be determined, it is likely that stressors associated with the pandemic played a part in the rise of overdose mortality.

The state is aware that overall provider capacity has been affected by workforce shortages and challenges created by the pandemic. For examples, SUD providers in Minnesota discussed their experiences of staffing shortages during the COVID-19 pandemic that resulted in administrative burden and challenges related to meeting requirements of the Demonstration. The increase noted for service utilization metrics (i.e., outpatient, inpatient, and withdrawal management services) may be in response to elevated need related to the COVID-19 pandemic. The increase in all-drug overdose and opioid overdose mortality is true of nationwide trends in overdoses, mostly driven by easier access to more lethal drugs. In 2020, preventable deaths by drug overdose increased by 27 percent amongst Minnesotans[xi]. This is an increase from 792 deaths in 2019 to 1,008 deaths in 2020[xii]. These numbers are consistent with the national trends. Although the true impact that the pandemic played on preventable deaths by drug overdose cannot be determined, it is likely that stressors associated with the pandemic played a part in the rise of overdose mortality.

State Response

The State would like to thank NORC for their thorough evaluation of the Demonstration implementation. While the Demonstration is in year 3 of the State's 5-year commitment to CMS, the State in actuality has implemented the majority of the Milestone components in the last 15 months. The evaluation by NORC reflects the progress of the Demonstration as well as the areas of focus and improvement for the next two years. The State will use the space below to identify steps that they have taken and will take to improve the Demonstration's implementation and effectiveness in preparation for an extension application.

Milestone 1: Access to Critical Levels of Care for OUD and Other SUDs

According to the State's approved Implementation Plan's Milestone 1, the State must incorporate ASAM 2.1 Intensive Outpatient into the state plan by January 2022. There is currently pending legislation that will define 1.0 Outpatient and 2.1 Intensive Outpatient within state statute. This pending definition focuses on service duration within each level of care and does not include the other service requirements from the ASAM Criteria. This will be a first step in the process of fully implementing the ASAM Criteria into Minnesota statute.

The State acknowledges the delay in implementing the milestone goal, however, the implementation process revealed significant gaps and misalignments between the ASAM Criteria for 1.0 and 2.1 and state statute. Following the Implementation Plan as stated

[xi] Minnesota drug overdose deaths jumped in pandemic year. (2021, May 3). Cloquet Pine Journal. https://www.pinejournal.com/newsmd/minnesota-drug-overdose-deaths-jumped-in-pandemic-year

[xii] Centers for Disease Control and Prevention. (2020). Coronavirus Disease 2019. https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html

would have created two systems of care for Medicaid beneficiaries in Minnesota. The misalignment would limit Medicaid beneficiaries' access to care and create inequitable standards, not in line with the goals and objectives of the Demonstration nor Medicaid as a whole.

To remedy this the State is conducting a gap analysis reviewing all levels of care compared to current state statute. Once the gap analysis is completed, the State will gather external and internal stakeholder input and develop a more robust plan to align all Minnesota state statute with ASAM. The State believes the adjusted action will expand access to the full SUD continuum of care for Medicaid beneficiaries and is more supportive of the Demonstration's goals and objectives than the initially approved Implementation Plan milestone.

Milestone 2: Use of Evidence-Based, SUD-Specific Placement Criteria

Although NORC has not labeled Milestone 2 as medium or high risk, the State would like to comment regarding on-going work. The State is working on developing robust training opportunities to support providers at any level of experience and comfort with the ASAM Criteria. The State is using early adopter feedback on previous trainings in an effort to build on lessons learned and expand access to a variety of ASAM trainings. The goal is to have ASAM training for all levels of understanding, implementation, program size, and geographic needs.

The State received numerous comments on the struggles providers experienced with the roll out of utilization management (UM). The state recognizes that the rollout was rushed. The State and the UM vendor are examining sustainable models for all Minnesota SUD providers, discussed further in Milestone 4 and Milestone 6.

Milestone 3: Use of Nationally-Recognized SUD-Specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities

Milestone 3 is another area NORC did not label as high or medium risk. The State, however, would like to address part of the milestone, specifically section 3b, implementation of state process for reviewing residential treatment provider compliance with standards. The Implementation Plan indicates the State will have a clinical review process conducted by the State's Licensing Division in place by July 1, 2021. The State identified that this role would be better placed in the Behavioral Health Division given the clinical focus. Due to administrative challenges, including division changes, hiring freeze, and staff on-boarding, there were further delays to the residential review process.

The review process was created in January 2022 with a planned implementation date of July 2022. In this review process, the State will assess clinical documentation and evidence to assure providers enrolled in the Demonstration have taken meaningful steps to implement the ASAM Criteria.

Milestone 4: Sufficient Provider Capacity at Critical Levels of Care Including for Medication-Assisted Treatment for Opioid Use Disorder

The State continues to address and work on implementation concerns for Milestone 4. During the time of this evaluation, the State has implemented an interim utilization management process that reduces the workload burden of enrolled providers while maintaining consistent clinical feedback. Through listening sessions with SUD providers the State is gathering provider input in collaboration with Kepro, the UM vendor, to develop an improvement plan for a sustainable UM system.

The State has also implemented changes to the enrollment process, which has shortened the wait time to enroll. This updated process uses virtual meetings in addition to drop-in technical assistance sessions to give providers face-to-face time with the Demonstration Team.
Additionally, the State has added the Clinical Review Specialist, also discussed in Milestone 3 of the State Response, to help with enrollment technical assistance. To prevent delays in the demonstration provider enrollment process, two additional staff resources (the Operations Lead and Supervisor) are also assisting with enrollment. The State continues to explore further improvements and application adjustments.

Milestone 5 Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD

The State continues to share and educate providers about federal resources for access to MAT. The State shares SAMHSA resources for methadone take-home supplies as they meet with providers to discuss enrollment in the Demonstration and possibly barriers to MAT access. The State will expand these education efforts as part of the on-going Demonstration training. MNPMP was not expanded as indicated in the Implementation Plan (Action Item 5.2). DHS did not have a role in this decision, as a separate state agency runs the MNPMP. The Covid-19 pandemic likely played a role in this decision. The State would also like to note the federal changes in buprenorphine prescription likely expanded access to MAT, however, this metric is not tracked specifically within the Demonstration; therefore, the available metrics may not reflect the full effects of recent policy changes.

Milestone 6: Improved care coordination and transitions between levels of care

The State is actively addressing the concerns in Milestone 6. As identified in the State's response to Milestone 1 and Milestone 4, the State is working on continuous quality improvement for the UM process. This process involves collaborative stakeholder feedback with the UM vendor. As of March 1, 2022, the percentage of FFS MA and BHF cases reviewed dropped from 100% to 30% for residential and withdrawal management levels of care and 15% for outpatient levels of care. This was to reduce the paperwork burden on providers. The State and UM vendor are reviewing an updated placement grid that would allow for more alignment with the ASAM Criteria. Additionally, the State would like to

acknowledge the implementation of the Direct Access process July 1, 2022. This process while outside the Demonstration will support the State's movement towards the ASAM Criteria for SUD treatment. The core components of Direct Access include: sun setting the Minnesota Matrix, guaranteeing client choice, and reducing the wait to access care.

State Response Next Steps

The State is working on updates to the Implementation Plan to reflect lessons learned. According to Minnesota statute, the State must apply for a Demonstration extension. With this extension, the State plans to expand the scope of the Demonstration to incorporate lessons learned and improve care in Minnesota. The State intends to begin drafting the extension beginning in early state fiscal year 2023 (July 1st, 2022) and will approach CMS for any technical assistance needs. The State believes the planned changes and modifications will address the medium risk milestones, prepare the state for residential and withdrawal management provider mandated enrollment upon CMS approval, and achieve CMS's six goals and objectives.

Exhibit 20. Summary of Mid-Point Assessment of Overall Risk of Not Achieving Demonstration Milestones

Milestone	% fully completed action items	% monitoring metric goals met	% critical monitoring metric goals met	Key themes from stakeholder feedback	Risk level	NORC recommended modifications	State response and planned modifications
Milestone 1	100% (3/3)	71% (5/7)	60% (3/5)	• Providers confirmed clients mostly had access to ASAM critical levels of care before the Demonstration, with the exception of withdrawal management or detox services. • State administrators and providers recognize the need to support small and rural providers for mandatory participation	Low	--	--
Milestone 2	100% (5/5)	50% (1/2)	50% (1/2)	• The state has provided diverse opportunities for training and TA but providers still want additional support. • State administrators worked with 8 early adopters to improve implementation. • Providers felt unprepared for the UM roll out.	Low	--	--
Milestone 3	83% (5/6)	N/A	N/A	• Concerns from providers about the impact of the Demonstration led to legislation that mandated provider participation and increased reimbursement rates.	Low	--	--
Milestone 4	100% (3/3)	33% (1/3)	0% (0/2)	• Providers report increasing capacity to deliver 24 hour mental health and medical services. • The administrative burden of Demonstration participation is a concern, especially with the new UM process. • State administrators recognized the need for additional provider-level data to monitor state capacity.	Medium	The state should consider • efforts to improve provider-level data • continuing onboarding and training providers. • additional legislation to preserve reimbursement increases to support delivery system infrastructure.	See State Response above

Milestone	% fully completed action items	% monitoring metric goals met	% critical monitoring metric goals met	Key themes from stakeholder feedback	Risk level	NORC recommended modifications	State response and planned modifications
Milestone 5	33% (1/3)	66% (2/3)	50% (1/2)	• Providers report a shift in attitudes toward MAT that aligns with the Demonstration. • Providers report that the MNPMP is helpful but not all are using it regularly. • Some providers noted that due to their location their clients could not access OTP clinics offering methadone.	Medium	The state should • identify continued supports for the increase in providers prescribing and monitoring MAT use. • continue to use Project ECHO to expand rural access to MAT. • consider a separate assessment of the impact of emerging opioid trends on Demonstration outcomes such as overdoses per 100,000 Medicaid beneficiaries.	See State Response above
Milestone 6	100% (6/6)	0% (0/5)	0% (0/4)	• Providers report that care coordination in MN is good but the Demonstration offered a chance to rethink coordination with mental and physical health providers to improve access to care and patient outcomes. • Providers expressed concerns regarding the assessment and placement for residential services, given that the Minnesota Matrix and the ASAM criteria were not fully aligned. • Providers discussed administrative burdens and the delay in the UM process, so this reduced their capacity to monitor progress. • State administrators acknowledge gaps in state statutes for ASAM standards for hours of outpatient (1.0), intensive outpatient (2.1) and partial hospitalization (2.5)	Medium	The state should consider: • leveraging the Evaluation Workgroup to assess challenges to in care coordination. monitoring metrics • ensuring all Demonstration providers are properly trained and supported on the UM process and documentation. • legislation that aligns state regulations for intensive outpatient treatment and residential treatment.	See State Response above

Assessment of State's Capacity to Provide SUD Services

State Capacity to Provide SUD Services at Mid-Point

Per Milestone 4, MN DHS is using the monitoring metrics to track the number of providers who are enrolled in Medicaid and qualified to deliver SUD services, and specifically, those who can provide buprenorphine or methadone as part of medication for OUD. To help ensure providers achieve ASAM guidelines, in quarter four of Demonstration Year 2, the state developed and published SUD treatment service requirements, assessment and placement criteria, and staffing requirements consistent with the ASAM Criteria. Additionally, the state wrote a MAT policy aligned with ASAM and SAMHSA guidance, for all SUD providers participating in the Demonstration, including non-residential. The State included the Demonstration rate enhancements in 2021 MCO contracts.

In June of 2020, NORC, as the independent evaluator, conducted a baseline PCA for the state, using data from the one-year period prior to the start of the Demonstration, which provided a starting point for the state to understand how many providers (organizations) and services were available to Medicaid clients with SUD. In the baseline PCA, NORC identified the number of organizations and prescribers of buprenorphine and naltrexone that Medicaid clients utilized for SUD treatment, including MAT for OUD. As the data were from the baseline, NORC refers CMS to that report but highlights some key takeaways and next steps below.

In Minnesota, exclusive of prescriptions for medications, provider *organizations* submit claims for services, but there is no process to determine the number and type of health care personnel who are employed in those organizations. Thus, although claims are useful for identifying how much and where clients are seeking care, they cannot be used to create ratios of clients per provider, since a provider is an organization with an unknown number of staff members that may provide SUD services. Moreover, an organization may be classified under more than one type of provider, for example, as both a Community Mental Health Center and as a Chemical Health provider, which can hamper efforts to describe the specific number of each type of provider.

Thus, while MN DHS has some information on the ratios of clients to each provider, a provider may have a varying number of personnel. For example, the baseline PCA found that while community mental health centers provided clinically managed withdrawal management services to an average of nine clients per provider, the centers ranged from providing these services to between 1 and 406 clients. Chemical health providers provided treatment coordination to an average of 31 clients each (ranging from 1 to 492 clients per provider). Consolidated provider organizations provided considerably different number of outpatient treatment group services, with a range of one to 52,253 services per provider.

Prescription claims data do allow for MN DHS to determine the number of clients per unique prescriber. There was an average of 17 patients per waived prescriber, with a maximum of 210. This reflects variation in patient waiver limits, and presumably, in provider comfort and capacity in prescribing an addictive substance, as well as patient preferences. However, IHS facilities provided prescriptions to an average of 62 unique clients, potentially indicating a higher burden for these providers, although the number of individual practitioners working at these facilities cannot be ascertained with the data. The range of services provided for each type of service varied among provider types. For example, with outpatient treatment services, hospital providers rendered between two and 11,915 services per provider, compared to chemical health providers, who rendered between one and 106,218 services per provider. The range was likely affected by the number of individual practitioners working for each provider, for which NORC does not have data.

MN DHS cannot assess capacity vis-à-vis a benchmark for ideal provider capacity (e.g., ratios of practitioners per 1,000 beneficiaries with SUD) for SUD services, as such guidelines at the state level are not available nor are they proscribed by the ASAM. The state and ASAM also do not offer guidelines on the specific staffing mixtures for each level of care to determine what sufficient capacity means. A different approach to determining sufficiency of capacity may be to look at trends in the proportion of beneficiaries expressing an unmet need for SUD treatment. However, currently there are no state-level sources of data on the proportion or number of Medicaid beneficiaries who express an unmet need for SUD treatment.

Changes in Minnesota Capacity

To increase capacity, MN DHS is using grant funds to conduct trainings on OUD treatment (such as the training sessions delivered through Project ECHO) for providers on pain management and OUD treatment. In addition, MN DHS is working with provider and stakeholder groups who have concerns related to MAT, with respect to accepting clients who are using methadone (providers had concerns about methadone use in residential group settings and with access and “take home” supplies from clinics). The state reached an agreement with providers wherein providers must have two types of MAT (an antagonist and a partial agonist) in alignment with the SUPPORT Act.[xxiv] This allows behavioral health patients to taper off MAT as medically appropriate, rather than a program-wide policy that may exclude them from care-seeking. As discussed earlier, the expansion of the modalities (to include audio-only), the types of providers eligible to delivery SUD services via telehealth, and the changes in federal regulations that ease prescribing requirements (i.e., longer refills and allowing beneficiaries to have a telehealth visit with a doctor before receiving a prescription refill) will help meet the needs of all Medicaid beneficiaries.

Identified Needs for Additional Capacity

As discussed above, one the key takeaways from the baseline PCA was the need to understand unique personnel at organizations, and the credentials, or staffing mixture. To

date, the sufficient or appropriate levels have been determined by states, not by the ASAM, and consider both availability of providers in a geographic region and driving distance to these regions.

Going forward, it may interest the state to work with provider groups and stakeholders to determine a process to collect data on the number of individual providers at organizations, their eligibility to provide each level of SUD service in the ASAM guidelines, their acceptance of Medicaid patients, and driving distances. For example, the state could work with providers and MCOs to verify a certain minimum number of providers, such as comprehensive Alcohol and Drug treatment providers, in Prevention Regions.[13]

MCOs may also have the capability to provide these data, including lists of qualified practitioners (physicians, nurse practitioners, physician assistants, clinical nurse specialists, certified registered nurse anesthetist, and certified nurse-midwifes) with a waiver to prescribe buprenorphine. MN DHS can work with MCOs to identify an acceptable process for collecting this information, and frequency of reporting it.

13 Minnesota has seven Prevention Regions, with Coordinators that each create a system of support services for people and organizations to engage in addressing the root causes of substance abuse.

Next Steps

Overall, using the criteria provided by CMS, NORC assessed three milestones as a low risk of the state not reaching the milestone (Milestones #1, #2, and #3) and three milestones as medium risk of the state not reaching the milestone (Milestones #4, #5, #6). It is important to note that the completion of some action items related to the Demonstration is dependent on the legislative process. Specifically, there is existing legislation that will define Outpatient 1.0 and Intensive Outpatient 2.1 within state statute. The section below provides a summary description of the milestones assessed as medium risk and the state's current and proposed actions for improving progress on these milestones.

Milestone 4: Sufficient Provider Capacity at Critical Levels of Care Including for Medication-Assisted Treatment for Opioid Use Disorder.

For both critical monitoring metrics around provider availability, there was a decrease in availability based on the available data. However, it is important to note that this observed reduction in providers may not accurately reflect the available number of prescribers of buprenorphine (i.e., the number of beneficiaries on MAT increased). This is due to the claims-based metrics reflecting provider organizations, rather than individual prescribers and is described in the section directly above. MN DHS completed all of the action items associated with this milestone.

To improve progress towards Milestone 4, MN DHS has implemented an interim utilization management process that reduces the workload burden of enrolled providers and allows for consistent clinical feedback. Through listening sessions with providers, MN DHS is gathering provider input in collaboration with Kepro, the UM vendor, to develop an improvement plan for a sustainable UM system. MN DHS has also implemented changes to the enrollment process, which has shortened the wait time to enroll. This updated process uses virtual meetings in addition to drop-in technical assistance sessions to give providers face-to-face time with the MN DHS Demonstration team. Additionally, the MN DHS team has added a Clinical Review Specialist, also discussed in Milestone 3 of the State Response, to help with enrollment technical assistance. The Operations Lead and Supervisor are also assisting with enrollment. The State continues to explore further improvements and application adjustments.

Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD.

For the four critical metrics related to OUD and opioid abuse treatment and prevention, there was insufficient data for two of the metrics (NORC reported on metrics that had at least 11 observations for the first and last quarter of the assessment). For another metric—concurrent use of opioids and benzodiazepines—there was a decrease, and MN DHS made progress on this metric. For the fourth critical metric—overdose death rate per

100,000 Medicaid beneficiaries—there was in increase in this metric. MN DHS also completed 1 of 3 of the action items associated with this milestone.

To improve progress towards Milestone 5, MN DHS continues to share with and educate providers about federal resources for access to MAT. Specifically, MN DHS shares SAMHSA resources for methadone take-home supplies as they meet with providers to discuss enrollment in the Demonstration and potential barriers to MAT access. MN DHS will expand these education efforts as part of the on-going Demonstration training. MN DHS acknowledges that the federal changes in buprenorphine prescribing likely expanded access to MAT, however, this metric is not tracked specifically within the Demonstration; therefore, the available metrics may not reflect the full effects of recent policy changes.

MNPMP was not expanded as indicated in the Implementation Plan (Action Item 5.2). DHS did not have a role in this decision, as a separate state agency operates the MNPMP. The COVID-19 pandemic likely played a role in this decision.

Milestone 6: Improved care coordination and transitions between levels of care.

For the four critical metrics related to care coordination and transitions, the available data indicated a decrease in both the percent of initiation and engagement of alcohol and other drug dependence treatment, the follow-up after emergency department visit for alcohol or other drug dependence, and the follow-up after emergency department visit for mental illness. There was also an increase in readmissions among beneficiaries with SUD. It is important to note that the absolute changes in the metrics used for this milestone are very minimal. MN DHS also completed all 6 of the action items associated with this milestone.

To improve progress towards Milestone 6, as identified in MN DHS's response to Milestone 4, MN DHS is working on continuous quality improvement for the UM process. This process involves collecting collaborative stakeholder feedback with the UM vendor. As of March 1, 2022, the percentage of FFS MA and BHF cases reviewed dropped from 100% to 30% for residential and withdrawal management levels of care and to 15% for outpatient levels of care. This shift was to reduce the paperwork burden on providers. MN DHS and the UM vendor are reviewing an updated placement grid that would allow for more alignment with the ASAM Criteria. Additionally, MN DHS would like to acknowledge the implementation of the Direct Access process July 1, 2022. This process—while outside the Demonstration—will support the movement towards implementation of the ASAM Criteria for SUD treatment. The core components of Direct Access include sun setting the Minnesota Matrix, guaranteeing client choice, and reducing the wait to access care.

Attachment A. Independent Assessor Description

NORC at the University of Chicago (NORC) will conduct all activities to fulfill the evaluation requirements of Minnesota's SUD System Reform Section 1115(a) Demonstration Project. Since its founding in 1941, NORC has become a pivotal organization for national and global exploration and reflection. Working closely with NORC partners and clients, NORC has shaped the questions, gathered and analyzed the data, and derived the insights that have allowed governments, nonprofit organizations, businesses, and citizens around the world to make more informed public and personal decisions about issues ranging from health care and education to economic development and the workforce. In the process, NORC has also been one of the leading innovators in research methodology and the adoption of new technologies that have helped shape the field of modern research and set the standard for rigorous, culturally sensitive, transparent, and unbiased inquiry into the most pressing issues facing society.

Attachment B. Key Informant Interview Protocols

Enrolled Provider Focus Group Protocol

Minnesota 1115(a) Substance Use Disorder System Reform Demonstration Project
Evaluation Planning Phase

Introduction and consent

- Introduce facilitators.
- Thank you very much for your time today.
- The purpose of our conversation today is to collect information for Minnesota's 1115(a) Substance Use Disorder System Reform Demonstration Project
- We have to cover a few ground rules before we get started.
    - We've scheduled this meeting to last 90 minutes. If you need to stop for any reason, that's fine. We know you are busy, and your participation is voluntary.
    - It is okay for you not to answer any question if you don't want to.
    - We won't share anything you have to say as coming from you personally but given the small number of participants in this study, we cannot guarantee your confidentiality.
- Do you have any questions before we begin?
- We do have a member of our team taking notes so we can write our report, and we are recording this to make sure we get everything. The notes and recording will only be used by NORC to write our report. Is that okay?
- Do you consent to participate in this interview?

Participant Introduction

1) First, let's go around the virtual room and tell us briefly the name of the organization you are with, your current job title and professional background, and how you are directly involved in implementing the SUD Demonstration waiver.

General Effects of the Waiver

2) First, why did your organization decide to participate in the Demonstration project?
3) In general, how did you expect to see the waiver affect substance use disorder and opioid use disorder treatment across the state, if at all? Have you been surprised by any changes due to the waiver?

4) To date, how has the waiver program and preparation for the new requirements affected service delivery by your organization?
   a. Client assessment and placement (capacity)
   b. Staffing
   c. Partnerships
5) For residential treatment providers, what has been the impact of the waiver and proposed changes to provider qualifications based on national standards?
6) Has your participation in the Minnesota Prescription Monitoring Program changed?

Training and Technical Assistance

7) In order to achieve the Demonstration milestones, Minnesota is providing training and technical assistance for providers and updated guidance, what kinds of training and resources have you received? Have you found them helpful?
8) What additional types of assistance/support would be helpful to you as you continue to move forward with your alignment efforts?

Success and Challenges

9) What have been some of the successes to date regarding these new programs or services?
   Probes:
   a. Improved alignment with ASAM criteria
   b. Improved client access to critical levels of care for OUD and SUD , care coordination and care transitions
   c. Coordination of care with MCOs to ensure access to evidence-based SUD placements
   d. Expansion of capacity to deliver MAT services for OUD and client access to MAT

10) What factors do you think will affect further progress toward meeting the state's SUD milestones?
    Probes:
    a. Provider capacity
    b. Regulatory environment
11) Has the waiver affected the stability or sustainability of your organization? How? Are there any other additional changes you are considering?
12) Is there anything else about the waiver you would like to discuss?

State Administrators/Staff Interview Protocol

Minnesota 1115(a) Substance Use Disorder System Reform Demonstration Project
Evaluation Planning Phase

Introduction and consent

- Introduce facilitators.
- Thank you very much for your time today.
- The purpose of our conversation today is to collect information for Minnesota's 1115(a) Substance Use Disorder System Reform Demonstration Project
- We have to cover a few ground rules before we get started.
    - We've scheduled this meeting to last 1 hour. If you need to stop for any reason, that's fine. We know you are busy, and your participation is voluntary.
    - It is okay for you not to answer any question if you don't want to.
    - We won't share anything you have to say as coming from you personally but given the small number of participants in this study, we cannot guarantee your confidentiality.
- Do you have any questions before we begin?
- We do have a member of our team taking notes so we can write our report, and we are recording this to make sure we get everything. The notes and recording will only be used by NORC to write our report. Is that okay?
- Do you consent to participate in this interview?

Background

1) Can you please briefly describe why the state of Minnesota decided to pursue an 1115 SUD waiver?
2) We are interested in the goals and milestones that were established before recent legislative developments. What, if any, additional amendments or changes are needed to the existing waiver? E.g., adding partial hospitalizations.
    a. Can you describe the next steps for the state?
3) What is the status of legislative initiatives that affect the implementation of the 1115 SUD Demonstration Waiver?
    a. Probes:
    b. Residential treatment
    c. Reimbursement rates
4) What, if any, other administrative changes are needed and have they started too?

Implementation

5) Next, we have some questions about the original goals and milestones.
6) What were some of the early internal successes with the waiver implementation (starting July 22, 2020)?
    a. Internal challenges?

   b. What is the status of state plan amendments (SPA)?
7) What is the status of the SPA on Screening, Brief Intervention and Referral to Treatment (SBIRT)?
8) For the SPA with SBIRT, what has the state done to prepare providers to deliver an initial set of services, such as individual or group treatment, care coordination, and peer support? Probes:
   a. Training and technical assistance (TA)
   b. Establish targets
   c. Update standards and staffing manuals
9) What were some of the early external successes with the waiver implementation?
   a. External challenges? (e.g. provider uptake)
10) Can you share a bit about the decision of the Certified Community Behavioral Health Clinics (CCBHCs) to not to participate in the initial phase of the Demonstration?
   a. What changes have been made in response?
11) Minnesota's implementation plan also describes efforts in the areas of quality improvement and workforce development. What is the status of those efforts?
12) What is the status of the development of the independent utilization review process for FFS and MA beneficiaries and the alignment with managed care organization (MCO) practices?
   a. What, if any, changes were needed to MCO contracts?

American Society of Addiction Medicine (ASAM) Criteria

13) What were the results of the assessment of the state's current evidence-based assessment policies and alignment with the waiver's American Society of Addiction Medicine (ASAM) placement criteria? Is the state proposing changes to the Minnesota Rules (9530.6622) or Statutes (245G.05)?
      i. Probes:
   b. Where did MN need to strengthen provider capacity to align with ASAM criteria?
   c. What, if any, changes are needed to the summary and documentation and the initial services plan?
14) How much training in the ASAM dimensions and levels of care has occurred?
   a. What is the status of the new provider manuals?
   b. What is the state's future plans?

Waiver Goals and Milestones

15) An important Demonstration milestone is the Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD. What is the status of efforts to clarify Opioid Prescribing Guidelines, improve pharmacy management, and educate providers?

16) A specific and related OUD goal of the Demonstration is to broaden access to medication-assisted treatment (MAT). What has happened in the state with regards to MAT prescribing since the initial Demonstration implementation began?
    a. How will the state use the Provider Capacity Assessment?
    b. How many mid-level providers have been authorized?
    c. During the pandemic, was access to MAT via telehealth expanded?
17) The Demonstration is also focused on care coordination. What, if any, work has begun with providers on training and TA about care coordination, or about monitoring of referral arrangements?
    a. What, if any, improvements have been made to technology to improve coordination (e.g., Omnibus Care Plan)?
18) What have been the lessons learned to date as the state implements the 1115 SUD Demonstration Waiver?
19) What are the challenges that the state will need to address to achieve all of its goals and CMS' milestones? Probe:
    a. Enrollment of providers who accept Medicaid
20) Is there anything that I haven't asked about implementation of the Demonstration that you would like to add?

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