STATE OF MINNESOTA
Office of Governor Tim Walz
Lt. Governor Peggy Flanagan
130 State Capitol ♦ 75 Rev. Dr. Martin Luther King Jr. Blvd. ♦ Saint Paul, MN 55155-1611

December 19, 2023

Xavier Becerra
Secretary of the Department of Health and Human Services
Hubert H. Humphrey Building, Room 120F
200 Independence Ave., S.W.
Washington, D.C. 20201

Re: Renewal of Minnesota's Section 1115 Waiver titled Minnesota Substance Use Disorder System Reform (No. 11-W00320/5)

Dear Secretary Becerra:

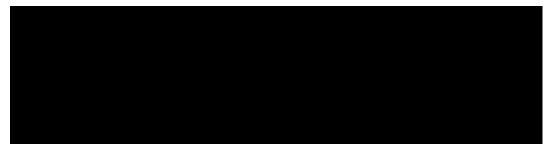
I am pleased to submit Minnesota's application to extend its Substance Use Disorder Reform § 1115 demonstration waiver through June 30, 2029.

The Minnesota Substance Use Disorder System Reform waiver is in fifth year of operation. The waiver is authorized under section 1115(a) of the Social Security Act. It supports Minnesota's continuum of services to provide the most effective substance use disorder (SUD) treatment based on the use of national standards, and permits federal funds while Medicaid beneficiaries are receiving SUD treatment in residential facilities. These funds provide critical aid to help address the onogoing opioid crisis and ensure recovery supports remain accessible to Minnesotans struggling with addiction.

The Substance Use Disorder System Reform waiver is currently approved through June 30, 2024. I am submitting this letter requesting that a waiver extension be approved for an additional five year period. While progress has been make in meeting the goals set forth in the waiver, more time is needed to fully implement the planned service continuum changes.

If you have any questions regarding this request, please contact Julie Marquardt, Interim State Medicaid Director at julie.a.marquardt@state.mn.us.

Sincerely,



Tim Walz
Governor

DEPARTMENT OF HUMAN SERVICES

Minnesota Substance Use Disorder System Reform

Section 1115 Waiver Demonstration Extension Request

12/19/2023

For accessible formats of this information or assistance with additional equal access to human services, write to dhs.info@state.mn.us, call 651-431-2000, or use your preferred relay service. ADA1 (2-18)

Contents

Minnesota Substance Use Disorder System Reform 1

Section I – Background and Historical Narrative 4

Background 4

Future Steps 6

Current Need 6

Figure 1: Opioid Overdose Deaths 7

Future Goals 12

Section II – SUD Waiver Extension 13

Extension request, change and expected outcome 13

Figure 2: Opioid Overdose Deaths by Race 15

Section III - Waivers and Expenditure Authorities 16

Current waiver expenditure authority 16

Section IV - Quality Assurance and Monitoring 17

Independent Evaluation 17

Section V - Evaluation Activities 18

Section VI – Demonstration Financing and Budget Neutrality 18

Table 1: Fee-for-Service 19

Table 3: Fee-for-Service and Managed Care 19

Table 4: Member Months 20

Institution for Mental Diseases, Fee-for-Service Months 21

Institution for Mental Diseases, Managed Care Months 21

Table 5: Per Member Per Month Projections 21

Institution for Mental Diseases, Fee-for-Service Per Member Per Month 22

Institution for Mental Diseases, Managed Care Per Member Per Month 22

Table 6: Fee-for-service Institution for Mental Diseases Medicaid Expenditure Group 23

Table 7: Managed Care Institution for Mental Diseases Medicaid Expenditure Group 23

Section VII – Public Notice and Comment Process Section 24

Public Notice 24

Public Hearings 24

Use of electronic mailing list or similar mechanism to notify the public 25

Tribal Consultation 25

Comments received by the state during the 30-day public notice period 26

Stakeholder Support 26

Post Award Public Forums 27

Section VIII – Demonstration Administration 27

Contact 27

Attachments

Attachment	Title	Page
Attachment A	Draft Interim Evaluation Report	28
Attachment B	State Register Notice	104
Attachment C	GovDelivery Notice	105
Attachment D	Tribal Letter	106
Attachment E	Public Comments	107
Attachment F	Letters of Support	122

Section I – Background and Historical Narrative

Background

The Centers for Medicare & Medicaid Services (CMS) approved Minnesota's Substance Use Disorder (SUD) System Reform waiver (waiver) for the period of July 1, 2019 through June 30, 2024. The waiver is managed by the Minnesota Department of Human Services (DHS) and operates under section 1115(a)(2) of the Social Security Act. This Medicaid demonstration authority provides federal funds for Medicaid beneficiaries receiving residential SUD treatment in facilities defined as an Institution for Mental Diseases (IMDs) under federal Medicaid law. This waiver request seeks to continue the waiver authority for five years. While progress has been made in treatment, SUD use and related deaths continued to increase during the initial waiver period. It is unknown the extent to which the COVID-19 public health emergency impacted these trends.

The waiver was developed in 2018 and 2019 in response to the growing public health crisis of opioid use disorders (OUD) and SUD in Minnesota and supports broader reforms of SUD service delivery. Participation in the waiver requires states to implement nationally recognized evidenced-based treatment guidelines. It also requires participating states to provide a comprehensive set of SUD treatment services under the Medicaid program, including outpatient, intensive outpatient, medication assisted treatment (MAT), residential inpatient and medically supervised withdrawal management. For purposes of this extension request, these services as a group are referred to as critical levels of care.

This demonstration provides critical support for Minnesotans receiving SUD treatment services that would otherwise be ineligible for federal Medicaid reimbursement. Over half of Minnesota's residential treatment beds are in IMDs, and continued receipt of Medicaid funding for residential SUD treatment facilities is critical to the state's larger reform efforts to address the opioid crisis.

DHS' initial waiver implementation plan requires development of a comprehensive and coordinated network of providers that offer the levels of care consistent with American Society of Addiction Medicine (ASAM) Criteria. The ASAM Criteria is recognized nationally as a comprehensive and evidence-based standard of care. Providers that elect to meet the ASAM Criteria and certify that they offer the critical levels of care (listed above) receive an enhanced Medicaid payment rate. Providers may offer the critical levels of care consistent with ASAM Criteria independently or through referral agreements with other providers. For purposes of this extension request,

these providers are referred to as certified. DHS supports providers in meeting the provider certification requirements through published standards, technical assistance, utilization management, training on the ASAM Criteria and an enhanced payment rate.

In May 2023, there were 436 active DHS-licensed SUD providers in Minnesota. Of those, 156 were certified. This is an increase from 82 SUD providers in January 2021. In addition to certifying SUD providers, DHS is implementing broader SUD reform efforts resulting in increased SUD service utilization. One primary service delivery change is implementation of a Direct Access to treatment policy, which went into effect in July 2022. Direct Access allows a recipient to access a comprehensive assessment from any eligible vendor of the service. This results in faster access to SUD treatment services. In the years leading up to waiver implementation, DHS also expanded Medicaid state plan services as part of SUD system reform efforts. These included the addition of screening, brief intervention and referral to treatment (SBIRT), treatment coordination, peer recovery support services and withdrawal management. The additional SUD services, combined with direct access to treatment and a growing number of certified providers, is leading to more engagement with SUD treatment.

In the waiver implementation plan, DHS committed to adding intensive outpatient services to the Medicaid state plan. In 2022, DHS, through Governor Walz's legislative proposals, sought an amendment to state law to authorize the state plan change, but this provision was not adopted by the Minnesota Legislature. Subsequently, the 2023 Minnesota Legislature passed law authorizing coverage of intensive outpatient services through the state plan and adopting service definitions and staffing requirements consistent with the following ASAM levels of care:

- ASAM level 0.5 early intervention
- ASAM level 1.0 outpatient
- ASAM level 2.1 intensive outpatient
- ASAM level 2.5 partial hospitalization
- ASAM level 3.1 clinically managed low-intensity residential
- ASAM level 3.3 clinically managed population-specific high-intensity residential
- ASAM level 3.5 clinically managed high-intensity residential

Future Steps

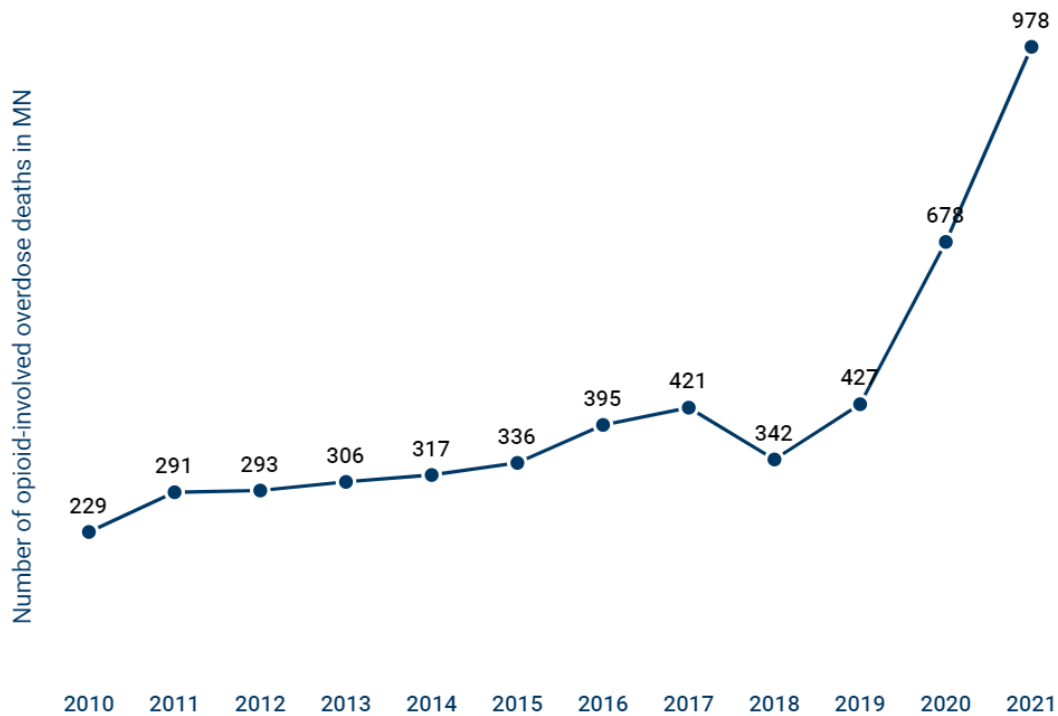
As described earlier, participating providers may offer the critical levels of care independently or through referral arrangements. State law passed in 2023 requires the implementation of a full continuum of ASAM levels of care and requires all DHS-licensed SUD providers be certified by January 1, 2025.

The state's adoption of the ASAM standards in state law will also assist DHS in responding to the soon-to-be-released fourth edition of the ASAM Criteria manual and the expected corresponding service standard changes.

Current Need

The time frame that DHS began transitioning to the ASAM Criteria spans the COVID-19 public health emergency and essentially affects all data analysis. However, the numbers show that opioid-involved overdose deaths among Minnesotans increased 44% from 2020 to 2021, and the number of deaths has more than doubled since 2019.

Figure 1: Opioid Overdose Deaths[1]



Data from the Minnesota Department of Health identifies 978 opioid-involved overdose deaths in calendar year 2021. This is a 236% increase from 291 opioid-involved overdose deaths in calendar year 2011. Emergency room non-fatal overdoses also increased dramatically from 1,686 in 2016 to 4,394 in 2021. While Minnesota is not unique in experiencing increased overdose deaths, the data illustrates the continuing need for improved treatment engagement and options for people with SUD.

States participating in this section 1115 demonstration opportunity are required to develop and submit implementation plans detailing the state's strategy for improving access to and quality of addiction treatment and meeting six CMS-identified milestones. The following section updates the state's progress toward meeting the required milestones as detailed in the state's approved OUD/SUD implementation plan submitted to CMS on September 27, 2019.

---

[1] Minnesota Department of Health (2023, January 13). Opioid Overdose Deaths. Drug Overdose Dashboard. Retrieved July 28, 2023, from https://www.health.state.mn.us/communities/opioids/opioid-dashboard/index.html

A. Access to Critical Levels of Care for SUDs

DHS provides coverage of outpatient services, medication assisted treatment (MAT), intensive levels of care in residential and inpatient settings and medically supervised withdrawal management. Minnesota's state Medicaid plan provides coverage for the required services, except for intensive outpatient services.

All certified providers in the state must offer MAT or facilitate access to MAT services wherever clinically appropriate. The amended DHS implementation plan committed to covering intensive outpatient services under the Medicaid state plan by July 2022. Unfortunately, since the Minnesota Legislature reached an impasse at the end of its 2022 session, most legislation being considered did not get resolved and DHS was not authorized to cover the service. As a result of the 2023 legislative session, enacted state law authorizes DHS to add coverage of intensive outpatient and partial hospitalization services to the SUD benefit set in January 2025.

B. Use of Evidence-based SUD-Specific Patient Placement Criteria

DHS requires providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools and implement a utilization management approach such that beneficiaries have access to SUD services at the appropriate level of care and that there is an independent process for reviewing placement in residential settings. Pursuant to the state's implementation plan for this milestone, DHS adopted the ASAM Criteria as the evidence-based standard for patient placement criteria and developed a method for providers to submit clinical documentation for utilization management reviews. DHS completed and continues to provide outreach and training related to the ASAM Criteria and utilization management processes.

DHS contracted with a vendor to support the transition to ASAM standards. The vendor trained DHS staff and providers to increase their knowledge, build skills and help them adopt evidence-based practices consistent with ASAM. The vendor also completed a train-the-trainer series for DHS staff to better prepare them in supporting statewide ASAM education for providers at all experience levels. DHS staff will offer additional provider training opportunities in late 2023.

DHS currently contracts with a vendor to conduct utilization management of certified providers. These reviews help ensure that beneficiaries receive the appropriate level of care and that SUD treatment services satisfy ASAM Criteria. DHS' contract with the medical review agent provides the required independent process for

reviewing placements in residential settings, including types of services, hours of clinical care, and credentials of staff as required by DHS' Special Terms and Conditions with CMS. DHS' policy division staff notifies the DHS Office of the Inspector General when the utilization management vendor discovers possible overpayment or claims issues that may reach the threshold of fraud, waste or abuse as outlined in state law.

State law requires DHS-licensed residential SUD providers to be certified by January 1, 2024, and DHS-licensed nonresidential SUD providers to be certified by January 1, 2025. Once certified, all providers participating in the Medicaid program will be subject to this utilization review process. DHS is providing ongoing support to the provider community to ensure they can meet ASAM Criteria.

C. Use of Nationally Recognized, SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities

DHS uses the ASAM Criteria as the nationally recognized, evidenced-based standards for SUD treatment. DHS published standards in October 2020 that apply to certified providers. DHS' contracted utilization management vendor monitors, reviews, and reports on provider's performance in implementing the ASAM Criteria. State law requires all residential, inpatient and outpatient providers to meet the ASAM Criteria by January 2025.

D. Sufficient Provider Capacity at Critical Levels of Care Including MAT for OUD

DHS completed the required assessment of the availability of providers enrolled in Medicaid and accepting new patients in the critical levels of care, including those that offer MAT.[2]

E. Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and OUD

DHS issued opioid prescribing standards based on recommendations received in 2018 from the Opioid Prescribing Work Group and published an addendum to these standards related to opioid tapers in 2020. The

---

[2] NORC. Minnesota 1115(a) Substance Use Disorder System Reform Demonstration Project Evaluation, Provider Capacity Assessment: Baseline Assessment Report, Dec. 30, 2020.

work group, comprised of treatment and program service professionals, was legislatively tasked to provide recommendations to DHS to improve opioid treatment, including prescribing protocols and quality improvement processes. DHS supports strengthening oversight of prescribing practices in law and will continue to provide educational information for best practice standards in opioid prescribing.

This milestone requires the implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse, expanded coverage of and access to naloxone for overdose reversal and implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs. Additionally, Minnesota has taken several steps to minimize the prevalence of opioid abuse and OUD. In 2019, the Opiate Epidemic Response bill was signed into law, which raises funds from prescribers, drug manufacturers and distributors to fight the opioid crisis. The law also created the Opioid Epidemic Response Advisory Council (OERAC). The council has several charges, all focused on developing and implementing a comprehensive and effective statewide effort to address opioid addiction, including distribution and use of the funding.

In April 2022, Governor Tim Walz established the Opioids, Substance Use, and Addiction Subcabinet and the Governor’s Advisory Council on Opioids, Substance Use, and Addiction under Executive Order 22-07. The primary function of the subcabinet and advisory council is to coordinate the state’s resources in response to OUD and SUD.

The 2023 state legislature increased funding for project ECHO[3] hubs that support best practice models in medications for opioid use disorder (MOUD).[4]

---

[3] Project ECHO is an established, evidence-based national telemetering program developed by University of New Mexico. The ECHO model consists of a “hub” where specialists work in an interdisciplinary team and “spokes” that connect with other providers through videoconferences for case-based learning.

[4] Medications for opioid use disorder (MOUD) is the language enacted by legislation in 2022 to replace Medication Assisted Treatment (MAT). This aligns with national naming conventions and decreases stigmatization. It includes all FDA-approved medications for treatment OUD.

Lastly, the waiver implementation plan included coordination with the Minnesota Board of Pharmacy (board), specifically, to report ongoing efforts by the board to increase utilization of the Minnesota Prescription Monitoring Program (MNPMP). This is a tool to prevent over prescribing of prescription drugs and Minnesota's equivalent to the federal Prescription Drug Monitoring Program (PDMP).

The board updated its software to support prescribing decisions and integrating interstate data.[5] The new software automatically analyzes recipients' prescription histories and risk factors, displays prescription drug data, and supports decisions around recipients' care needs. The software also integrates data into electronic health records between 43 states facilitating searches across a broad range of databases.

Use of the MNPMP has nearly doubled from January 2020 (2,452,955 total searches) through Dec. 2022 (4,824,382 total searches). In parallel, the number of entities with accounts to use the prescription monitoring program increased from 22,345 (in 2020) to 25,402 (in 2022), an increase of 13.7%.[6]

DHS is distributing grant funding through OERAC targeted at reducing opioid abuse and other OUDs. The total funding available is $20,649,221 and focuses on six categories listed below. The grants are part of a multi-faceted strategy to eliminate health disparities related to OUD and reduce deaths in Minnesota. To be eligible for grants, programs must respond to a request for proposal process. The six identified strategies are as follows:

1. Primary prevention and education for opioid related SUDs;
2. Secondary prevention and harm reduction for opioid related SUDs;
3. Workforce development and training on the treatment of opioid related SUDs;
4. Expansion and enhancement of a continuum of care for opioid related SUDs;
5. Chronic pain and alternative treatments; and
6. Emerging or innovative strategies and practices aimed at improving the impact of opioid related SUDs on the state of Minnesota.

---

[5] Minnesota Board of Pharmacy (2022) "2021 Prescription Monitoring Program Annual Report."

[6] Minnesota Board of Pharmacy, Prescription Monitoring Program Analytics Dashboard Web Page, June 9, 2023.

DHS continues to work with the Governor's Opioids, Substance Use, and Addiction Subcabinet and the Advisory Council on Opioids, Substance Use and Addiction with the goal of supporting their recommendations on addressing and combatting opioid abuse and OUD. DHS also continues to meet with providers to offer technical assistance and training on the ASAM Criteria and provides resources for methadone take-home supplies and discusses barriers and solutions to providing MOUD access. Increased funding passed in the 2023 legislative session for Project ECHO will continue to support expanded access to MOUD and addresses the recommendation in the independent waiver evaluator's mid-point assessment.

F. Improved Care Coordination and Transitions between Levels of Care

This milestone requires implementation of policies to ensure residential and inpatient facilities link beneficiaries, especially those with OUD, with community-based services and supports following stays in these facilities. State law requires all licensed SUD providers to provide discharge planning, including documentation of continuing care requirements that address ongoing behavioral health treatment as needed.

The state's existing continuum of care for SUD treatment includes treatment coordination and peer support services to support all continuing care recommendations including transitions between more and less intense or frequent services, and referrals with specific attention to continuity of mental health care. Certified providers must provide the agency with verification of formal referral arrangements to ensure access to different levels of care.

Future Goals

As DHS worked through implementation of its milestone deliverables, it became evident that gaps existed within the critical levels of care proposed in DHS' implementation plan. Specifically, Partial Hospitalization (ASAM 2.5) and Medically Monitored Intensive Inpatient levels of care (ASAM 3.7) were identified as necessary components to achieving a full continuum of evidence-based care.

In response to the identified gaps, state law was amended to authorize coverage of additional SUD treatment services, including intensive outpatient and partial hospitalization services. By January 2025, Minnesota's Medicaid program will cover all SUD services across the ASAM continuum of care. Additionally, DHS is planning for level of care modifications in anticipation of the publication of the ASAM fourth edition manual which is expected to revise ASAM withdrawal management levels of care. Once published, more specific work will be

identified to align current withdrawal management levels of care into the new levels of care provided in the ASAM fourth edition manual.

To support the ongoing transition to ASAM Criteria and its comprehensive continuum of care, DHS will continue to advance:

1. Reducing regulatory burdens by realigning standards to support providers in the transition to ASAM Criteria;
2. Streamlining provider requirements for residential services;
3. Transitioning all providers to use of ASAM levels of care by January 1, 2025;
4. Requiring providers to assure staffing and access to services that meet recipients' mental health needs;
5. Expanding statewide utilization management reviews with fidelity to ASAM Criteria; and
6. Hiring staff to provide ASAM Criteria training and complete data analysis and evaluation.

Section II – SUD Waiver Extension

Extension request, change and expected outcome

A. Extension request

DHS requests to continue waiver authority for the five-year period through June 30, 2029, to support its efforts to continue expanding the state's evidence-based SUD continuum of care. To continue this work, authority for federal financial participation is necessary when services are provided in residential programs that are IMDs. These placements are based on medical necessity and the recipients' needs and subject to utilization management review.

Consistent with CMS' guidance for section 1115 waiver demonstrations for SUD reform, the waiver supports recipients' access to the appropriate levels of treatment for SUD, from early intervention services to high-intensity treatment in residential and inpatient settings when needed. Consistent with the key goals and objectives for the waiver program, DHS transitioned to the use of the ASAM Criteria. This includes use of evidenced-based placement criteria and implementation of utilization management to oversee fidelity to ASAM.

DHS published standards supporting the transition to ASAM in October of 2020 that included all ASAM critical levels of care identified in the waiver implementation plan. As part of the extension of the waiver and further development of the continuum of care, DHS will add intensive outpatient (ASAM 2.1) and partial hospitalization (ASAM 2.5) services to its state plan in January 2025. DHS will also begin work on implementing medically monitored intensive inpatient (ASAM 3.7) when the new standards have been defined in the ASAM fourth edition and once authorized in the state plan.

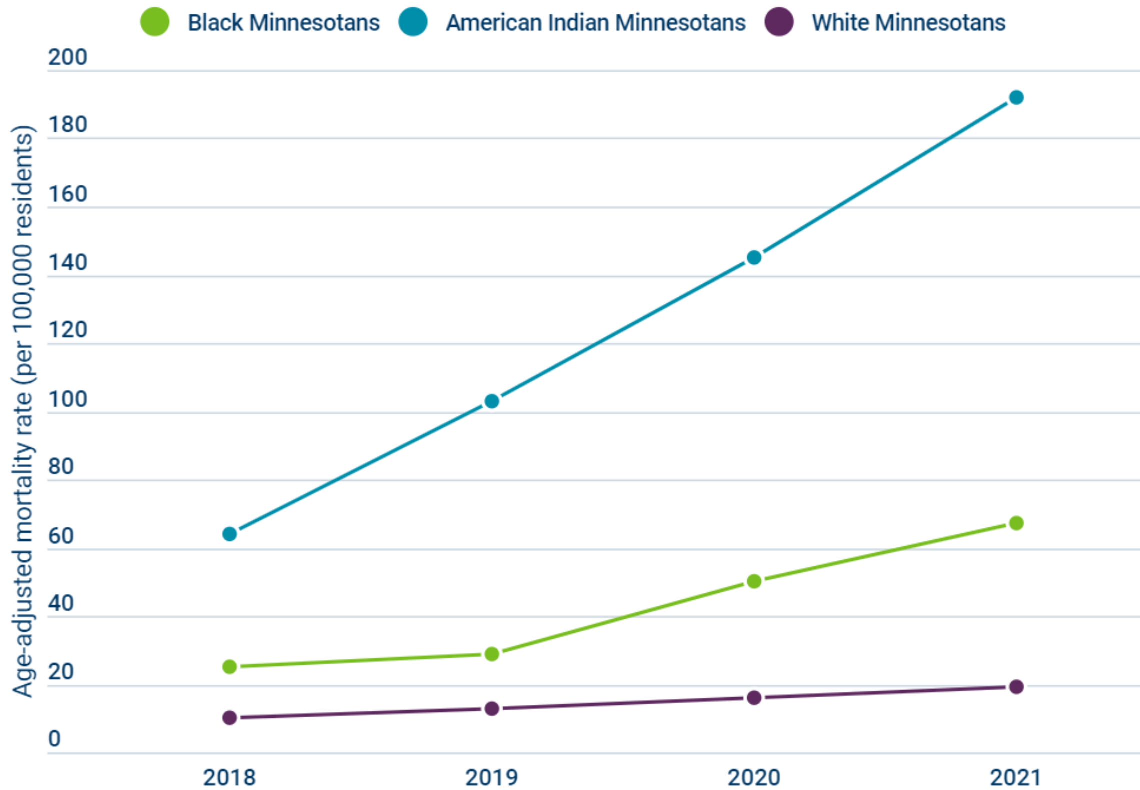
The state's waiver sought to evaluate whether requiring provider referral networks for SUD treatment would improve treatment outcomes for Medicaid beneficiaries. The state issued new standards for participating providers and established certification and utilization management processes based on the ASAM Criteria. The operation of two sets of standards for SUD providers serving Medicaid beneficiaries is inconsistent with the state's goals for SUD reform. As a result, the state is fully adopting service definitions, hours of clinical care and staff credentialling requirements for all providers consistent with the ASAM Criteria by January 1, 2025.

B. Change and expected outcome

Adding coverage of additional SUD services and implementation of coverage standards consistent with ASAM for all services in Minnesota's SUD benefit set will fill treatment gaps, improve treatment coordination and increase access to the full continuum of medically necessary SUD treatment services. This is expected to result in more effective treatment engagement. This will also assist providers by having a single service delivery model that offers a full continuum of medically necessary SUD treatment to best meet recipients' needs.

Further, offering the full continuum of ASAM levels of care is expected to improve identification of the need for and access to culturally responsive services. Culturally responsive assessments and treatment remain DHS priorities. The need is evidenced by data from the Minnesota Department of Health Drug Overdose Dashboard showing that compared to their white counterparts, American Indian Minnesotans were 10 times more likely to die from a drug overdose, and Black Minnesotans were more than three times as likely to die from a drug overdose than white Minnesotans. These significant disparities highlight the need for innovative approaches to culturally responsive assessment and treatment.

Figure 2: Opioid Overdose Deaths by Race[7][8]



Some progress has been made to increase access to culturally responsive services. In 2021, rate enhancements for defined culturally specific and culturally responsive programs were implemented. The rate enhancement applies to SUD programs certified by DHS to be focused on improving service quality to and outcomes of a specific population community that shares a common language, racial, ethnic or social background by advancing health equity to help eliminate health disparities in those communities. Tribal human service agencies may grant this certification for SUD programs they license in Minnesota.

---

[7] Minnesota Department of Health (2023, Jan. 13). Opioid Overdose Deaths. Drug Overdose Dashboard. Retrieved July 28, 2023, from https://www.health.state.mn.us/communities/opioids/opioid-dashboard/index.html.

[8] Title added by DHS.

Services in the programs that receive this rate enhancement are designed to be responsive to an individual within a specific population's community values, beliefs and practices, health literacy, preferred language and other communication needs. The programs must be compliant with the national standards for culturally and linguistically appropriate services or other equivalent standards and at least fifty percent of individuals employed to provide treatment services must be members of the identified community being served.

Merging the culturally responsive standards into the implementation of all services in ASAM's continuum of care is expected to improve outcomes of recipients.

Section III - Waivers and Expenditure Authorities

Current waiver expenditure authority

A. Programmatic description and expenditure authorities

The state requests to extend its current waiver expenditure authority. Under the authority of section 1115(a)(2) of the Social Security Act, expenditures made by the state for the items identified below (which are not otherwise included as expenditures under section 1903) will be regarded as expenditures under Minnesota's title XIX plan for the period of this extension.

Expenditures are for otherwise covered services furnished to otherwise eligible individuals primarily receiving treatment and withdrawal management services for SUD and who are short-term residents in facilities that meet the definition of an Institution for Mental Diseases (IMD).

B. Requirements not applicable to the expenditure authorities

All requirements of the Medicaid program expressed in law, regulation and policy statement, not expressly waived or identified as not applicable in the list below, shall apply to the expenditure authorities.

C. Expenditure reporting

The state reports waiver expenditures to CMS through the CMS-64 report and quarterly budget neutrality reports specific to the waiver. Past expenditure and projected waiver budget neutrality estimates are provided in Section VII of this request, Demonstration Financing and Budget Neutrality.

Section IV - Quality Assurance and Monitoring

Independent Evaluation

DHS contracted with the University of Chicago (NORC) to complete the midpoint and interim evaluation of the demonstration. The evaluation covered the seven state-specific goals designed to achieve progress toward the standardized national milestones for the demonstration.

1. Increased rates of identification, initiation and engagement in treatment for OUD and other SUDs
2. Increased adherence to and retention in treatment
3. Fewer readmissions to the same or higher level of care where the readmission is preventable or medically inappropriate
4. Improved access to care for physical health conditions among Medicaid beneficiaries
5. Reduced number of opioid-related overdoses and deaths in the state of Minnesota
6. Patients allowed to receive a wider array of evidence-based services that are focused on a holistic approach to treatment
7. Reduced utilization of emergency departments (EDs) and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services

The NORC evaluation also examined the status of each of the milestones and offered recommendations. See Attachment A, Draft Interim Evaluation Report, Minnesota Substance Use Disorder System Reform Section 1115(a) Demonstration Project Evaluation. The State received CMS' comments concerning the draft report on October 24, 2023. The State will work with the contractor to address the comments and recommendations.

A. Fee-for-Service

All certified providers must participate in the utilization management process by submitting clinical documentation of services provided to the utilization review vendor. Effective April 2023, the DHS utilization review vendor implemented proprietary software specific to reviewing the three evaluation components for SUD services with fidelity to the ASAM Criteria. The new software is expected to provide a more consistent method for DHS to evaluate certified providers.

Utilization management reviews include three primary components to evaluate whether: (1) recipients' levels of care are appropriate, (2) services provided were medically necessary specifically, the types of services, hours of clinical care, and credentials of staff for residential treatment and (3) care coordination provided appropriate referrals for additional services.

B. Managed Care

DHS' contracts with Managed Care Organizations (MCO) require that they provide all services under the Medicaid state plan. MCOs are also contractually obligated to provide the ASAM critical levels of care as defined in DHS' published standards and to have a utilization review process that aligns with DHS' requirements. If a recipient is unable to find coverage for SUD treatment services at the assessed level of care through the MCO's in-network providers, the MCO must cover the appropriate service using out-of-network providers.

Section V - Evaluation Activities

The NORC midpoint assessment (dated March 2022) provided a status update and rated the risk level of whether the required milestones would be met. The progress made on the milestones to date, coupled with the 2023 legislative changes (including rate increases) and transitioning all providers to being licensed and certified by 2025 addresses the risks identified in the midpoint assessment.

Of note, the midpoint assessment commented on the impact of COVID-19 Public Health Emergency and the increases in SUD diagnoses in Minnesota and nationally. The report identified that the increased service need was pared with barriers to service access, including reduced healthcare engagement by recipients. Given the conclusion of the public health emergency, recipients' overall health care engagement (in all service categories) is expected to return to pre-pandemic levels, which supports a more robust evaluation of SUD treatment engagement in future evaluations.

Section VI – Demonstration Financing and Budget Neutrality

A. Projected expenditures

The following tables provide the budget neutrality projections, including the member months and per member per month (PMPM) cost for each waiver year (WY) in the extension period (within the applicable state fiscal year

(SFY)). The data is separated by Medicaid recipients whose SUD services are covered through fee-for-service (FFS) or under managed care, and each represents a separate Medicaid expenditure group (MEG) covered by the waiver.

Table 1: Fee-for-Service

FFS IMD MEG	WY 6 / SFY 2025	WY 7/SFY 2026	WY 8/SFY 2027	WY 9/SFY 2028	WY 10 / SFY 2029
Member months	9,622	10,032	10,386	10,791	11,200
PMPM	$4,304	$4,476	$4,655	$4,841	$5,034
Total Computable	$41,413,088	$44,903,232	$48,346,830	$52,239,231	$56,380,800

Table 2: Managed Care

Managed care IMD MEG	WY 6/SFY 2025	WY 7/SFY 2026	WY 8/SFY 2027	WY 9/SFY 2028	WY 10/SFY 2029
Member months	21,963	22,407	22,859	23,320	23,791
PMPM	$1,010	$1,050	$1,092	$1,136	$1,182
Total computable	$22,182,630	$23,527,350	$24,962,028	$26,491,520	$28,120,962

Table 3: Fee-for-Service and Managed Care

TOTAL WAIVER	WY 6/SFY 2025	WY 7/SFY 2026	WY 8/SFY 2027	WY 9/SFY 2028	WY 10/SFY 2029
Total computable	$63,595,718	$68,430,582	$73,308,858	$78,730,751	$84,501,762

B. Member Months

The following table provides the historic and projected member months.

Table 4: Member Months

	WY 1*/SFY 2020	WY 2*/SFY 2021	WY 3*/SFY 2022	WY 4/ SFY 2023	WY 5/SFY 2024
IMD FFS MEG	0	2,778	4,447	6,263	8,825
IMD managed care MEG	0	1,940	8,209	12,825	20,974
Waiver Total	0	4,718	12,656	19,088	29,799

* Actual data based on CMS-64 for the quarter ending March 31, 2023

	WY 6/SFY 2025	WY 7/SFY 2026	WY 8/SFY 2027	WY 9/SFY 2028	WY 10/SFY 2029
IMD FFS MEG	9,622	10,032	10,386	10,791	11,200
IMD managed care MEG	21,963	22,407	22,859	23,320	23,791
Waiver Total	31,585	32,439	33,245	34,111	34,991

The member months were calculated using actual member months based on the CMS-64 reports through the quarter ending March 2023, plus DHS' estimates of the additional population expected to receive services in IMDs later in the extension period. This is the result of additional providers meeting the new standards adopted by the state.

Institution for Mental Diseases, Fee-for-Service Months

The FFS MEG assumes the annual projected growth of 6.2% for state fiscal year (SFY) 2025 with annual growth averaging 4.3% for SFY 2025 to SFY 2029.

Institution for Mental Diseases, Managed Care Months

The managed care MEG is based on the actual number of managed care waiver recipients that were covered in IMDs in November 2022, plus a residual population expected to join the waiver by January 2024. From that point, projections are trended at 2.0% per year. For purposes of this section waiver recipients are those who are enrolled in a managed care plan and receive treatment in a certified residential facility subject to the IMD exclusion.

Table 5: Per Member Per Month Projections

	WY 1/SFY 2020	WY 2*/SFY 2021	WY 3*/SFY 2022	WY 4/SFY 2023	WY 5/SFY 2024
PMPM/IMD Fee for Service MEG		$ 3,055.13	$3,467.36	$4,142.00	$4,218.00
PMPM/IMD Managed Care MEG		$716.66	$895.03	$951.00	$972.00
Annual Trend/IMD Fee for Service MEG			13.5%	19.5%	1.8%
Annual Trend/IMD Managed Care MEG			24.9%	6.3%	2.2%

* Actual data based on CMS-64 for quarter ending March 31, 2023

	WY 6/SFY 2025	WY 7/SFY 2026	WY 8/SFY 2027	WY 9/SFY 2028	WY 10/SFY 2029
PMPM/IMD Fee for Service MEG	$4,304.00	$4,476.00	$4,655.00	$4,841.00	$5,034.00
PMPM/IMD Managed Care MEG	$1,010.00	$1,050.00	$1,092.00	$1,136.00	$1,182.00
Annual Trend/IMD Fee for Service MEG	2.0%	4.0%	4.0%	4.0%	4.0%
Annual Trend/IMD Managed Care MEG	3.9%	4.0%	4.0%	4.0%	4.0%

Institution for Mental Diseases, Fee-for-Service Per Member Per Month

The FFS PMPM includes rate adjustments for certified providers. A 15% rate increase was applied from the beginning of waiver activity and increased to 25% effective January 1, 2022. The increment to a 25% increase equates to approximately a 9.6% increase over two fiscal years and a trend increase of about 4.8% per year. Additionally, the increasing number of recipients in the first 30 months of the waiver seems to have brought in higher-cost recipients, which increased the FFS PMPM.

The PMPM amount is projected to stabilize at $4,218 beginning in January 2023. The trend increases for the waiver extension period reflect 4.0% rate increases each January, beginning in January 2025.

Institution for Mental Diseases, Managed Care Per Member Per Month

The managed care MEG shows a 24.9% increase in the PMPM for state fiscal year 2022 over state fiscal year 2021. Two main factors contribute to this: (1) in part to a change in the mix of capitation rates between the two periods; and (2) an increase of about 15% in state-paid capitation rates for IMD residents, effective January 2022. The change for state fiscal year 2023 represents annualization of the January 2022 increase.

The state forecast assumes 4.0% capitation rate increases each January, beginning January 2024. This results in an approximately 2.0% increase for state fiscal year 2024 and a 4.0% increase for the subsequent years.

The PMPM amounts are considerably less than the FFS projections because they do not represent the cost of SUD residential treatment for the waiver recipient (defined above), but only the capitation costs which without the waiver would be ineligible for federal funding. Capitation rates have the costs of SUD residential treatment spread over a population, most of whom do not receive that service in a given month.

C. Historical expenditures

The following tables provide the revised cost neutrality projections from waiver year one with actual data through waiver year three.

Table 6: Fee-for-service Institution for Mental Diseases Medicaid Expenditure Group

	WY 1/SFY 2020	WY 2/SFY 2021	WY 3/SFY 2022	WY 4/SFY 2023	WY 5/SFY 2024
Member months		2,778	4,447	6,263	8,825
PMPM		$3,055.13	$3,467.36	$4,142.00	$4,218.00
Total Computable		8,487,143	15,419,362	25,941,346	37,223,850

Table 7: Managed Care Institution for Mental Diseases Medicaid Expenditure Group

	WY 1/SFY 2020	WY 2/SFY 2021	WY 3/SFY 2022	WY 4/SFY 2023	WY 5/SFY 2024
Member months		1,940	8,209	12,825	20,974
PMPM		$716.66	$895.03	$951.00	$972.00
Total Computable		$1,390,313	$7,347,336	$12,196,575	$20,386,728

Section VII – Public Notice and Comment Process Section

Public Notice

A notice requesting public comment on the proposed SUD waiver extension request was published in the Minnesota State Register on September 25, 2023. The notice provided information about the 30-day comment period from September 25, 2023 to October 27, 2023 on the draft waiver extension request and a link to the DHS website with more information. An electronic version of the draft waiver extension request was published on the DHS website on September 21, 2023. The webpage is updated on a regular basis and includes information about the public notice process, opportunities for public input and provides a link to the waiver application. After the extension request is submitted, the webpage will be updated to inform visitors of the upcoming federal comment period on the SUD extension request and to provide the link to the federal website when it is available. This version of the waiver extension request will include all attachments. A copy of the Minnesota State Register Notice is provided as Attachment B.

Information about the waiver and the planned extension request was also provided to the state Medicaid Advisory Committee on February 14, 2023.

Public Hearings

A notice providing information about two public hearings concerning the proposed SUD waiver extension request was published in the Minnesota State Register on September 25, 2023. The notice provided information about two public meetings seeking state-wide participation. One was held October 10, 2023 via teleconference. The other was held October 12, 2023 in-person at the Minnesota Department of Human Services building located at 540 Cedar Street, St. Paul, Minnesota. Both provided external parties the opportunity to comment on the waiver request. See Attachment B.

Use of electronic mailing list or similar mechanism to notify the public

In addition to posting information on its website, DHS used GovDelivery[9] to notify the public of the proposed SUD waiver extension. On September 22, 2023, an email was sent via GovDelivery to provide information about DHS' intent to request an extension for the SUD waiver and opportunities to provide comments. The email also included that more information is maintained on the SUD waiver webpage. See Attachment C. A second email will be sent to provide notice that the final submitted version of the waiver is on the website and to alert external parties that a federal comment period on the waiver request is expected soon. DHS will post information about the federal comment period on its website.

Tribal Consultation

There are eleven Tribal Nations in Minnesota, seven Ojibwe reservations and four Dakota (Sioux) communities. The seven Ojibwe reservations are: Grand Portage, located in the northeast corner of the state; Bois Forte, located in far northern Minnesota; Red Lake, located in northern Minnesota west of Bois Forte; White Earth, located in northwestern Minnesota; Leech Lake, located in the north central portion of the state; Fond du Lac, located in northeastern Minnesota west of Duluth; and Mille Lacs Band of Ojibwe, located south of Brainerd in the central part of the state. The four Dakota communities are: Shakopee Mdewakanton Sioux, located south of the Twin Cities near Prior Lake; Prairie Island Indian Community, located near Red Wing; Lower Sioux Community, located near Redwood Falls; and Upper Sioux Community, whose lands are near the city of Granite Falls.

While these eleven Tribal Nations frequently collaborate on issues of mutual benefit, each operates independently as a separate and sovereign entity government – a state within a state or nation within a nation. Recognizing American Indian tribes as sovereign nations with distinct and independent governing structures is critical to the work of DHS. DHS recognizes each American Indian tribe as a sovereign nation with distinct and independent governing structures. It is vital for the state to have strong collaborative relationships with tribal governments. To support this for health and human services programs, DHS has a designated staff liaison in the

[9] GovDelivery is a subscription-based email system used by Minnesota state government to share information with the public. It is also sent to specific provider and stakeholder groups as applicable.

Medicaid Director's office who is responsible to inform and, as applicable, coordinate Medicaid issues with the eleven Tribal Nations. Furthermore, Minnesota Executive Order 19-24 affirms the Government-to-Government Relationship between the State of Minnesota and Minnesota Tribal Nations.

The Tribal Health Directors Work Group was formed to address the need for a regular forum for formal consultation between tribes and state staff. Work group attendees include Tribal Chairs, Tribal Health Directors, Tribal Social Services Directors and the DHS liaison. Other DHS leaders often participate in the meetings. The Native American Consultant from CMS and state agency staff attend as necessary depending on the topics covered. The DHS liaison attends all Tribal Health Directors Work Group meetings and provides updates on state and federal activities. The liaison arranges for appropriate DHS policy staff to attend the meetings to receive input from Tribal representatives and to answer questions.

Notice of the planned waiver extension was provided during the Tribal and Urban Indian Health Directors meeting on March 9, 2023, May 25, 2023, and August 24, 2023. Additionally, DHS staff met with the American Indian Advisory Council (AIAC) on March 16, 2023, and provided an update on the waiver and extension status.

On September 25, 2023, a letter was sent to all Tribal Chairs, Tribal Health Directors, Tribal Social Services Directors, the Indian Health Service Area Office Director and the Director of the Minneapolis Indian Health Board clinic informing each of the state's intent to submit a request to extend the SUD waiver and inviting consultation. The letter also informed Tribes of the public input process and provided a link to the SUD waiver web page. Please refer to Attachment D for a copy of the letter.

Comments received by the state during the 30-day public notice period

DHS received three comments regarding the proposed SUD waiver extension during the comment period from September 25 to October 27, 2023. A copy of the comments and the state's responses are provided in Attachment E.

Stakeholder Support

DHS received two letters of support for continuing the SUD waiver. Copies of the letters are provided in Attachment F.

Post Award Public Forums

Due to the COVID-19 pandemic, in lieu of in-person public hearings, three teleconferences were held to provide external parties the opportunity to comment on the waiver request. The teleconference dates were January 20, 2021, January 20, 2022, and January 26, 2023.

Section VIII – Demonstration Administration

Contact

Christina Samion

Federal Relations

Minnesota Department of Human Services

P.O. Box 64983

St. Paul, MN 55164-0983

(651) 431-5885

christina.samion@state.mn.us

Attachment A

NORC at the University of Chicago

DRAFT INTERIM EVALUATION REPORT

July 2023

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

Presented by:
NORC at the University of Chicago

Presented to:
Minnesota Department of Human Services
Behavioral Health Division

Table of Contents

Executive Summary 1

Demonstration Summary 1
Principal Results 2
Interpretation 3
Recommendations of the Evaluation 4

General Background Information 5

Introduction 5
Demonstration Policy Goals 5
Demonstration Overview 7
Legislative Changes 8
Impact of the COVID-19 Pandemic on Demonstration Implementation 10
Population Groups Impacted by the Demonstration 11
Demonstration Goals, Waiver Milestones, and Evaluation Questions 11
CMS-Required Milestones 11
Demonstration Driver Diagram 15

Methodology 17

Evaluation Design 17
Evaluation Measures and Sources 17
Analytic Methods 18
Claims-Based Measures 18
Quantitative Methods 19
Qualitative Methods 20

Methodological Limitations 21

Results 22

Progress on Implementation Plan 22
Provider Enrollment and Approval and Utilization Management 24
Milestone 1: Access to Critical Levels of Care for OUD and Other SUDs 30
Summary of Measures 30
Individual Measure Results 30
Milestone 2: Use of Evidence-Based, SUD-Specific Placement Criteria 35
Milestone 3: Use of Nationally Recognized SUD-Specific Program Standards 36

Referrals to ASAM Levels of Care 37
Working with Managed Care Organizations 38
Milestone 4: Sufficient Provider Capacity at Critical Levels of Care 39
Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Misuse and OUD 41
Summary of Measures 41
Individual Measure Results 42
Milestone 6: Improved Care Coordination and Transitions between Levels of Care 51
Summary of Measures 51
Individual Measure Results 53

Conclusions 63

Lessons Learned, Interpretations, and Policy Implications 65
Interactions with Other State Initiatives 66

Recommendations 68
Recommendations 68

References 69

List of Figures

Exhibit 1. Demonstration goals, evaluation questions, demonstration milestones, and measure or qualitative data 12

Exhibit 2. Demonstration driver diagram 16

Exhibit 3. Data sources used in the interim evaluation report 17

Exhibit 4. State implementation activities 22

Exhibit 5. Growth in enrolled providers and locations by level of care, 2020-2022 25

Exhibit 6. Medicaid beneficiary population, CY2017-CY2021 27

Exhibit 7. Characteristics of the Minnesota Medicaid population with SUD, baseline and Demonstration periods 28

Exhibit 8. Summary of measures for Milestone 1 30

Exhibit 9. Proportion of beneficiaries with OUD initiated with MOUD, CY2017-CY2021 31

Exhibit 10. Proportion of beneficiaries with OUD initiated with a MOUD by urban/rural status,* CY2017-CY2021 32

Exhibit 11. Provider rating of Year 2 MN 1115(a) SUD Demonstration effectiveness 33

Exhibit 12. Enrolled provider participation in training and TA by type 34

Exhibit 13. Integration of Kepro UM into enrolled provider workflow 36

Exhibit 14. Minnesota providers' self-reported ability to provide referrals at each ASAM LOC 37

Exhibit 15. Self-reported provider activities for coordinating MCO member care* 39

Exhibit 16. Self-reported provider administrative and clinical staffing capacity 40

Exhibit 17. Summary of measures for Milestone 5 41

Exhibit 18. Proportion of beneficiaries with a new diagnosis of AOD who initiated treatment within 14 days, CY2017-CY2021 42

Exhibit 19. Time to treatment for beneficiaries with an AOD use or dependence, CY2017-CY2021 43

Exhibit 20. Proportion of beneficiaries with a new diagnosis of SUD who engaged in treatment within 34 days, CY2017-CY2021 44

Exhibit 21. Proportion of beneficiaries receiving pharmacotherapy for OUD for ≥180 days of continuous treatment, CY2017-CY2021 45

Exhibit 22. Proportion of beneficiaries with an SUD who had an ambulatory visit for prevention services, CY2017-CY2021 46

Exhibit 23. Drug overdose and opioid overdose mortality 49

Exhibit 24. MOUD treatment changes reported by providers since Demonstration implementation 50

Exhibit 25. Changes in service capacity reported by providers since Demonstration implementation 50

Exhibit 26. Self-reported provider challenges in providing MOUD to Demonstration patients 51

Exhibit 27. Summary of measures for Milestone 6 52

Exhibit 28. All-cause readmissions among beneficiaries with an SUD, CY2017-CY2021....53

Exhibit 29. ED utilization among beneficiaries with an SUD, CY2017-CY2021....56

Exhibit 30. ED utilization within 30 days of discharge from a residential treatment facility among beneficiaries with an SUD, CY2017-CY2021 59

Exhibit 31. Follow-up contacts for beneficiaries with alcohol or other SUD and an IMD stay, CY2017-CY2021....60

Exhibit 32. Follow-up contacts for beneficiaries with alcohol or other substance use disorder and an ED visit, CY2017-CY2021 61

Executive Summary

The following executive summary provides an overview of the Demonstration, the principal results, interpretations, and recommendations included in this interim evaluation report.

Demonstration Summary

Minnesota's Substance Use Disorder System Reform Section 1115(a) Demonstration (the Demonstration) was approved by the Centers for Medicare & Medicaid Services (CMS) on July 22, 2020 for a demonstration period of July 1, 2019 through June 30, 2024. The Demonstration supports a full continuum of care with a focus on ensuring that individuals are matched to an appropriate level of care, based on the requirements established by the American Society of Addiction Medicine (ASAM). In January 2021, Minnesota began officially training and providing technical assistance to substance use disorder (SUD) participating providers.

The Demonstration was designed to achieve progress toward standardized national milestones. Minnesota's state-specific Demonstration goals include the following:

1. Increase rates of identification, initiation, and engagement in treatment for opioid use disorder (OUD) and other SUDs
2. Increase adherence to and retention in treatment
3. Fewer readmissions to the same or higher level of care (LOC) where the readmission is preventable or medically inappropriate
4. Improved access to care for physical health conditions among Medicaid beneficiaries
5. Reduced number of opioid-related overdoses and deaths in the state of Minnesota
6. Patients allowed to receive a wider array of evidence-based services that are focused on a holistic approach to treatment
7. Reduced utilization of emergency departments (EDs) and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services

There were several external factors that affected the implementation and impact of the Demonstration. The effects of the COVID-19 pandemic included reduced access to care and increased rates of SUD diagnoses and demands for services. Then, in 2021, the Minnesota legislature passed changes that impacted the Demonstration. These legislative changes, notably the requirement of all residential and withdrawal management (WM) providers to participate in the Demonstration was a shift from the original Demonstration design that was a voluntary program for a small group of providers.

NORC at the University of Chicago (NORC) is the Independent Evaluator of the demonstration. The Minnesota Department of Human Services (DHS) has contracted with NORC to conduct an

independent mixed-methods evaluation of the Demonstration. This interim evaluation report is part of the overall evaluation.

The target population of the Demonstration is all individuals enrolled in Minnesota Medicaid who receive any services for SUD. For most of the evaluation analyses, beneficiaries with an OUD or SUD must also satisfy criteria for specific enrollment periods. This approach is an intent-to-treat (ITT) design: the analysis includes all eligible Medicaid beneficiaries, regardless of what, if any treatment they received from enrolled providers. This design avoids volunteer bias that results from limiting evaluation participants to beneficiaries receiving care from participating providers.

This report evaluates the two-year period before the Demonstration—January 1, 2017, to December 31, 2018—and a two-year period during the Demonstration from January 1, 2020, to December 31, 2021. It also includes a qualitative assessment of Demonstration implementation through 2022, based on a survey of enrolled providers that was conducted in early 2023. Both quantitative and qualitative methods were used for this evaluation.

Principal Results

As of April 2023, 92 unique SUD/OUD providers, operating in 171 facilities or locations, were enrolled in the Demonstration.

In this report, results are reported for each milestone:

Milestone 1: Access to Critical Levels of Care for OUD and Other SUDs. The proportion of beneficiaries with an OUD initiating medication for opioid use disorder (MOUD) increased by nearly 13 percent (5.8 percentage points) between the baseline and Demonstration periods. In addition, providers reported that the Demonstration is effective in assessing patients and then directed them to an appropriate LOC.

Milestone 2: Use of Evidence-Based, SUD-Specific Placement Criteria. MN DHS has primarily focused on the implementation of a new process and system for utilization management (UM) through the Kepro UM program. Eighty-four percent of respondents reported that the Kepro UM was either fully or somewhat integrated into their workflows. Providers continued to underscore that Kepro UM is time-consuming and has high administrative costs.

Milestone 3: Use of Nationally Recognized SUD-Specific Program Standards. Most Demonstration providers reported that they can provide access for patients with Medicaid through referral to ASAM LOCs 1.0, 2.1, 3.1, 3.3, 3.5, and 3.7. Level 3.1—clinically managed low-intensity and population-specific services—providers reported limited bed availability and a lack of low-intensity treatment centers. Similarly, most providers can refer patients to Level 3.3—clinically managed high-intensity and population-specific services—but providers face challenges finding openings, noting “There is only one program in MN offering this level of care, very hard to get someone into that program.” Another noted, “There is only one [Level 3.3] program in Minnesota and it does not serve women.”

Milestone 4: Sufficient Provider Capacity at Critical Levels of Care. When asked about staffing adequacy for delivering treatment to Demonstration participants in the provider survey, 23 out of 25 respondents selected “Strongly Agree” or “Agree.” Providers who felt that they did not have adequate staffing noted that additional administrative support and mental health professionals are needed to support the treatment of Demonstration participants.

Milestone 5: Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Misuse and OUD. There was an average absolute 1.1 percentage point increase in initiation of treatment within 14 days of diagnosis between baseline and initial Demonstration periods, with a small decline observed between CY2020 and CY2021. Timely treatment (the proportion of beneficiaries who initiated medication within two weeks) increased by 2.6 percent (1.0 percentage point). The average time to treatment in the baseline and Demonstration periods remained similar. Minnesota did not experience a reduction in drug overdose deaths during the Demonstration period, which is consistent with national trends and trends in other states.

Milestone 6: Improved Care Coordination and Transition between Levels of Care. For all five measures associated with Milestone 6, we observed progress toward the state’s target of follow-ups after ED visit for alcohol and other drug (AOD) use or dependence. We observed no change in ED utilization per 1,000 beneficiaries for SUD, but there was an increase in readmission, ED visits following treatment, and follow-up after ED visit for AOD use or dependence.

Interpretation

Given the challenges of the COVID-19 pandemic, the results of this evaluation are likely atypical for the anticipated change for some measures. Comparisons with other state trends are not possible due to the varying nature and timing of the intensity of the pandemic. These analyses only include data through 2021. In addition, the number of providers enrolled in the Demonstration has grown since the 2021 legislative mandate passed that required all residential and WM providers to enroll in the Demonstration and meet provider standards requirements by January 1, 2024. In addition to the 2021 mandate, several factors support the hypothesis that the final evaluation report results may look different:

- Staffing. State staffing challenges, including a hiring freeze, staff shortages, and staff turnover during the pandemic
- Beneficiaries. This report does not include the experiences and perception of the patients covered by the waiver and served by Demonstration providers.
- Enhanced rates. The requirement for residential (and outpatient providers) participation in the model, along with enhanced payment rates, may lead to increased access to services at these facilities for beneficiaries.
- Implementation of direct access. This change could expand beneficiary choice and enable quicker referrals to access SUD services and will improve care coordination.

- MOUD prescribing. The state expects an increase in the number of providers actively prescribing MOUD due to state-wide initiatives to expand eligibility for prescribing as well as removal of the requirement for a Drug Enforcement Administration (DEA) "X-waiver" to prescribe buprenorphine.

Recommendations of the Evaluation

Minnesota could consider the following actions:

- Collaborate with providers to examine what is needed to improve follow-up services, from the ED as well as any treatment services, such as improved infrastructure or more personnel.
- Continue examining how to obtain comprehensive information on the health workforce that serves Medicaid beneficiaries.
- Consider mechanisms to monitor and assess the quality of care provided through managed care. For example, some states have used financial incentives tied to one or more SUD care continuum performance measures to enforce quality of care.
- Maintain commitment to telehealth for SUD services.

In addition, data on the service delivery to managed care organization (MCO) enrollees who are treated by Demonstration providers who participate in MCO utilization review processes was not available for this evaluation. MN DHS may consider implementing a survey of organizations to capture other data that may inform MN DHS of treatment quality and adequacy.

General Background Information

Introduction

On May 31, 2016, the governor of Minnesota signed Minn. Stat. § 254B.15, directing the MN DHS commissioner to design a reform of Minnesota's SUD treatment system in order to ensure that a full continuum of care is available for individuals with SUDs.[i] In fulfilling this statute under the authority of Minnesota Statutes, section 256B.0759,[ii] the Minnesota Substance Use Disorder System Reform Section 1115(a) Demonstration Project (the Demonstration) from the 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 (LOC). With Minnesota's American Society of Addiction Medicine (ASAM) LOC requirements published in October 2020 and the monitoring protocol approved on January 5, 2021, Minnesota officially began the rollout of training and technical assistance (TA) to participating providers on January 14, 2021.

The state of Minnesota has contracted with NORC to conduct an independent evaluation of the Demonstration. NORC is an objective, nonpartisan research institution that delivers reliable data and rigorous analysis to guide critical programmatic, business, and policy decisions. NORC is conducting an independent mixed-methods evaluation of the Demonstration for MN DHS, informed by NORC's experience in developing and implementing rigorous qualitative and quantitative data collection and analytic approaches. This interim evaluation report is part of the overall evaluation.

Demonstration Policy Goals

Minnesota is pursuing a multi-agency strategy to make SUD treatment more accessible and integrated with the larger health care system. The Demonstration is structured with respect to seven state-specific goals designed to achieve progress toward the following six standardized national 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 LOC, including medication-assisted treatment (MAT)[1]

[1] MAT is also referred to as medication for opioid use disorder (MOUD).

5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD
6. Improved care coordination and transition between levels of care

The state-specific goals are:

- Goal 1. Increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs
- Goal 2. Increased adherence to and retention in treatment
- Goal 3. Fewer readmissions to the same or higher LOCs where the readmission is preventable or medically inappropriate
- Goal 4. Improved access to care for physical health conditions among Medicaid beneficiaries
- Goal 5. Reduced number of opioid-related overdoses and deaths in the state of Minnesota
- Goal 6. Patients allowed to receive a wider array of evidence-based services that are focused on a holistic approach to treatment
- Goal 7. Reduced utilization of EDs and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services

In 2019, the Minnesota 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.[2] 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. In October 2019, CMS approved a state plan amendment to cover screening, brief intervention, and referral to treatment (SBIRT). 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 treating OUD is supported and encouraged by MN 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.[iii]

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 time.[iv] These dimensions include: 1) acute intoxication and potential for withdrawal; 2) biomedical conditions, complications, and past history; 3) emotional, behavioral, and

---

[2] 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.

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).

Before the start of the Demonstration, Minnesota implemented evidence-based placement criteria that were based on the ASAM six-dimensions model. To meet the goal of fully aligning the Minnesota Medicaid SUD care system with the ASAM LOCs, Minnesota is using a mix of the Demonstration, pilot programs, licensing reforms, and other regulatory tools to establish a comprehensive continuum of care.3

In October 2023, Minnesota will submit a request to extend the Demonstration. The renewal application acknowledges the barriers faced in legislation and in moving to a standardized model (as developed by ASAM) of SUD delivery, and it provides plans for continuing to make progress on the existing milestones.

Demonstration Overview

The Demonstration tests new ways to strengthen the state's behavioral health care system by improving access to treatment for the ASAM critical levels of care.[v] 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 through:

- Implementing new federal Medicaid funding opportunities for SUD services provided to patients in intensive residential settings (i.e., institutions for mental diseases [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 LOC to ensure that beneficiaries receive the treatment they need
- Establishing a network of providers interested in providing the comprehensive continuum of ASAM LOCs to individuals in need of SUD treatment

Providers who 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 cost-effective. These include 12-step facilitation therapy, brief cognitive behavioral therapy, motivational interviewing to enhance treatment engagement, and contingency management.

---

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

Providers also have access to training and TA 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.

Legislative Changes

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

- Requiring mandatory enrollment for 245G-licensed residential SUD providers and licensed 245F WM providers by January 2024, including out-of-state SUD and WM providers receiving payment through the Minnesota Health Care Program (MHCP) for eligible recipients
- Enhancing the payment rate for outpatient treatment services, MAT, 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

As originally designed, the Demonstration was a voluntary program for a smaller group of providers among the state's more than 400 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. SUD treatment providers enrolled in the Demonstration must ensure that certain requirements are implemented. MN DHS contracted with Kepro, a utilization management vendor, using an integrated platform for quality oversight, care management, and assessment and eligibility. Kepro is conducting utilization reviews of the services delivered to monitor compliance with ASAM criteria.

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 WM providers. Withdrawal management programs, vs. detoxification programs, encourage people to consider treatment, provide a higher level of medical services to assist with more acute withdrawal symptoms, and contain additional program service requirements to encourage all patients to enter programs for ongoing recovery. IMDs (facilities enrolled and approved in the Demonstration) can now bill for WM provided at IMDs, which used to be paid for by the state Behavioral Health Fund (BHF). A licensed WM provider, regardless of IMD status, is also eligible to receive payment for WM services. Hospitals are exempt from WM licensing requirements and are therefore eligible vendors of WM services. Licensed WM providers must enroll in the Demonstration by January 1, 2024, regardless of IMD status.

In May 2023, the Minnesota legislature passed additional changes to state law. These changes included adding the following ASAM Levels of Care:

- Established ASAM LOCs 0.5, 1.0, 2.1, 2.5, 3.1, 3.3, 3.5
- Required all outpatient programs to enroll in Demonstration by January 1st, 2025
- Required all hospital-based residential programs must enroll in Demonstration by January 1st, 2025

In addition, a grant provision in the governor's 2024 Budget Recommendations for WM Start-up Funding provides funding for startup and capacity-building grants for WM services.

MN DHS has also begun a contract (as mandated in the 2021 legislation) for a SUD community of practice (CoP), to be implemented from December 2022 until June 30, 2025, to "improve treatment outcomes for individuals with substance use disorders and to reduce disparities by using evidence-based and best practices through peer-to-peer and person-to-provider sharing."[vii] The CoP will consist of behavioral health care providers from various disciplines and professional levels, consumers, family members, researchers, recovery peers, and advocates. The goals of the CoP include the identification of challenges to implementing ASAM criteria, including gaps in SUD treatment services, supportive services, and using culturally specific models to address barriers to care across diverse communities.

Rate increases for enrolled providers were established when the demonstration was enacted in 2019, with increases of 15 percent for residential and 10 percent for outpatient. They increased an additional 10 percent in 2021, for total increases of 25 percent for residential and 20 percent for outpatient by January 1, 2022. As of July 1, 2022, the Direct Access program was fully implemented. Under Direct Access, individuals can go directly to a provider they choose to receive a comprehensive assessment and access care immediately.[4] During the 2023 legislative session an increase in capitation payments to managed care and county-based purchasing plans for behavioral health services was approved. These capitation rate increases, effective January 1, 2024, must be used to increase payment rates to behavioral health service providers. Also approved during the 2023 legislative session was funding to strengthen workforce capacity. With this funding, the DHS Behavioral Health Division will be able to hire approximately 30 new full-time employees. Recommendations for supportive housing are also included in the governor's 2024 human services budget, discussed below in the Interactions with Other State Initiatives section.

[4] Minnesota Department of Human Services. Direct Access. https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/alcohol-drug-other-addictions/sudreform/

Impact of the COVID-19 Pandemic on Demonstration Implementation

In March 2020, Minnesota had just begun implementing its Demonstration when the COVID-19 pandemic emerged, and a public health emergency (PHE) was declared.[5] As the state described in its quarterly Medicaid Section 1115 SUD Demonstration Monitoring Reports, staff shortages, increase in COVID-19 cases, and other issues resulted in outpatient and residential facilities' reducing admissions or discontinuing service. The monitoring metrics and the data in this report reflect these impacts.

The state also experienced a twofold increase in SUD diagnoses and demands for services during the PHE; these increases in use and unmet treatment needs mirrored national trends during the same time.[viii,ix,x] Moreover, barriers to accessing treatment and an overall reduction in documented health care seeking were reported.[xi,xii] At the same time, changes to buprenorphine access rules at the state and federal levels and state legislation to expand telehealth might have increased access to services, although it is outside the scope of this report to determine the impact of these effects.

As in other states,[xiii] Minnesota also experienced resource and staffing shortages throughout the PHE.[xiv,xv] State staff reported during interviews conducted for the midpoint assessment (MPA) that, although there was some progress on billing system changes and some legislative progress on related initiatives, such as Direct Access, 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 in part due to reprioritization of resources related to the PHE, such as changes in timelines and deliverables, adjustments in scope, delays, and budgets.[xvi] MN DHS was able to overcome some of the resource shortages, as they implemented Direct Access for treatment and billing processes for SUD services.[6]

To support the SUD reform and Demonstration requirements, DHS has been filling vacancies for the following positions: Deputy assistant commissioner of behavioral health, director of SUD services, supervisor of SUD reform and redesign, 1115 Demonstration operations lead, and project manager positions to oversee contracts for paperwork reductions and systems improvement, and CoP. Funding for these positions was authorized as part of the 2023 legislation. DHS is also seeking to post openings for an ASAM policy lead and trainer, a quality assurance and continuing improvement (QAI) specialist to oversee UM and compliance, and a contracts coordinator to manage contracts required for implementation of SUD reform and redesign.

---

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

[6] Direct Access refers to eligible members' ability to select the SUD provider from whom they want to receive services, including assessment and treatment.

Population Groups Impacted by the Demonstration

All persons with full Medicaid coverage are eligible for the services provided by the Demonstration. Some claims-based metrics were limited to persons with continuous enrollment as defined by MN DHS.[7] A further subset of claims-based measures is reported on the members of the beneficiary population who have an OUD. The target population largely consists of persons with an SUD and individuals 18 to 64 years of age. The Demonstration is statewide.

Demonstration Goals, Waiver Milestones, and Evaluation Questions

In Exhibit 1**,** we list the evaluation questions addressed in this report and describe how they align with the Demonstration goals and the six CMS-required milestones (listed below), along with the quantitative and qualitative data used in this report to assess progress toward the goals. In addition to the data analysis undertaken in this report, we incorporate findings and updates to information from the implementation plan developed by the MN DHS, as well as NORC's findings in the Baseline Provider Capacity Assessment and MPA.

CMS-Required Milestones

1. Access to critical levels of care for SUDs
2. Widespread 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 LOC, including MAT
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD
6. Improved care coordination and transitions between LOCs

[7] The major programs that are considered full coverage are: MA, NM, RM, IM, KK, LL, FF, JJ, BB, XX. Please see the following link for a description of each major program: https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=ID_008922#recipient.

Exhibit 1. Demonstration goals, evaluation questions, demonstration milestones, and measure or qualitative data

Goal 1. Increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs.

Hypothesis: The Demonstration will increase the share of beneficiaries who are identified and treated for OUD/SUD in ways that are consistent with evidence-based care.

Demonstration Milestone: 1 and 4

Evaluation Questions:

1. To what extent did implementation of the 1115 SUD Demonstration result in increased screening and identification of members with SUD?

2. Did efforts to improve initiation and engagement facilitated by the 1115 SUD Demonstration result in Minnesota Medicaid beneficiaries with SUD, including OUD, receiving more treatment for SUD?

Measure or Qualitative Data in This Report:

Quantitative, claims-based:

- Percentage of beneficiaries with engagement in alcohol and other drug-dependence treatment
- Percentage of beneficiaries with initiation in alcohol and other drug-dependence treatment
- Time to treatment

Quantitative, non-claims-based:

- Number of enrolled at each level of care

Qualitative:

- MN Provider Survey

Goal 2. Increased adherence to and retention in treatment.

Hypothesis: The Demonstration will improve adherence to treatment plans.

Demonstration Milestone: 1,2, 3 and 6

Evaluation Questions:

1. To what extent and how did implementation of the 1115 SUD Demonstration result in improvement in:

a. Adherence to the plan of treatment?
b. Retention of Minnesota beneficiaries with SUD in addiction recovery management?
c. Duration of pharmacotherapy, including MAT for OUD, among Minnesota beneficiaries?

Measure or Qualitative Data in This Report:

Quantitative, claims-based:

• Follow-up after IMD stay, for persons with alcohol and other drug (AOD) use or dependence, persons with alcohol or other SUD and discharged from an IMD with a follow-up visit within 7 and 30 days of discharge

• Follow-up after ED visit for AOD use or dependence

• Percentage of patients with OUD initiated with MAT

• Continuity of pharmacotherapy for OUD

Qualitative:

• MN Provider Survey

Goal 3. Fewer readmissions to the same or higher LOCs where the readmission is preventable or medically inappropriate.

Hypothesis: The Demonstration will reduce readmissions to the same or higher LOC among beneficiaries with SUD.

Demonstration Milestone: 2, 3, and 4

Evaluation Questions:

1. Did the more comprehensive continuum of covered SUD services and care facilitated by the 1115 SUD Demonstration result in fewer readmissions to the same or higher LOC among beneficiaries with SUD? Quantitative, claims-based:

Measure or Qualitative Data in This Report:

• All-cause readmissions during the measurement period among beneficiaries with SUD: The count of 30-day readmissions: ≥1 acute readmission for any diagnosis within 30 days of the index discharge date for beneficiaries with an SUD

Goal 4. Improved access to care for physical health conditions among Medicaid beneficiaries.

Hypothesis: The Demonstration will increase use of preventive health services.

Demonstration Milestone: 1 and 4

Evaluation Questions:

1. Did beneficiaries increase use of preventive health services after implementation of the 1115 Demonstration?

2. Do SUD services providers believe that access to care for physical health conditions has improved since implementation of the 1115 SUD Demonstration?

Measure or Qualitative Data in This Report:

Quantitative, claims-based:

- Percentage of beneficiaries with an SUD receiving ambulatory or preventive care

Goal 5. Reduced number of opioid-related overdoses and deaths in the state of Minnesota.

Hypothesis: The Demonstration will increase use of preventive health services.

Demonstration Milestone: 2,3 and 5

Evaluation Questions:

1. Did the mortality rate among Minnesota beneficiaries with SUD/OUD decrease after implementation of the 1115 Demonstration?

2. Did overdose-related mortality rates among Minnesota beneficiaries with SUD/OUD decrease after implementation of the 1115 SUD Demonstration?

Measure or Qualitative Data in This Report:

Quantitative, MN cause of death data linked to Medicaid enrollment data:

- OUD mortality rate

Goal 6. Patients allowed to receive a wider array of evidence-based services that are focused on a holistic approach to treatment.

Hypothesis: The Demonstration will increase the share of beneficiaries who are treated for OUD/SUD in ways that are consistent with evidence-based care.

Demonstration Milestone: 1 and 4

Evaluation Questions:

1. What are the challenges to implementing ASAM's critical levels of care?

2. To what extent and how did implementation of the 1115 SUD Demonstration result in the incorporation of evidence-based standards into SUD treatments?

3. To what extent did the 1115 SUD Demonstration enable providers to deliver the comprehensive continuum of services and care for SUD and OUD?

Measure or Qualitative Data in This Report:

Qualitative: MN Provider Survey

Goal 7. Reduced utilization of EDs and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services.

Hypothesis. The Demonstration will reduce the utilization of EDs, avoidable hospitalizations, hospitalizations for ambulatory-care-sensitive conditions, and intensive inpatient services.

Demonstration Milestone: 4 and 5

1. Did implementation of the 1115 SUD Demonstration result in the following, among Medicaid beneficiaries with SUD, after receipt of treatment services:

   a. Improved use of preventive care?
   b. Reduced ED utilization?
   c. Fewer avoidable hospitalizations?
   d. Fewer hospitalizations for ambulatory-care-sensitive conditions?
   e. Fewer avoidable hospitalizations during and after receipt of addiction recovery management services?

Measure or Qualitative Data in This Report:

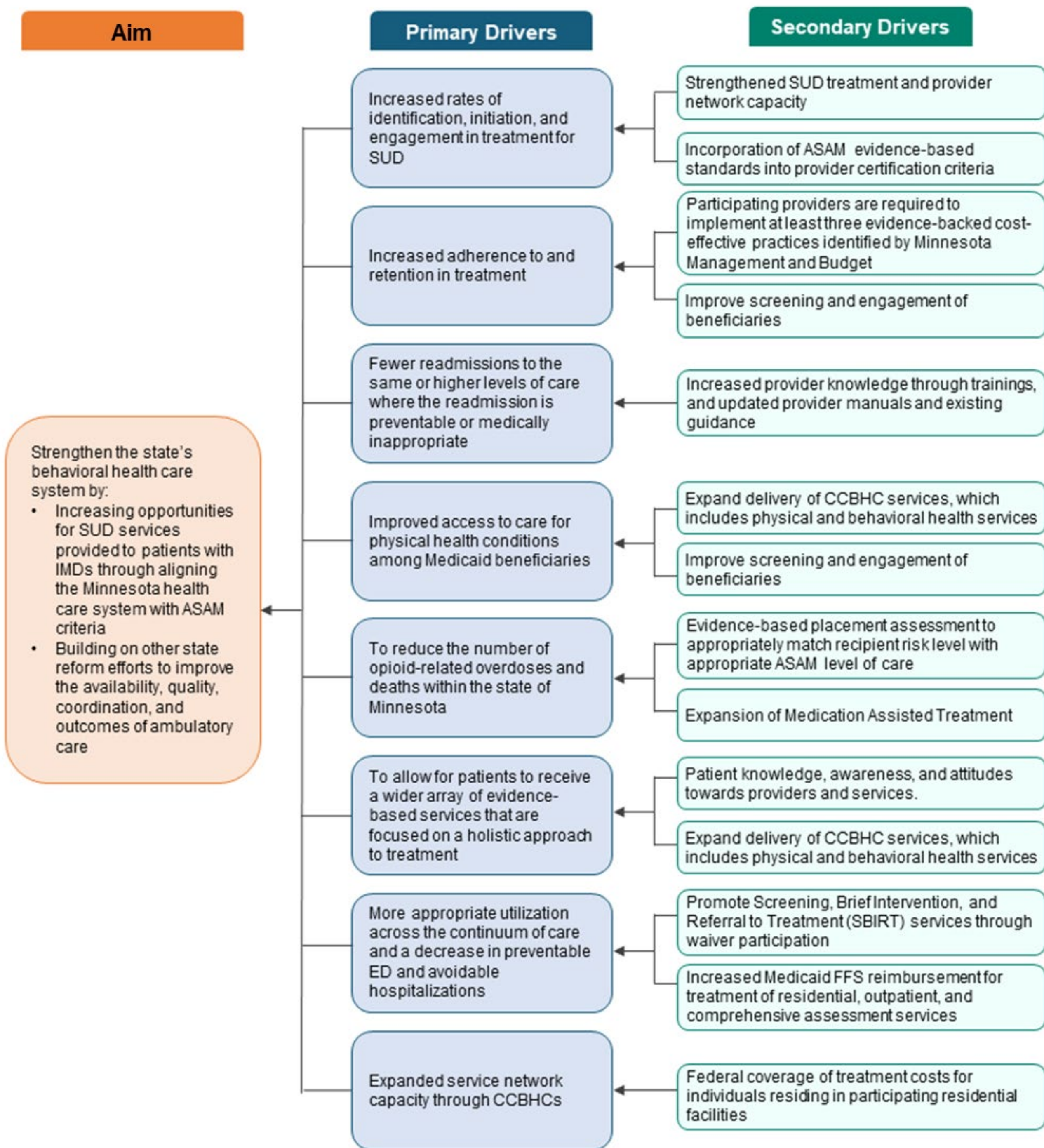
Quantitative, claims-based:

- ED visits following discharge from treatment
- Follow-up after ED visit for alcohol and other drug misuse or dependence
- Percentage of beneficiaries with an SUD receiving ambulatory or preventive care
- ED utilization per 1,000 beneficiaries for SUD

Demonstration Driver Diagram

Exhibit 2 illustrates the primary and secondary drivers for the Demonstration’s aim of strengthening the state’s behavioral health system by increasing opportunities for SUD services provided to patients at IMDs through aligning the Minnesota health care system with ASAM criteria and building on other state reform efforts to improve the availability, quality, coordination, and outcomes of ambulatory care.

Exhibit 2. Demonstration driver diagram[8]



[8] Certified Community Behavioral Health Clinic (CCBHC) an integrated clinic and service delivery model that uses a cost-based reimbursement structure. Source: https://mn.gov/dhs/partners-and-providers/policies-procedures/behavioral-health/ccbhc/

Methodology

Evaluation Design

The evaluation approach is guided by the goals of the Demonstration. Exhibit 3 presents our overall evaluation approach to addressing the research questions, including data sources and analytic methods. The claims-based measures for this interim evaluation report align with the CMS monitoring protocol. For the final evaluation report (summative evaluation), we will include additional metrics and use quarterly data (where applicable) to establish quarterly and annual trends in an interrupted time-series design. For reasons related to the timing of the Demonstration implementation, this report does not include all metrics.

The 1115 Demonstration period covers July 1, 2019, through June 30, 2024. This report examines the two-year period before the Demonstration—January 1, 2017, to December 31, 2018—and a two-year period during the Demonstration from January 1, 2020, to December 31, 2021. It also includes a qualitative assessment of Demonstration implementation through 2022 based on a survey of enrolled providers that was conducted in early 2023. Data are structured on a calendar year. The interim evaluation period excludes a 12-month ramp-up period of calendar year (CY) 2019, during which changes to the provider manual regarding ASAM LOCs were disseminated, provider trainings initiated, and service coverage changes newly implemented. Apart from the ramp-up period, there are no further restrictions on the time period assessed for the Demonstration phase due to the COVID-19 pandemic.

Evaluation Measures and Sources

Exhibit 3 provides a description of the data sources used for the interim evaluation report.

Exhibit 3. Data sources used in the interim evaluation report

Data Sources	Description
Claims-based measures	MN DHS provided NORC with files for 11 measures from the Minnesota Medicaid system.
Provider survey	NORC completed an online survey of all enrolled provider organizations on the implementation of the Demonstration.
MN DHS Minnesota Substance Use Disorder System Reform Demonstration CMS Monitoring Reports Part B	The state provided NORC with CMS Part B Monitoring Reports for Demonstration Year 1/Quarter 2 through Demonstration Year 4/Quarter 2 that included narrative descriptions of the progress toward each milestone and Demonstration implementation.

Data Sources	Description
OUD mortality data	MN DHS provided NORC with data from state death certificates that included cause of death, linked to the beneficiary enrollment files.
Implementation plan	NORC assessed progress toward completing the actions identified in the implementation plan.
Midpoint assessment	NORC's prior findings in the midpoint assessment are used to inform qualitative progress on goals and identify areas for opportunity for improvement and integration with other state initiatives.
Baseline provider capacity assessment (PCA)	NORC reviewed the baseline PCA to identify progress toward areas of improvement indicated in the baseline PCA.
State documents	MN DHS provided NORC with written responses to questions identified by the NORC evaluation team, the state's request for proposals for a contractor to support the state in the development of the SUD community of practice, the state's request for proposals for a contractor to minimize regulatory paperwork and improve systems for SUD programs.
Kepro utilization management report	MN DHS provided NORC with a document summarizing findings from Kepro's quality and utilization management report.
Supporting literature	We reviewed existing peer-reviewed and grey literature[9] to contextualize the impacts from COVID and to understand Medicaid policy options that MN DHS may want to consider in support of progress toward Demonstration goals.

Analytic Methods

Claims-Based Measures

***Target group*.** The target population of the Demonstration is all individuals enrolled in Medicaid who receive any services for SUD. For most analyses, beneficiaries with an OUD or SUD (a qualifying claim that uses an OUD/SUD diagnosis code as the primary diagnosis) must also satisfy criteria for specific enrollment periods (e.g., continuous enrollment). This approach is an intent-to-treat (ITT) design: the analysis includes all eligible Medicaid beneficiaries, regardless of what, if any, treatment they received from enrolled providers. This ITT design avoids the volunteer bias from limiting the evaluation to only beneficiaries who received care from participating providers. Currently only residential providers are

[9] Grey literature is information that falls outside the mainstream of published journal and mongraph literature, not controlled by commercial publishers, and includes sources such as reports, conference abstracts or papers, and governmental or private sector research. Source: https://www.nihlibrary.nih.gov/services/systematic-review-service/literature-search-databases-and-gray-literature

required to participate and must enroll by 2024. We examined all metrics at the beneficiary level and conducted event-level analyses for a subset of measures.

Comparison group. The use of an ITT design and the lack of an available out-of-state or within-state comparison group precludes a comparison group. All providers are eligible for participation in the Demonstration, and all Medicaid beneficiaries with an SUD/OUD are eligible for services (although some outcome measures require full benefits and specific enrollment duration for inclusion in analyses). Both of these factors limit the construction of a comparison group. Providers who do not participate may be different in unobserved ways from those who do participate with respect to factors that are not captured in claims data (such as case mix at facilities, geographic distances, staff mix and credentials across the referral network, and telehealth capabilities). At the same time, the state anticipates a "spillover" effect of establishing ASAM criteria statewide: Providers in the state are expected to engage with ASAM guidelines, although nonparticipating providers will not be required to demonstrate adherence to ASAM criteria. Nonparticipating providers may adopt the ASAM framework, as this approach becomes part of the culture of care in the state, and the evaluation would have no way of knowing if this is occurring. Furthermore, beneficiary placement is expected to be made on the basis of ASAM LOC guidelines. It may be that more severe cases are assigned to providers with a greater treatment capacity. For example, patients' SUD severity may influence which IMD they are referred to, and the capacity to manage severe patients may be associated with participation in the Demonstration. Comparisons to patients with private coverage are not appropriate due to differences in social risk factors and other unmeasurable barriers to health that Medicaid patients may have that are not typically present in a commercially insured population. We compare outcomes for beneficiaries in the baseline and demonstration periods.

Quantitative Methods

We computed descriptive statistics for the target population in the baseline and Demonstration periods. We used serial cross-sectional and pre-post analysis to test hypotheses concerning the research questions related to program reach and impact.

Descriptive summary statistics. Summary statistics are reported to characterize the baseline period and Demonstration period populations with respect to demographic characteristics, number of months of coverage, dual-eligibility status, distribution of the populations among the prevention regions (PRs), and the presence of OUD and chronic conditions.

Multivariable regression analysis. We used a serial cross-sectional and pre-post design, implemented in generalized linear multivariable regression models with the appropriate distribution model (logistic models for binary outcomes and linear regression for event-level analyses), and report adjusted outcomes, testing for significant differences (at $\alpha = .05$) between each year and between the baseline and Demonstration periods. Adjusted regression models controlled for differences in duration of coverage, demographics (age, race/ethnicity, sex), dual eligibility with Medicare, and five of the most prevalent chronic conditions (asthma, depression or anxiety, liver disease, arthritis, and diabetes), and

the distribution of the beneficiaries among the seven MN DHS PRs.[10] For outcomes not specifically assessed on beneficiaries with an OUD diagnosis, we also adjusted for a diagnosis in the past 12 months. We clustered standard errors at the beneficiary level to account for repeated observations of the same beneficiaries in the data over time. We report outcomes observed during the two-year baseline period before the Demonstration implementation date, using calendar years January 1, 2017, to December 31, 2018, and a post-period January 1, 2020, through December 31, 2021.This excludes 2019 as ramp-up period. Results are presented in tables and graphs.

Unadjusted overdose deaths analysis. As part of Goal 5, we reported the unadjusted number and rate of deaths per 1,000 Medicaid beneficiaries and rate per beneficiaries with OUD for the latter. This is consistent with CMS metrics 26 and 27 for drug overdose deaths. MN DHS provided these counts, using data from the National Vital Statistics System Mortality Multiple Cause-of-Death Files, linked to Medicaid beneficiary enrollment data to report on overall death rates. Overdose deaths are those from the International Classification of Diseases-10 (ICD-10) codes for underlying cause of death: X40-X44 (unintentional drug poisonings), X60-X64 (suicidal drug poisonings), X85 (homicidal drug poisoning), and Y10-Y14 (drug poisoning of undetermined intent). OUD deaths are those resulting from T40.1 (heroin), T40.2 (natural and semisynthetic opioids), T40.3 (methadone), and T40.4 (synthetic opioids other than methadone).

Qualitative Methods

To strengthen NORC's understanding of perspectives on implementation of the Demonstration and its outcomes, we conducted two qualitative data collection activities. First, NORC conducted a voluntary survey aimed to reach all enrolled Demonstration providers. Second, NORC completed a document review of the baseline, midpoint, and quarterly monitoring Part B reports for Demonstration years three and four. These documents informed NORC's survey data collection and analysis. The survey was conducted using the Qualtrics online survey platform and consisted of 19 closed and open-ended questions. Twenty-five providers responded to the survey, which was conducted from January 24, 2023, to March 17, 2023. The reported provider survey data reflect the implementation experiences of those providers. The 25 respondents represent all ASAM critical LOCs and 97 facility locations that bill for 45 different national provider identifiers. There was only one respondent providing Level 3.3, clinically managed high-intensity and population-specific services. Many respondents represent providers and facilities in the Minneapolis-Saint Paul region, but there were also respondents from central and southern regions of the state.

For the final evaluation, NORC will conduct primary data collection through a series of in-depth interviews with beneficiaries and other key Demonstration participants, including consumer advocates, providers, managed care plans, and state Medicaid staff members. The beneficiary interviews will aim to understand recent experiences in accessing SUD-related care, barriers, and facilitators to obtaining

[10] See the MN DHS Prevention Regional Coordinators website for the counties in each region: https://rpcmn.org/index.php.

SUD treatment, and ways in which health insurance can better support access to care. These will be done at the end of the fourth Demonstration year (reflecting the delay in implementation of the Demonstration), as this will allow a better understanding of the changes that have occurred during the Demonstration period.

Methodological Limitations

Data availability. The study period for this interim report was limited to a two-year period post-demonstration to accommodate claims data availability and to align with CMS reporting requirements. Further data were aggregated to the annual level to facilitate alignment with metric calculation and to limit the burden to the MN DHS.

Because of the limitations in time and advance preparation, and the difficulty in determining progress with the Demonstration during the COVID-19 pandemic, the scope of the interim evaluation report is a more limited set of measures and analyses. The final evaluation report will use a quarterly data analysis and interrupted-time series to enable a deeper understanding of the trends before and during the Demonstration and will include additional metrics as more providers become approved for each level of ASAM care. Apart from examining trends in medication for OUD in urban and rural areas, we do not report results for any subgroups, noting cautious interpretation of all results in this report due to the impact of the COVID-19 pandemic. Since we are cautious in interpreting the overall results, we did not seek to examine variation among subgroups.

Although it is not within the scope of this report to evaluate the potential impact of the pandemic on the number of providers and their capacities, the availability of services, and beneficiaries' care-seeking behaviors, we qualify our findings from review of the existing literature on the pandemic's impact on the health care system.

Qualitative data. As noted above, our provider survey aimed to collect data from all enrolled Demonstration providers, but participation was voluntary. We conducted extensive follow-up by email and phone with all providers who did not complete the survey. Nonetheless, the survey findings may reflect selection bias on the part of providers who were motivated or had the capacity to participate in the survey. Although participating providers represented providers across the state who deliver all ASAM LOCs, the results may not include the experiences and viewpoints of all of the provider organizations in the Demonstration, especially those of smaller SUD/OUD providers that operate with limited administrative staff.

Results

Progress on Implementation Plan

As of March 2022, when the midpoint assessment was completed, the state had achieved 23 of the 27 total action items across the six milestones. Three of these were ongoing and one was suspended. Below we provide an update on those implementation plan action items as well as ongoing progress on other activities needed to implement the Demonstration (Exhibit 4), as described in the Part B monitoring reports from October 2021 through December 2022 (Demonstration Year 3/Quarter 2 to Demonstration Year 4/Quarter 4). Prior to the midpoint assessment, in July of 2021, Minnesota submitted an updated Implementation Plan to CMS with an appendix that discussed the state's Health IT Plan and the impact of diverse technology initiatives on the Demonstration. In addition, providers continue to enroll in the Demonstration. The state is seeking to pass legislation codifying all ASAM levels of care in the state plan authority.

Exhibit 4. State implementation activities

MS#	Implementation Update	Current Status
1	Begin state plan coverage of intensive outpatient treatment (Level 2.1)	Ongoing: The proposal included in the governor's budget recommendations to the legislature includes coverage of all SUD services, with provider requirements and service standards consistent with ASAM levels, including Level 2.1.
2	Activities to improve access to SUD treatment services across the continuum of care for Medicaid beneficiaries	Ongoing: The state has worked with internal and external stakeholders to adopt service definitions and provider qualifications consistent with the ASAM LOCs currently provided under the state's waiver authority.
2	Planned activities to improve providers' use of evidence-based, SUD-specific placement criteria	Ongoing: The state continues to work with the University of Nevada, Reno Center for the Application of Substance Abuse Technologies (UNR-CASAT) and is now creating its own training model to ensure a long-term solution to support the community in understanding ASAM. The state has also developed a more robust TA process to provide support to agencies in utilizing the placement criteria.
3	Develop residential treatment provider review process and initiate ongoing monitoring process	Ongoing: Kepro has developed the initial review process, which will be reviewed with MN DHS as necessary. The state continues discussions to update the placement criteria document to be more concise for providers and assist in making proper placement determinations and transitions to step-down levels of care.

MS#	Implementation Update	Current Status
3	Review process for residential treatment providers' compliance with qualifications	Ongoing: Due to staffing shortages, this process was not able to begin in 2022. MN DHS plans to implement the review process in 2023 following the conclusion of the PHE. The process has been finalized, and the state is hiring a quality assurance and continuous improvement specialist to oversee UM and compliance reviews.
5	Continue to support use of the Minnesota Prescription Monitoring Program (MNPMP) when prescribing and use of the prescribing guidelines Identify opportunities for expanding MNPMP functionality and use	Ongoing: DHS works with clinical consultants who engage directly with prescribers to understand the Minnesota Opioid Prescribing Guidelines (2018) and promote use of the PDMP as practice standard. In order to achieve enhanced connectivity between the state's PDMP and any statewide, regional, or local health information exchange, the Minnesota legislature would need to pass legislation to allow this. The current legislative makeup has a strong data-privacy concern and has not expressed interest in passing legislation to allow for connectivity between the PDMP and state or local health information exchanges (HIEs). Regardless, collaboration between MN Board of Pharmacy (BOP), DHS, Minnesota Department of Health (MDH), and other SUD treatment entities will focus on increasing the potential connectivity between the existing PMP and other HIE's, and submitting legislative language that would allow for such exchanges of information. BOP, DHS, MDH, and other stakeholders will, on an ongoing basis, explore streamlining of collaboration and communication between all existing SUD monitoring programs and the MN PDMP.
4	Planned activities to assess the availability of providers enrolled in Medicaid and accepting new patients across the continuum of SUD care	Ongoing: The state is implementing a contract to increase transfer of knowledge about ASAM criteria (through communities of practice). The governor's budget recommendations to the legislature include a requirement for all outpatient SUD programs receiving payment through the state's medical assistance (MA) program to enroll and participate in the demonstration by January 2025. In addition to this proposal, several proposals were introduced as part of the governor's budget recommendations that are aimed at addressing workforce shortages.
5	Implementation of opioid prescribing guidelines and other interventions related to prevention of OUD	Ongoing: As part of the 2023 legislative proposal, the state is proposing a stronger mandate regarding MAT/MOUD services. This would ensure a more expansive service coverage area for individuals seeking MOUD services. In addition, it would ensure that individuals statewide will be protected in their ability to utilize MOUD while participating in treatment. MN DHS oversees the Opioid Prescribing Improvement Program (OPIP), a clinical quality improvement effort that reviews claims for opioid prescriptions data to identify outliers in the opioid-prescribing community. Once identified, MN DHS partners with individual opioid prescribers and their health systems/clinics to identify any existing knowledge gaps.

MS#	Implementation Update	Current Status
5	Implementation of opioid prescribing guidelines and other interventions related to prevention of OUD	Ongoing: As noted above; in addition, MN DHS will continue to refine the reports to meet the needs of OPIP. There are quality improvement thresholds for five of the seven opioid prescribing sentinel measures. Providers whose prescribing rate is above the threshold for any of the five measures will be required to participate in the quality improvement program if they also prescribed above a certain volume of opioid analgesic prescriptions to Minnesota Medicaid and MinnesotaCare enrollees in the measurement year.
6	Implementation of policies supporting beneficiaries' transition from residential and inpatient facilities to community-based services and supports	The state's Direct Access initiative was operational beginning on July 1, 2022. This will enable beneficiaries to access a comprehensive assessment for an LOC determination at a location of their choice. The state anticipates that this implementation will increase access and utilization and improve care coordination across LOCs and provider agencies. The state has also implemented a paperwork reduction group to identify areas across the SUD system where documentation requirements can be streamlined to reduce burdens on transitions. The state is working with providers to assist in making placement determinations and transitions to step-down LOCs.

Provider Enrollment and Approval and Utilization Management

Minnesota continues to enroll providers as the January 2024 deadline approaches for the mandatory enrollment of residential and WM providers that receive funding from the state. In 2022, Minnesota also began legislative efforts to extend mandatory participation to outpatient providers enrolled in in the state's medical assistance (MA) program. During the 2023 Minnesota legislative session, legislation was passed that requires all outpatient programs and all hospital-based residential programs to enroll in the Demonstration by January 1, 2025. Exhibit 5 below shows the considerable growth in the number of providers and locations enrolled and approved for each LOC during the first three years of the Demonstration. In 2022, 31 new providers enrolled. Also, starting in 2022, with the anticipated increase in enrollment, the state began reviewing current providers' enrollment applications for any missing information needed to confirm and ensure compliance with the Demonstration requirements.[11]

Although implementation of the state process for reviewing residential treatment provider compliance had been delayed when this report was drafted, MN DHS reports that implementation will begin with the hiring of a QAI specialist and additional trainers, who will provide assistance and guidance to residential programs to facilitate compliance with ASAM criteria. However, there are existing processes in place to ensure provider certification. For example, clinical case approvals through utilization reviews are conducted by the MN DHS's UM contractor, Kepro. MN DHS is working to identify providers that are not aligned with the published standards of care consistent with the ASAM criteria. MN DHS also

[11] Medicaid Section 1115 SUD Demonstration Monitoring Report – Part B, Minnesota Substance Use Disorder System Reform Demonstration Year 3/Quarter 4.

reported continuous work with utilization management to identify opportunities to increase fidelity to the ASAM criteria.

Exhibit 5. Growth in enrolled providers and locations by level of care, 2020-2023[12]

Number of Unique Organizations (Unique Organizational-Level National Provider Identification Number) by Level of Care

Year	Level 1.0 Outpatient	Level 2.1 Intensive Outpatient	Level 3.1 Low-Intensity Residential	Level 3.3 Residential Services	Level 3.5 Clinically Managed High-Intensity Residential	Level 3.2 Clinically Managed Residential Withdrawal Management	Level 3.7 Medically Monitored Inpatient Withdrawal Management
2020	0	1	1	0	0	0	0
2021	35	36	29	1	31	4	3
2022	22	24	9	0	10	1	0
2023	9	8	3		5		
Total	**55**	**56**	**39**	**1**	**40**	**5**	**3**

Number of Unique Facilities

Year	Level 1.0 Outpatient	Level 2.1 Intensive Outpatient	Level 3.1 Low-Intensity Residential	Level 3.3 Residential Services	Level 3.5 Clinically Managed High-Intensity Residential	Level 3.2 Clinically Managed Residential Withdrawal Management	Level 3.7 Medically Monitored Inpatient Withdrawal Management
2020	0	5	3	0	0	0	0
2021	65	70	32	1	36	5	3
2022	38	40	11	0	10	1	0
2023	12	11	3		6		
Total	**102**	**114**	**47**	**1**	**47**	**6**	**4**

Notes: The number of unique organizations in each year was determined by counting newly approved locations, by organizational National Provider Identification (NPI) number. The total providers is not the sum of the 3.5 years, as some providers or groups disenrolled, as they ceased operating as the entity under which they enrolled. An organization may have

[12] The total number of providers and locations in this table reflects data through June 22, 2023.

multiple facilities. See ASAM criteria for description of each level of care: https://www.asam.org/asam-criteria/about-the-asam-criteria.

As part of the approval process, providers are required to: 1) establish and maintain formal patient referral arrangements to ensure access to the ASAM LOCs and 2) agree to submit data for UM that aligns with ASAM-based placement criteria. Approved participating providers are required to implement at least three evidence-based effective practices that support increased adherence to and retention in treatment. Participating providers receive increased payment rates to support their transition to the ASAM-based standards. MN DHS provided training manuals and training on ASAM criteria and, through Kepro, provided webinars designed to review the ASAM criteria and instruct enrolled providers regarding how to submit cases for utilization review.[13] MN DHS continues to provide these trainings. As noted in the MPA, MN DHS also expanded provider capacity to treat OUD through Project Extension for Community Healthcare Outcomes (ECHO). Minnesota is using Project ECHO to educate and engage many types of providers, including prescribers, social service staff, licensed alcohol and drug use counselors, and clinic administrators about MOUD.

As described in the MPA, in July 2021 MN DHS implemented its new UM process through Kepro. All enrolled providers were trained by Kepro on data collection and submission. Since then, the state has held listening sessions with SUD providers to gather their feedback so that they could collaborate with Kepro to improve the system. Specifically, they worked to reduce the administrative burden on providers. As described below, the state has received positive feedback regarding the changes made to the UM process with Kepro, which reduced the review to 15 percent of admissions for residential providers and 10 percent for outpatient providers. MN DHS has also implemented changes to the enrollment process to use virtual meetings in addition to drop-in TA sessions to give providers face-to-face time with MN DHS staff members. This resulted in a shortened wait time to enroll. The state also added a clinical review specialist, an operations lead, and a supervisor to provide TA with enrollment. These changes helped reduce delays brought about by PHE-related administrative challenges.

During the fall of 2021, MN DHS, in partnership with UNR-CASAT, through the National Frontier and Rural Telehealth Education Center (NFARtec), and the Great Lakes Addiction Technology and Transfer Center (ATTC) began web-based ASAM trainings. Trainings consist of an introductory “Navigating Levels of Care” webinar, a six-week enhanced professional learning series focused on the application of the ASAM criteria.

Also in 2021, MN DHS reported that they continued to identify gaps and misalignments between the ASAM criteria for 1.0 and 2.1 and the state statute, which would limit Medicaid beneficiaries’ access to care. MN DHS conducted a gap analysis and developed a plan to align the statute with ASAM LOCs. Then, beginning in February 2022, the state worked closely with SUD providers to listen and understand concerns about 1115 components and other state changes. Providers were most concerned about staffing shortages and paperwork burden, especially related to UM. The MN DHS

[13] MN DHS executed the Kepro contract for UM on February 2, 2021, and the UM process was implemented on July 1, 2021.

Demonstration team indicated that they have supported the Behavioral Health Division team to develop a proposal to assess and recommend improvements to minimize regulatory paperwork and improve reporting and billing systems, including changes to reduce administrative and paperwork burden for counselors, streamline and improve the process of licensure, and improve efficiencies in the payment system.

Claims-Based Results

The following section presents descriptive statistics showing the Medicaid beneficiary population based on the claims data. As shown in Exhibit 6, although the total Medicaid population increased in 2021 due in part to the continuous enrollment provision as part of the PHE, the percentage of the population with any SUD remained stable over time at just under 7 percent.

Exhibit 6. Medicaid beneficiary population, CY2017-CY2021

Study Period	Total Medicaid Population	Number of Beneficiaries with SUD	Percent with Any SUD
CY2017	1,470,658	98,862	6.7%
CY2018	1,464,418	99,941	6.8%
CY2020	1,411,642	94,660	6.7%
CY2021	1,521,510	102,977	6.8%
Total	**5,868,228**	**396,440**	**6.8%**

Overall, we do not observe substantial changes in the population between the baseline and Demonstration periods, but the average months of enrollment increased during 2020-2021 from 10.6 to 11.1. This is also due to the changes in the Medicaid enrollment process during the PHE, during which MN DHS halted the eligibility checks, as a condition of enhanced federal funding from the Families First Coronavirus Response Act.

Among Medicaid beneficiaries with an SUD, 28 percent have an OUD. In addition, approximately 57 percent are male, 62 percent are non-Hispanic White, and 17 percent have both Medicare and Medicaid (Exhibit 7). This population is disproportionately likely to have certain other mental health conditions, such as depression or anxiety (approximately 73 percent of Medicaid beneficiaries with an SUD vs. 28.3 percent of all adults in Minnesota[14]).

---

[14] KFF. Mental health in Minnesota; fact sheet. Available at: https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/minnesota.

Exhibit 7. Characteristics of the Minnesota Medicaid population with SUD, baseline and Demonstration periods

Medicaid Population with SUD Diagnosis	2017-2018	2020-2021	Difference
Average number of months of enrollment	10.6	11.1	0.5*
Female (%)	43.0	42.4	-0.7*

Age (% in group)

Medicaid Population with SUD Diagnosis	2017-2018	2020-2021	Difference
<18 years	3.9	3.1	-0.7*
18 to 65 years	91.7	91.7	0.0
65+ years	4.4	5.2	0.8*

Race/ethnicity (%)

Medicaid Population with SUD Diagnosis	2017-2018	2020-2021	Difference
Hispanic	5.6	6.3	0.6*
Non-Hispanic Black	17.7	17.8	0.2
Non-Hispanic Other	14.0	14.7	0.8*
Non-Hispanic White	62.8	61.2	-1.6*
OUD	27.3	28.0	0.7*

Program coverage (%)

Medicaid Population with SUD Diagnosis	2017-2018	2020-2021	Difference
Enrolled in Medicaid coverage with full benefits	96.0	96.4	0.5*
Dual eligibility	17.2	16.4	-0.8*

Chronic conditions (%)

Medicaid Population with SUD Diagnosis	2017-2018	2020-2021	Difference
Heart disease	4.9	5.1	0.2*
Asthma	27.5	21.9	-5.6*
Chronic obstructive pulmonary disease	8.1	7.7	-0.4*
Liver disease	8.8	9.5	0.6*
Arthritis	19.5	17.5	-1.9*
Depression or anxiety	73.2	73.9	0.6*
Diabetes	12.3	12.8	0.6*
Hypertension	38.2	39.5	1.4*

Region

Medicaid Population with SUD Diagnosis	2017-2018	2020-2021	Difference
1 – Northwest	5.6	5.7	-0.2*
2 – Northeast	9.3	9.3	0.1
3 – West Central	6.5	6.4	0.0
4 – East Central	9.8	10.3	0.0
5 – Southwest	7.0	7.2	0.5*
6 – Southeast	7.9	8.0	0.2*
7 – Metro	53.2	52.4	0.2*
Other region	0.7	0.6	-0.1

*Indicates significant difference at p<.05 between time periods. Programs defined as full coverage include medical assistance (MA and NM), refugee MA (RM), MA for those in an IMD (IM), MinnesotaCare (KK, LL, FF, JJ, BB, XX).[15]

[15] Minnesota Department of Human Services. Health care programs and services. Available at: https://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=ID_008922.

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

To ensure and increase access to critical LOCs for OUD and other SUDs, MN DHS reported a variety of actions related to the goals of increasing the proportion of patients in OUD and SUD treatment and adherence to and retention in treatment. Providers also reported that the Demonstration had been effective in assessing and directing patients to the appropriate treatment. In order to evaluate progress toward this milestone quantitatively, we analyzed data to assess the percentage of OUD patients who initiated MOUD. Data from a recent provider survey are also presented below to provide context for provider experience under the Demonstration. We do not report on SBIRT in this report.

Midpoint assessment. In the MPA, providers reported having knowledge of and experience with the ASAM standards because they were closely aligned with the Minnesota matrix for determining placement. However, providers noted that there were still challenges in applying ASAM criteria during assessment, as not all LOCs were available in the Demonstration. The MPA and the state noted (in their quarterly monitoring reports) that providers are performing SBIRT but may need more training on billing. The state provides information for providers regarding billing in the MHCP Provider Manual, and providers can contact the MHCP Provider Resource Center with questions.

During 2021, the state also experienced billing issues concerning WM and has noted that the lack of enhanced rates for WM services in the Demonstration may prevent facilities from transitioning to WM services over detoxification, which can still be paid for through the state's Behavioral Health Fund. MN DHS indicated the onboarding of the ASAM Training Lead will support and expand training in early intervention, now in state law (0.5 Early Intervention) and the Minnesota Health Care Programs (MHCP) Provider Resource Center can provide ongoing training/guidance on all billing requirements.

Summary of Measures

There was progress toward the state's target of increasing the proportion of OUD patients initiated with MOUD, formerly known as MAT, during the Demonstration period (Exhibit 8).

Exhibit 8. Summary of measures for Milestone 1

Measures Examined	State's Target	Directionality	Progress (Yes/No)
Percentage of OUD patients initiated with medication for OUD (MOUD)	Increase	Increase	Yes

Individual Measure Results

Exhibit 9 summarizes the results for the proportion of beneficiaries with an OUD who were prescribed MOUD. The proportion of beneficiaries initiating medication increased by nearly 13 percent between

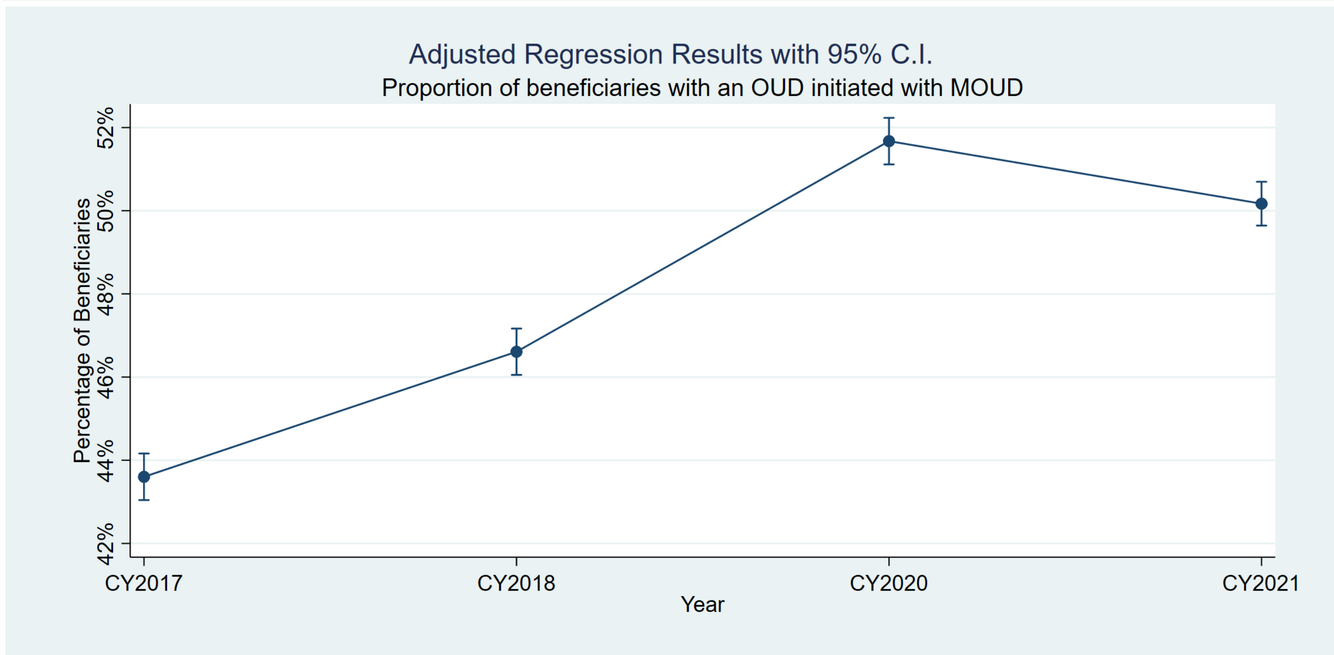
the baseline and Demonstration periods (5.8 percentage points). The largest increase, from 46.6 percent to 51.7 percent, was observed between CY2018 and CY2020. NORC used claims data to assess the unique prescribers of MOUD in the baseline PCA. The final evaluation report will include a reexamination of unique prescribers of MOUD, updating the baseline PCA. We anticipate an increase in the number of providers who are actively prescribing MOUD due to state-wide initiatives to expand eligibility for prescribing as well as to the national removal of the requirement for a Drug Enforcement Administration (DEA) "X-waiver" to prescribe buprenorphine.

Exhibit 9. Proportion of beneficiaries with OUD initiated with MOUD, CY2017-CY2021

Hypothesis: The demonstration will increase the proportion of beneficiaries with an OUD initiated with a MOUD.

Measure: Percentage of OUD patients initiated with MAT or MOUD

Measure steward: MN DHS constructed, following Healthcare Effectiveness Data and Information Set (HEDIS) value set for medication treatment for opioid misuse or dependence medications (which include buprenorphine, naltrexone, and methadone)



Study Period	Number of Beneficiaries with an OUD Who Were Prescribed MOUD	Total Number of Beneficiaries with an OUD	Percent	Change from Prior Year
CY2017	11,813	27,094	43.6%	-
CY2018	12,644	27,128	46.6%	+3.0%*
CY2020	13,499	26,125	51.7%	+5.1%*

Study Period	Number of Beneficiaries with an OUD Who Were Prescribed MOUD	Total Number of Beneficiaries with an OUD	Percent	Change from Prior Year
CY2021	14,671	29,244	50.2%	-1.5%*

Overall Change from 2017-2018 to 2020-2021

Study Period	2017-2018	2020-2021	Absolute Change[16]	Relative Change[17]
Overall	45.1%	50.9%	+5.8%*	+12.9%

*Indicates significant difference at p<.05 between time periods.

As shown in Exhibit 10, there was a slightly larger relative increase in the proportion of beneficiaries in rural areas who were prescribed an MOUD; the trend was not significantly different than in urban areas.

Exhibit 10. Proportion of beneficiaries with OUD initiated with a MOUD by urban/rural status,* CY2017-CY2021

Study Period	*No. Beneficiaries with an OUD Who Were Prescribed MOUD* Urban	No. Beneficiaries with an OUD Who Were Prescribed MOUD Rural	Total No. Beneficiaries with an OUD *Urban*	Total No. Beneficiaries with an OUD Rural	Percent Urban	Percent Rural	Urban vs. rural
CY2017	9,030	2,901	19,470	7,624	46.4	38.0	8.4
CY2018	9,754	3,014	19,765	7,363	49.4	40.9	8.5
CY2020	10,333	3,034	19,369	6,756	53.3	44.9	8.4
CY2021	11,309	2,941	21,762	7,482	52.0	43.5	8.5

Notes: Data from the Federal Office of Rural Health Policy (FORHP) were used to code ZIP Codes to urban and rural areas.

Overall Change from 2017-2018 to 2020-2021

Overall	2017-2018	2020-2021	Absolute Change	Relative Change
Urban areas	46.6	52.4	+5.8	+12.3

---

[16] Calculated as the baseline period value subtracted from the Demonstration period value.

[17] Calculated as Demonstration period value minus baseline period value, divided by baseline period value.

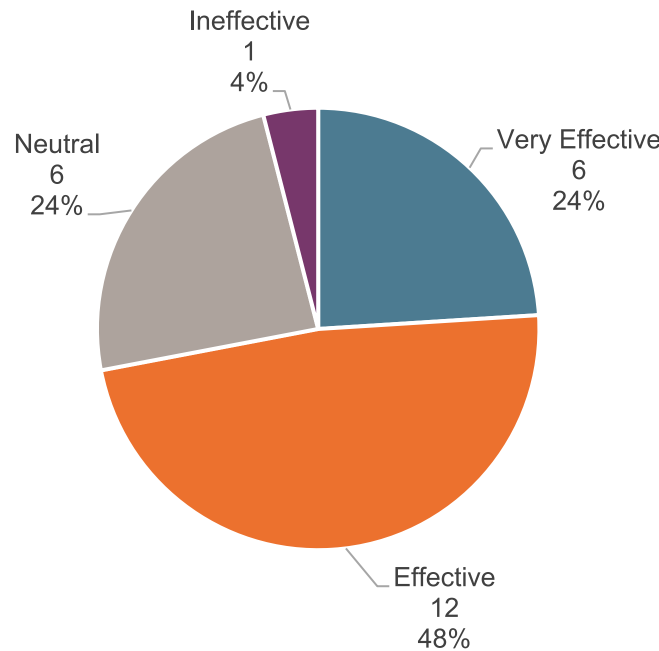
Overall	2017-2018	2020-2021	Absolute Change	Relative Change
Rural areas	41.0	46.7	+5.8	+14.1

Notes: Data from the Federal Office of Rural Health Policy (FORHP) were used to code ZIP Codes to urban and rural areas.

There is also qualitative evidence that the Demonstration's reforms are resulting in an increase in the proportion of patients in OUD and SUD treatment and adherence to and retention in treatment. MN DHS has taken steps to further align state regulations with the Demonstration and to expand provider participation. At the same time, Minnesota continues to develop and implement training and TA as more providers are enrolled in the Demonstration. Given the progress at the MPA and because participating providers attest to being ASAM-compliant upon enrollment in the Demonstration, the recent provider survey focused on the ongoing delivery of SUD/OUD services, including MOUD.

Providers reported on the survey that the Demonstration is effective in assessing patients and then directing them to the appropriate LOC. When asked how effective the patient assessment process was, 20 out of 25 providers said it was "Very effective" or "Effective" (Exhibit 11). Moreover, one provider noted that although patients seeking residential services are not often looking for a referral to an outpatient LOC, they are able to transition patients through their referral network when appropriate. The Demonstration's effectiveness in directing patients to the appropriate LOC and type of treatment will also be discussed below as part of Milestones 5 and 6.

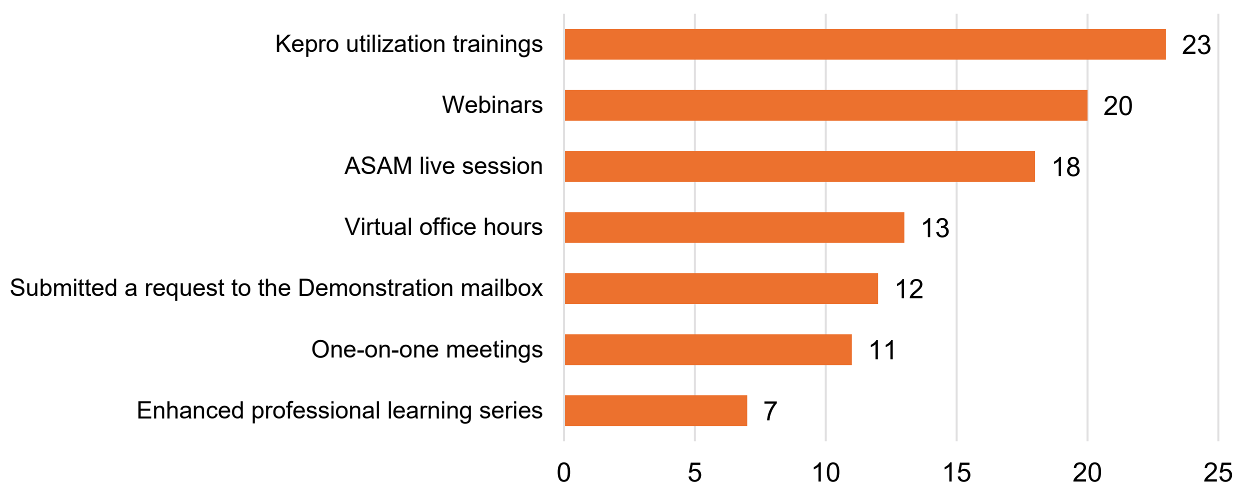
Exhibit 11. Provider rating of Year 2 MN 1115(a) SUD Demonstration effectiveness



Training and Technical Assistance

Providers responding to the survey reported high levels of participation in the state's training and TA sessions. The current findings, presented in Exhibit 12, are consistent with the 2021 provider focus group results detailed in the MPA. All except one respondent had attended a Kepro UM training, and almost all had attended a state webinar on the Demonstration and/or an ASAM live session. In addition, eight providers (33 percent) commented that they had no additional training needs at this time. For example, one stated, "I believe that we have had enough support as we have transitioned through the process." Another noted that the state's training and TA have improved, "I think that DHS has done a much better job of providing assistance/support to providers entering into the 1115." One provider commented that they would like to see the state offer another enhanced professional learning series, which was a more in-depth training offered during the first year of the Demonstration. Minnesota is aware of these training needs, and in the last quarter of 2022 Minnesota contracted with the University of Nevada for additional enhanced professional learning series and completed the training of the first cohort of providers to be ASAM trainers who can enhance the use of ASAM throughout the state, using a peer support model.[18] Fewer providers reported that they have taken advantage of the TA offerings, with approximately half of respondents attending virtual office hours or submitting a request through email. Despite more limited participation, the state views this as an important strategy for ongoing engagement with enrolled providers.

Exhibit 12. Enrolled provider participation in training and TA by type



However, other providers reported that the training and TA do not meet their needs, echoing the conclusion from the MPA that some providers did not find all the original trainings clear or tailored to their needs. Similarly, the state was aware of the need to ensure that training was available with

---

[18] Minnesota Substance Use Disorder System Reform Medicaid Section 1115 SUD Demonstrations Monitoring Report – Part B Version 4.0, Demonstration Year 4, Quarter 2.

mandatory provider participation. Some providers reported that the ASAM training was too focused on clinical documentation and was too much of a time commitment. They suggested that the state provide trainings for more staff members or different levels of staff, such as the licensed alcohol and drug counselors (LADCs). For Kepro UM training, one provider suggested that MN DHS develop additional resources: "I believe having some 'cheat sheets,' if you will, would be helpful. For example, I have helped numerous other treatment centers write down a step-by-step sheet on how to submit paperwork into Kepro." Another provider identified the need for WM training as a need for enrolled providers: "Opportunity exists for WM providers to increase care and collaboration with additional staff and training; this includes additional trainings for best practices with MOUD for all levels of care, including referrals, appropriate placement, and eligibility/coverage from MCOs for MOUD patients.… Would like to see a CE [continuing education] event to increase awareness and effectiveness in the field."

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

To facilitate the use of evidence-based, SUD-specific placement criteria and meet the goals under Milestone 2, MN DHS has been primarily focused on the implementation of a new process and system for UM through the Kepro UM program that monitors and guides the application of ASAM standards when determining the appropriate LOC. The goals under this milestone include increased adherence to and retention in treatment, fewer readmissions to the same or higher LOCs where the readmission is preventable or medically inappropriate, and reduced number of opioid-related overdoses and deaths in the state. This is a significant ongoing operational change under the Demonstration. Data from a recent provider survey are presented below to provide context for provider experience concerning the Kepro UM program.

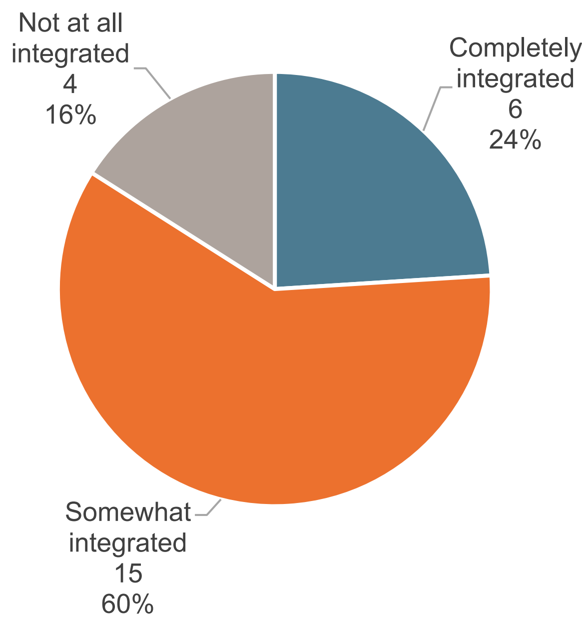
Midpoint assessment. At the time of the MPA, MN DHS had recently contracted with Kepro, implemented the process for UM, and begun training the enrolled providers on data collection and reporting. As noted above, training on UM as well as on the ASAM standards is ongoing for newly enrolled providers.

Since the initial reporting of the challenges providers faced in fulfilling the documentation and reporting requirements for the UM program, MN DHS has changed the Kepro UM requirements to cover only 10 percent of outpatient cases and 15 percent of residential cases.[19] On the survey, 84 percent of providers reported that the Kepro UM was either fully or somewhat integrated into their workflow processes (Exhibit 13). They continued to underscore that Kepro UM is time-consuming and has high administrative costs. In addition, some providers reported poor communication regarding changes concerning regulations and their interpretation for utilization review. In addition, Kepro requests the same information as insurers, requiring that the data be entered twice. One provider noted, "It has

[19] Minnesota Substance use Disorder System Reform Medicaid Section 1115 SUD Demonstrations Monitoring Report – Part B Version 4.0, Demonstration Year 3, Quarter 4.

created more work, therefore more staff, in a very challenging hiring environment." Nonetheless, approximately 42 percent of surveyed providers found the UM requirement changes to be helpful, and fewer providers, 33 percent, reported that they were either not very helpful or not at all helpful.

Exhibit 13. Integration of Kepro UM into enrolled provider workflow



One Demonstration provider commented, "KEPRO is not streamlined or seen as a helpful resource—inconsistency with regulations and interpretations, things changing without communication."

Milestone 3: Use of Nationally Recognized SUD-Specific Program Standards

To increase the use of nationally recognized SUD-specific program standards under Milestone 3, MN DHS reported a variety of actions related to the goals to increase adherence to and retention in treatment, reduce readmissions to the same or higher LOCs where the readmission is preventable or medically inappropriate, and reduce the number of opioid-related overdoses and deaths in the state. Data from a recent provider survey are also presented below to provide context for provider experience under the Demonstration. Providers reported about their ability to refer to other LOCs and any organizational changes they undertook as part of their participation in the Demonstration.

Midpoint assessment. As noted in the MPA, a broad group of action items help to achieve implementation of residential treatment provider qualifications that meet the ASAM criteria standards or other nationally recognized, evidence-based SUD-specific program standards. Moreover, this milestone was effected by the 2021 Minnesota Laws 2021, First Special Session, Chapter 7, Article 11, Sections 18-23, which required that residential treatment programs licensed by MN 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.

Milestone 3 is being further advanced by the continued opportunities for training and TA and MN DHS work with MCOs. As part of the Demonstration, all providers, both residential and outpatient, electing to participate must furnish verification of formal referral arrangements to ensure access to each of the ASAM LOCs. In addition, changes to MCO contracts may affect access to care and coordination for MCO enrollees and provider billing for these services.

Referrals to ASAM Levels of Care

We surveyed providers about their organizations' ability to provide access for patients with Medicaid to all ASAM LOCs through referrals. Most reported that they can provide access for patients with Medicaid through referral to ASAM LOCs 1.0, 2.1, 3.1, 3.3, 3.5, and 3.7. Exhibit 14 summarizes the results for each LOC.

Exhibit 14. Minnesota providers' self-reported ability to provide referrals at each ASAM LOC

Level	All or Most of the Time	Some	Never
1.0 Outpatient	88%	8%	4%
2.1 Intensive outpatient	92%	0%	8%
3.1 Clinically managed low-intensity residential treatment	76%	12%	12%
3.3 Clinically managed high-intensity and population-specific services	80%	12%	8%
3.5 Clinically managed residential services	96%	0%	4%
3.7 Medically managed withdrawal management	68%	20%	12%

Although most providers can provide access to Level 3.1 (clinically managed low-intensity and population-specific services) most of the time, those that are unable to do so cited limited bed availability and lack of low-intensity treatment centers. Similarly, most providers can refer patients to Level 3.3 (clinically managed high-intensity and population-specific services), but providers face challenges in finding openings at that level of care. One provider said, "There is only one program in MN offering this level of care, very hard to get someone into that program." Another noted, "There is only one program in Minnesota, and it does not serve women."

Providers reported the greatest challenge in accessing medically managed WM for their patients, with 32 percent of respondents reporting that they can access it never or only some of the time, and only 68

percent reporting that they can access it all or most of the time (Exhibit 14). In particular, providers commented that there are few programs—often not located nearby—and that there are no programs for adolescents. Most of the providers who responded "Never" reported that they do not offer this LOC. MN DHS has also been working to address the current gap in the state's statutes for LOC 3.7 by reaching out to ASAM and gathering internal information on the issues with the requirement that a physical exam be completed within 24 hours of admission.[20] However, when asked about organizational changes in the treatment of patients with OUD, some providers reported an increase in access and services. They noted that they are providing enhanced medical services such as MOUD and referring more patients to MOUD treatment and other providers noted that they can accept more clients due to MOUD offerings as well as increased screening and psychoeducation—i.e., a combination of cognitive-behavioral therapy, group therapy, and education about the disease[21]—for OUD.

Working with Managed Care Organizations

The MPA collected data when enrolled providers had just begun to bill and work with the MCOs serving Minnesota's Medicaid population. As a result, enrolled providers reported limited coordination and challenges in coordinating with the eight different MCO organizations. At the same time, state staff members responsible for contracting and oversight were actively engaged in aligning the Demonstration with the managed care program. The provider survey documents measurable progress in coordinating the care of enrollees who are treated by Demonstration providers. As shown in Exhibit 15, almost two-thirds of providers are coordinating care for patients and billing MCOs for these services. However, 52 percent (13) of providers also reported that they do not communicate as regularly at the organizational level with MCOs regarding patient referrals, assessment, and care coordination compared to the communications happening at the clinic or provider level. In addition, only 64 percent (16) of the providers are receiving reimbursement. One provider indicated that they are having to respond to MCO denials and participate in appeals, which may be a possible explanation for the lack of reimbursement after claims have been filed. The potential effects, if any, on quality of care for enrollees is not clear. According to MN DHS, they have limited information about MCO processes for monitoring quality of care and rely on maltreatment investigations and licensing visits to monitor quality of care. As noted, the final evaluation will incorporate interviews with enrollees in an effort to understand their experience of care. Although MCOs maintain a separate utilization review process from the Demonstration, efforts by MN DHS to align the two processes are ongoing. Specifically, Kepro has introduced InterQual medical review software that can be adopted by MCOs and integrated with their information technology and would standardize UM across the different populations.[22] Finally, fewer

---

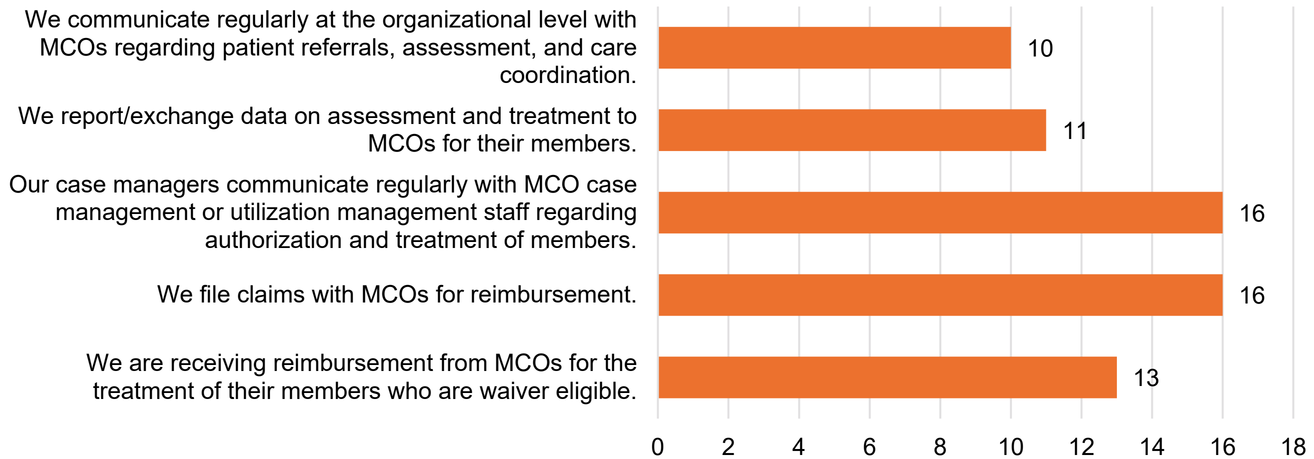
[20] Minnesota Substance Use Disorder System Reform Medicaid Section 1115 SUD Demonstrations Monitoring Report – Part B Version 4.0, Demonstration Year 4, Quarter 2.

[21] Sarkhel S, Singh OP, Arora M. Clinical practice guidelines for psychoeducation in psychiatric disorders general principles of psychoeducation. *Indian J Psychiatry*. 2020 Jan;62:S319-S323. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7001357/.

[22] Change Healthcare Partners (2002) The ASAM Criteria Powered by InterQual [PowerPoint slides] Change Healthcare LLC.

providers reported exchanging data on assessment and treatment with MCOs, although they are communicating about treatment plans.

Exhibit 15. Self-reported provider activities for coordinating MCO member care*



*Providers could select more than one response for this question, so the total does not add up to 25.

Milestone 4: Sufficient Provider Capacity at Critical Levels of Care

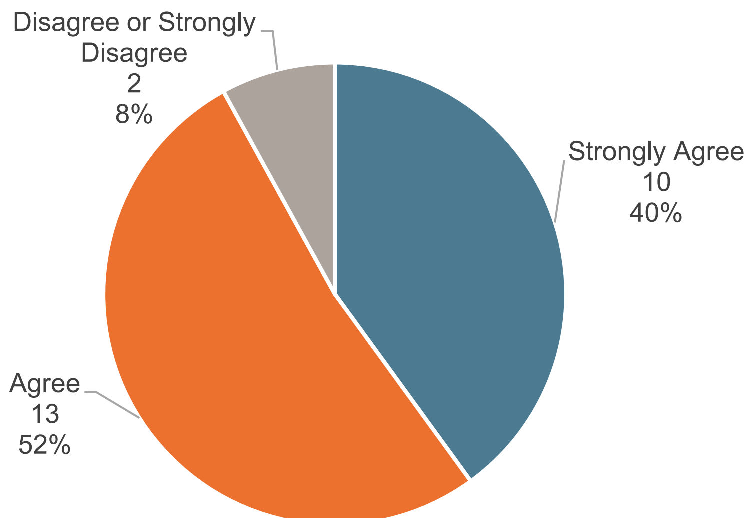
To ensure sufficient provider capacity at critical levels of care, Minnesota identified the need to conduct a provider capacity assessment that evaluated capacity at all LOCs and availability of MOUD, thereby establishing a baseline to measure progress during the Demonstration. In addition, the state required all enrolled providers to agree to Demonstration reporting requirements that also supported measurement of Demonstration outcomes. The goals associated with this milestone include increased rates of identification, initiation, and engagement in treatment for OUD and other SUDs; fewer readmissions to the same or higher LOCs where readmission is preventable or medically inappropriate; improved access to care for physical health conditions among Medicaid beneficiaries; a wider array of evidence-based services with a holistic treatment approach; and reduced utilization of EDs and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate through improved access to other continuum of care services. Data from a recent provider survey are also presented below to provide context for provider experience under the Demonstration.

Midpoint assessment. In the MPA, the state demonstrated progress by assessing provider capacity at the organizational level and on MAT/MOUD, but individual practitioner data were not available. Moreover, the MPA focus groups with state staff members and providers identified workforce shortages as a problem that was further aggravated by the PHE.

NORC is still unable to confirm the change in provider capacity at the individual practitioner level (apart from determining unique prescribers of MOUD), as state data limitations do not allow for counting

individual practitioners. In the final report, we will update the prior table on the number of enrolled providers at each level but will not be able to enumerate the total number of individual-level full-time-equivalents at each level.

Exhibit 16. Self-reported provider administrative and clinical staffing capacity



When asked about staffing adequacy for delivering treatment to Demonstration participants, 23 out of 25 respondents selected "Strongly Agree" or "Agree" (Exhibit 16). Providers who did not feel they had adequate staffing noted that additional administrative support and mental health professionals are needed to support the treatment of Demonstration participants. However, other respondents noted improvements, such as they had been able to increase salaries because of the increased reimbursement rates and the ability of LADCs to spend more one-on-one time with clients. They also noted plans to add more MOUD providers and interest in adding a prescribing provider to their practice. When asked about organizational stability and sustainability, for example, one provider shared, "We have seen more clients, and it has been easier to accept clients at a faster rate." Another provider noted, "Thus far, the waiver has improved our ability to provide care to our clients. Our organization continues to be stable and sustainable. We do not plan to make additional changes."

One Demonstration provider said, "The increased [waiver] rate has helped a little to sustain as counselor wages have increased greatly and [there has not been a] rate increase in general from DHS for a while." In contrast, some respondents shared ongoing staffing challenges since the Demonstration began that also had been identified in the MPA, such as retaining LADCs. One provider commented, "The waiver demonstration has increased our workload without rate increases due to being a Withdrawal Management program and the only level of care excluded from the rate adjustments." Some providers suggested rate increases to promote organizational sustainability. One wrote, "If all the payment issues are fixed, it will have a positive impact on our sustainability."

Providers reported staffing challenges both related to the Demonstration requirements and outside the Demonstration (i.e., general workforce shortages). For example, one provider noted that there have always been shortages of LADCs and mental health providers, "Due to staff shortages, we have struggled to provide the required amount of mental health practitioners based on the [number] of LADCs we have."

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

To implement comprehensive treatment and prevention strategies to address opioid misuse and OUD under Milestone 5, MN DHS reported a variety of actions related to the goals of reducing the number of opioid-related overdoses and deaths in the state and reducing utilization of EDs and inpatient hospital settings for treatment where the utilization is preventable or medically inappropriate. As discussed above, providers reported that the Demonstration had been effective in assessing and directing patients to the appropriate treatment. To evaluate progress toward this milestone quantitatively, we analyzed data to assess several measures, including the percentage of beneficiaries initiated into AOD treatment and overdose mortality. Data from a recent provider survey are also presented below to provide context for provider experience under the Demonstration.

Midpoint assessment. The MNPMP was the primary focus of Milestone 5 in the implementation plan, with the goal of supporting expanded access to MOUD. At the time of the MPA, plans to further develop the system had been suspended, but descriptive data on utilization indicated that there had been an increase in utilization during the first year of the Demonstration.

Summary of Measures

Between the baseline and initial Demonstration periods, initiation of treatment within 14 days of diagnosis and engagement in treatment within 34 days of diagnosis increased, representing progress in the desired directionality. For four of six measures associated with Milestone 5 (Exhibit 17), we do not observe progress toward the state's targets. This may be partially due to significant disruptions in utilization patterns due to the PHE. All findings were statistically significant.

Exhibit 17. Summary of measures for Milestone 5

Measures Examined	State's Target	Directionality	Progress (Yes/No)
Percentage of beneficiaries initiated into AOD dependence treatment	Increase	Increase	Yes
Proportion of beneficiaries with treatment initiated in <2 weeks (initiation of AOD treatment)	Increase	Increase	Yes
Percentage of beneficiaries with engagement in AOD dependence treatment	Increase	Decrease	No

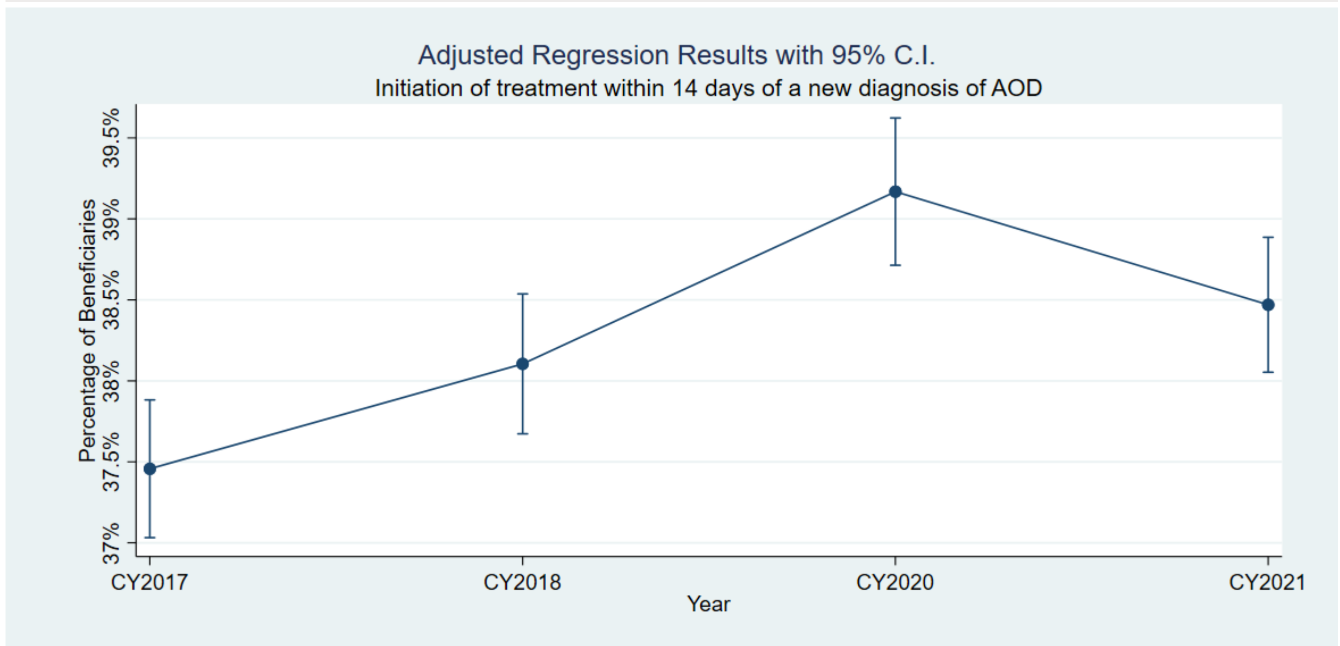
Measures Examined	State's Target	Directionality	Progress (Yes/No)
Continuity of pharmacotherapy for OUD	Increase	Decrease	No
Percentage of beneficiaries with an SUD receiving ambulatory or preventive care	Increase	Decrease	No
Overdose mortality (count and rate)	Decrease	Increase	No

Individual Measure Results

There was an absolute 1.1 percentage point increase in initiation of treatment within 14 days of diagnosis (Exhibit 18) between the baseline and initial Demonstration periods. However, a small decline was observed between CY2020 and CY2021 (a change of -0.6 percent). The overall number of beneficiaries with a new diagnosis of SUD increased between 2017 and 2021, from 49,600 to 52,430.

Exhibit 18. Proportion of beneficiaries with a new diagnosis of AOD who initiated treatment within 14 days, CY2017-CY2021

Hypothesis: The demonstration will increase the proportion of beneficiaries with a new diagnosis of AOD who initiate[23] treatment within 14 days of diagnosis.
Measure: Percentage of beneficiaries who initiate treatment in AOD dependence treatment
Measure steward: Medicaid Adult Core Set



[23] Treatment initiation is defined as ≥1 SUD-related treatment visit within 14 days of identification. Engagement is defined as receiving an additional two SUD-related treatment visits within 34 days after the initiation visit.

Study Period	No. Beneficiaries Who Initiated Treatment	Total No. Beneficiaries w. New Diagnosis of SUD	Rate	Change from Prior Year
CY2017	18,579	49,600	37.4%	No Data
CY2018	18,373	48,218	38.1%	0.6%*
CY2020	17,118	43,703	39.1%	1.0%*
CY2021	20,170	52,430	38.4%	-0.6%*

Overall Change from 2017-2018 to 2020-2021

Study Period	2017-2018	2020-2021	Absolute Change	Relative Change
Overall	37.8%	38.8%	1.1%*	2.6%

*Indicates significant difference at p<.05 between time periods. This measure was assessed on beneficiaries with a diagnosis of AOD in the relevant year and with continuous eligibility and full coverage, following 1115 Substance Use Disorder Demonstrations: Technical Specifications for Monitoring Metrics, v. 5.

Timely treatment (the proportion of beneficiaries who initiated medication within two weeks) increased by 2.6 percent, or 1.0 percentage point (Exhibit 19). The average time to treatment remained similar in the baseline and Demonstration periods (2.3 days vs. 2.2 days).

Exhibit 19. Time to treatment for beneficiaries with an AOD use or dependence, CY2017-CY2021

Measure: Number of days between diagnosis and treatment reported as the average time to treatment, conditional on any treatment

Study Period	Average Time to Treatment (Days)	Change from Prior Year (Days)
CY2017	2.3	No Data
CY2018	2.3	0.0
CY2020	2.2	-0.1*
CY2021	2.3	+0.1*

Overall Change from 2017-2018 to 2020-2021

Overall	2017-2018	2020-2021	Absolute Change	Relative Change
Proportion of beneficiaries with OUD and treatment within 2 weeks	37.8%	38.9%	1.0%*	2.8%
Average number of days	2.3	2.2	-0.1*	-4.4%

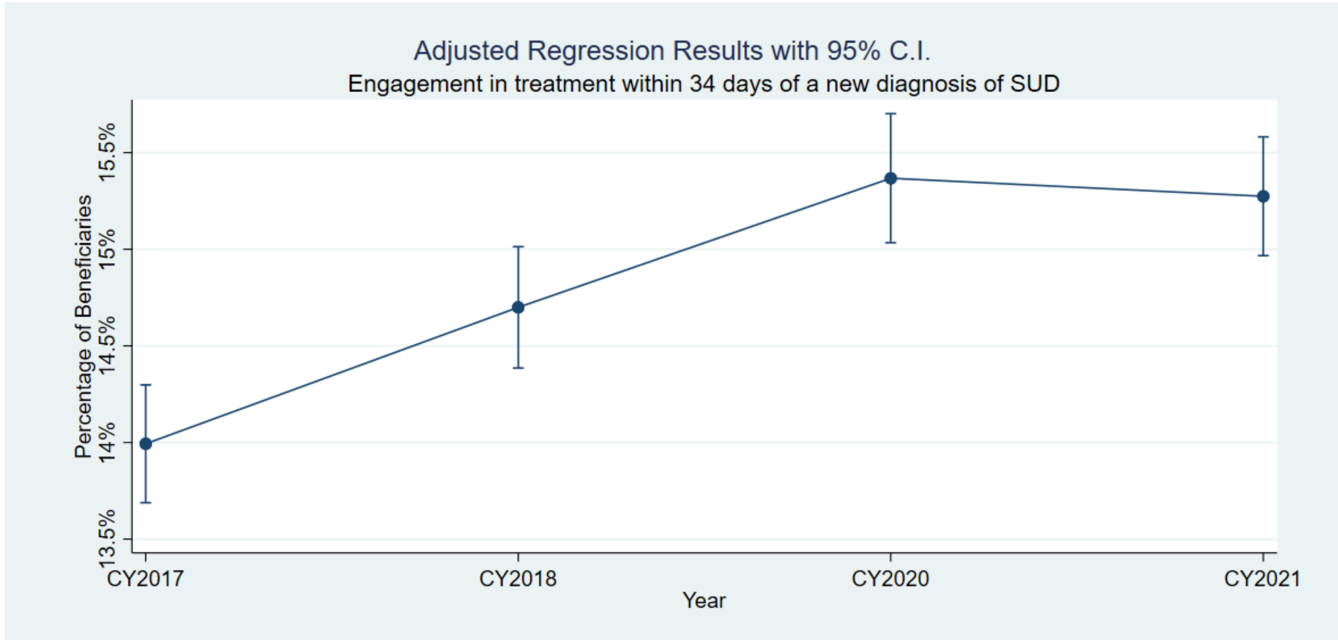
*Indicates significant difference at p<.05 between time periods.

Note: This measure was assessed on beneficiaries with a diagnosis of OUD in the relevant year and with continuous eligibility and full coverage, following 1115 Substance Use Disorder Demonstrations: Technical Specifications for Monitoring Metrics, v. 5.

There was a relative increase of 6.8 percent in the proportion of beneficiaries with a new SUD diagnosis who engaged in treatment within 34 days of diagnosis between the baseline and Demonstration periods (Exhibit 20). During the baseline period, timely treatment engagement increased by 0.8 percentage points between CY2017 (13.9 percent) and CY2018 (14.7 percent). Treatment engagement increased slightly during Demonstration CY2020 (15.4 percent) and dipped slightly in Demonstration CY2021 (15.3 percent).

Exhibit 20. Proportion of beneficiaries with a new diagnosis of SUD who engaged in treatment within 34 days, CY2017-CY2021

Hypothesis: The Demonstration will increase the proportion of beneficiaries with a new SUD diagnosis who engage in treatment within 34 days of diagnosis.
Measure: Percentage of beneficiaries with engagement in AOD dependence treatment
Measure steward: Medicaid Adult Core Set



Study Period	No. Beneficiaries Who Engaged in Treatment	Total No. Beneficiaries w. New Diagnosis of SUD	Rate	Change from Prior Year
CY2017	6,941	49,600	13.9%	No Data
CY2018	7,088	48,218	14.7%	+0.8%*
CY2020	6,716	43,703	15.4%	+0.7%*
CY2021	8,008	52,430	15.3%	-0.1%

Overall Change from 2017-2018 to 2020-2021

Overall	2017-2018	2020-2021	Absolute Change	Relative Change
Impact	14.3%	15.3%	1.0%*	6.8%

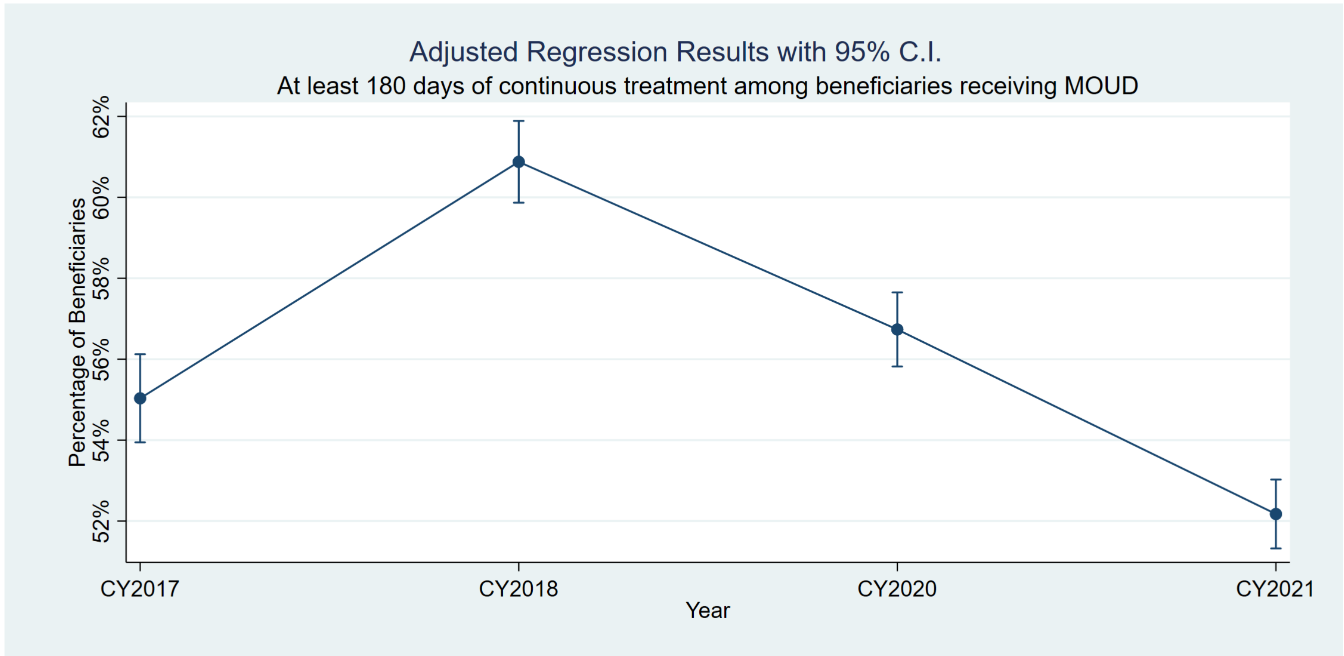
*Indicates significant difference at p<.05 between time periods. This measure was assessed on beneficiaries with a diagnosis of OUD in the relevant year and with continuous eligibility and full coverage, following 1115 Substance Use Disorder Demonstrations: Technical Specifications for Monitoring Metrics, v. 5.

There was a decrease in the proportion of beneficiaries receiving pharmacotherapy continuously for OUD for at least 180 days (Exhibit 21). During the baseline period, there was an increase between CY2017 (55.0 percent) and CY2018 (60.9 percent). However, the proportion of beneficiaries with a new SUD diagnosis who engaged in treatment within 34 days of diagnosis decreased during the Demonstration period.

Exhibit 21. Proportion of beneficiaries receiving pharmacotherapy for OUD for ≥180 days of continuous treatment, CY2017-CY2021

Hypothesis: The demonstration will improve continuity of pharmacotherapy for opioid use disorder.
Measure: Continuity of pharmacotherapy for OUD
Measure steward: National Quality Forum

Hypothesis: The demonstration will improve continuity of pharmacotherapy for opioid use disorder.



Study Period	No. Beneficiaries Receiving Pharmacotherapy for OUD Who Have ≥180 Days of Continuous Treatment	Total No. Beneficiaries Receiving MOUD	Rate	Change from Prior Year
CY2017	4,417	8,026	55.0%	No Data
CY2018	5,433	8,924	60.9%	+5.8%*
CY2020	6,176	10,885	56.7%	-4.1%*
CY2021	6,615	12,678	52.2%	-4.6%*

Overall Change from 2017-2018 to 2020-2021

Study Period	2017-2018	2020-2021	Absolute Change	Relative Change
Overall	58.1%	54.3%	-3.8%*	-6.5%

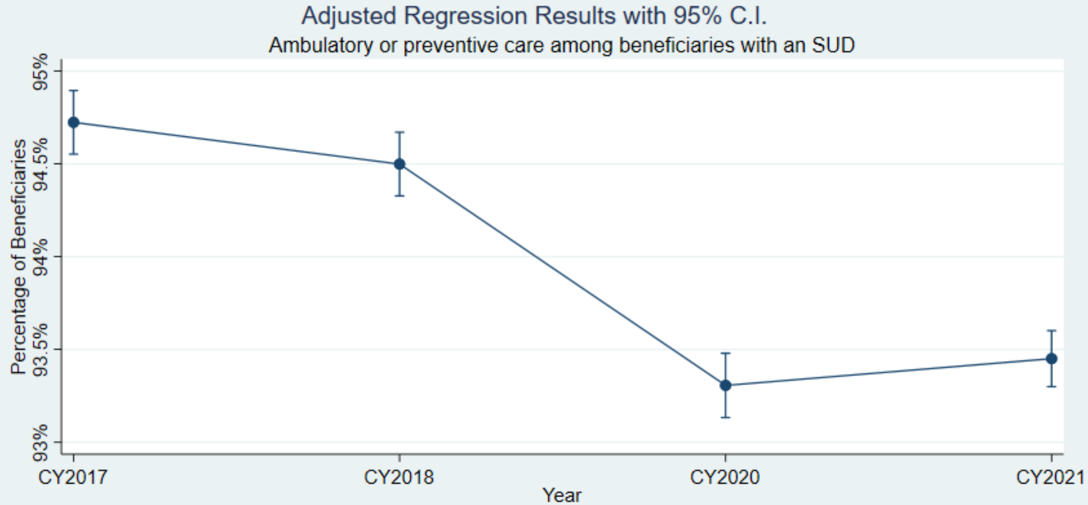
Exhibit 22. Proportion of beneficiaries with an SUD who had an ambulatory visit for prevention services, CY2017-CY2021

There was an overall decrease in the proportion of beneficiaries with an SUD receiving ambulatory or preventive care between the baseline and Demonstration periods, from 94.6 percent to 93.4 percent, representing a 1.2 percentage point change (Exhibit 22). There was an increase in the number of beneficiaries with an SUD who had an ambulatory preventive care visit.

Hypothesis: The demonstration will improve access to preventive services for beneficiaries with an SUD.

Measure: Percentage of beneficiaries with an SUD receiving ambulatory or preventive care

Measure steward: HEDIS measure/National Committee for Quality Assurance (NCQA)



Study Period	No. Beneficiaries w. SUD Who Had Ambulatory Preventive Care Visit	No. Beneficiaries with SUD	Rate	Change from Prior Year
CY2017	61,887	65,334	94.7%	No Data
CY2018	62,816	66,472	94.5%	-0.2%
CY2020	66,485	71,255	93.3%	-1.2%*
CY2021	78,425	83,921	93.5%	+0.1%

*Indicates significant difference at p<.05 between time periods. This measure was assessed on beneficiaries with a diagnosis of OUD in the relevant year and with continuous eligibility and full coverage, following 1115 Substance Use Disorder Demonstrations: Technical Specifications for Monitoring Metrics, v. 5.

Overall Change from 2017-2018 to 2020-2021

Type	2017-2018	2020-2021	Absolute Change	Relative Change
Percent of beneficiaries with SUD who had an ambulatory care visit	94.6%	93.4%	-1.2%*	-1.3%

*Indicates significant difference at p<.05 between time periods. This measure was assessed on beneficiaries with a diagnosis of OUD in the relevant year and with continuous eligibility and full coverage, following 1115 Substance Use Disorder Demonstration: Technical Specifications for Monitoring Metrics, v. 5.

Consistent with national trends and trends in other states, Minnesota did not experience a reduction in drug overdose deaths during the Demonstration period (Exhibit 23).[xvii,xviii] A Centers for Disease Control and Prevention (CDC) study that used data abstracted from death certificates and medical

examiner/coroner (ME/C) reports in 47 states and the District of Columbia reported that the rise in overdose deaths was driven mainly by two factors: 1) the physical and mental impacts of the pandemic, including isolation and loss of social support, job loss, and housing instability and 2) a reduction in the capacity and opportunities for intervention to prevent fatal outcomes. There was a 30 percent increase from 2019 to 2020 in drug overdose deaths nationwide.[xix]

Exhibit 23. Drug overdose and opioid overdose mortality

Year	MN Medicaid Population Eligible Medicaid Population	MN Medicaid Population Drug Overdose Deaths	MN Medicaid Population Rate/100K Medicaid Beneficiaries	MN Medicaid Population Beneficiaries with OUD	MN Medicaid Population OUD Deaths	MN Medicaid Population Rate/100K Population	MN Statewide+ Drug Overdose Death Rate/100K Population	MN Statewide+ Opioid Overdose Death Rate/100K Population	National^Drug Overdose Death Rate/100K Population	National^ Any Opioid Overdose Death Rate/100K Population
2017	1,426,151	414	29.0	27,275	236	865.3	13.3	6.1	21.7	14.9
2018	1,422,888	368	25.9	34,910	221	633.1	11.5	7.8	20.7	14.6
2020	1,378,449	460	33.4	32,942	431	1308.4	17.6	12.5	28.3	21.4
2021	1,461,412	831	56.9	35,524	603	1697.4	22.4	17.9	34.4	28.1

Notes: The population eligible for computing this metric are all beneficiaries with full coverage and ≥1 month of enrollment, consistent with metrics 26 and 27 in the CMS Medicaid Section 1115 Substance Use Disorder Demonstrations, Technical Specifications for Monitoring Metrics v. 5. The rate is (number of overdose deaths / number of beneficiaries) * 1,000. Data are for the calendar year (not Demonstration year).

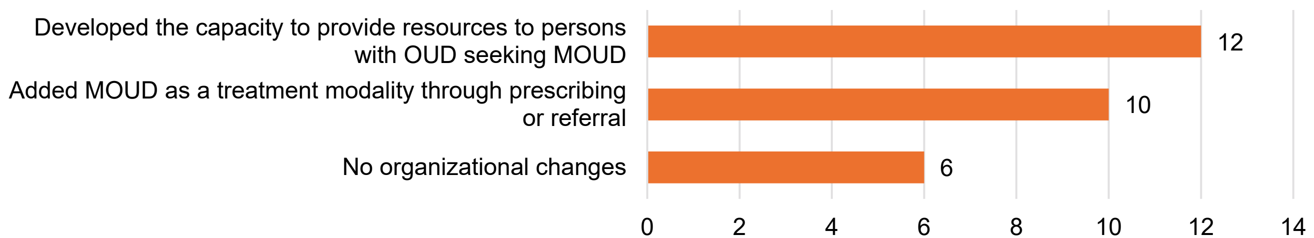
MN drug overdose death rate: https://www.cdc.gov/nchs/data/databriefs/db356_tables-508.pdf#page=2

MN Opioid Overdose rates are from: https://wonder.cdc.gov/controller/datarequest/D157;jsessionid=0BF98996E474E6F13B671628719D#Options
^National data on all drug overdose rates are from https://www.cdc.gov/nchs/products/databriefs/db394.html Accessed April 1, 2023

National data on opioid overdose for 2017-2020. Centers for Disease Control and Prevention. Overdose death rates involving opioids, by type, United States, 1999-2020. Available at: https://www.cdc.gov/drugoverdose/data/OD-death-data.html.

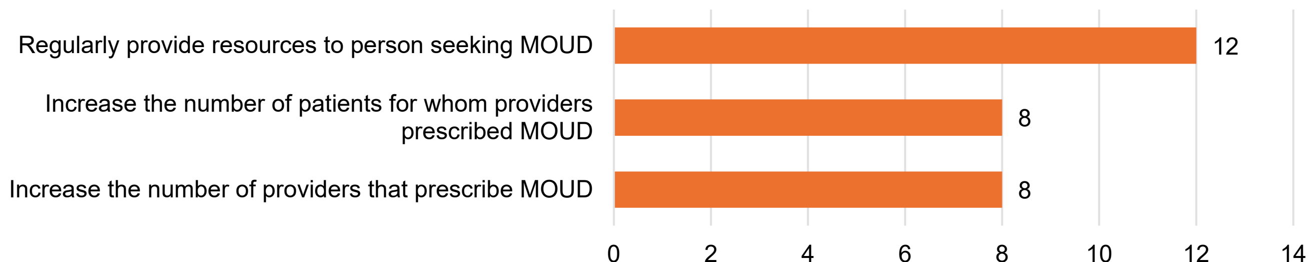
In the recent provider survey, 62 percent (n = 15) of survey respondents reported that they did not have to change the delivery of treatment services for the Demonstration, whereas the remaining 38 percent (n = 10) reported making changes (Exhibit 24). Importantly, providers that made changes highlighted client uptake because of the ability to serve a new service population, increased access to buprenorphine plus naloxone (Suboxone®) and WM providers, and the ability to prescribe MOUD directly from their providers and partnerships. One provider shared, “This was not a population we served before the waiver implementation. Our experience has been very positive.”

Exhibit 24. MOUD treatment changes reported by providers since Demonstration implementation



According to the survey, 28 percent (seven) of providers have increased the number of patients receiving MOUD prescriptions, a specific goal of the Demonstration. Twenty-four and 20 organizations reported offering MOUD referral and MOUD treatment, respectively (Exhibit 25). Among the 24 MOUD-referring organizations, two-thirds provided referrals to fewer than 100 patients. Among the 20 respondents that provided MOUD, two organizations served more than 250 individuals, and 75 percent prescribed MOUD to fewer than 100 patients. Three organizations reported that they do not prescribe MOUD, whereas only one organization reported providing MOUD only through prescription. Some survey respondents described challenges with providing MOUD treatment or referral to clients, including lack of client interest, limited MOUD-prescribing providers, inadequate mental health services to complement medication use, and insufficient organizational capacity (Exhibit 26).

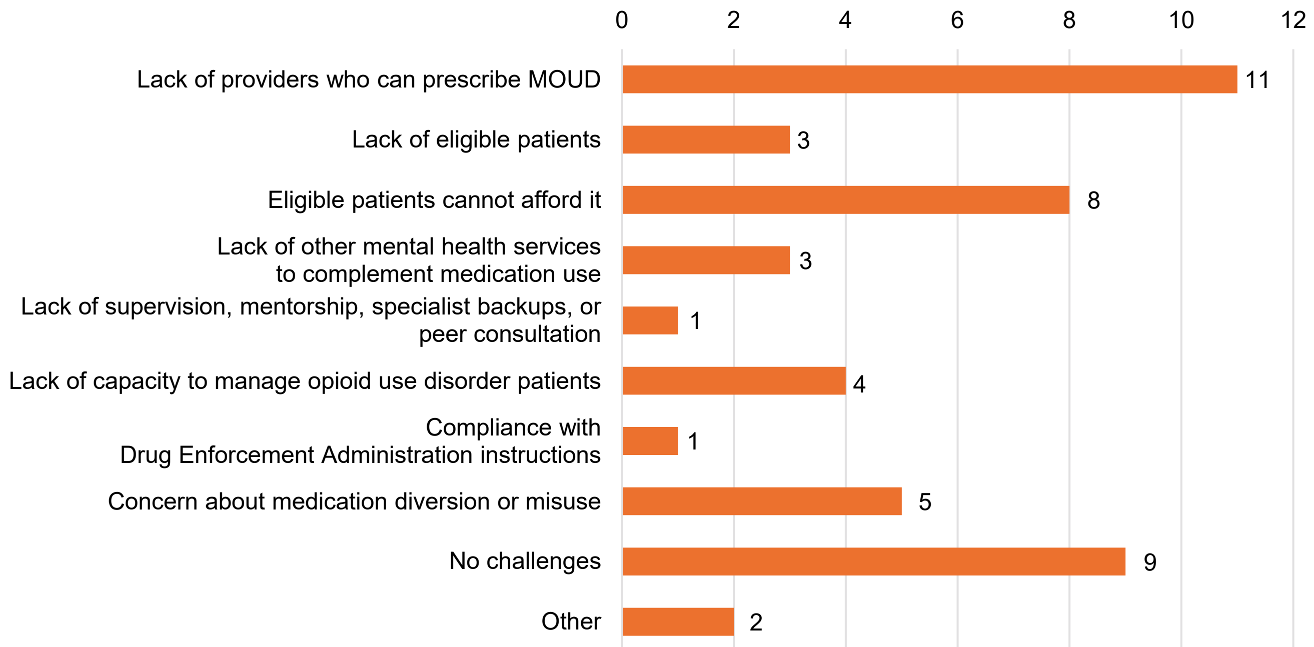
Exhibit 25. Changes in service capacity reported by providers since Demonstration implementation



Under the Demonstration, pharmacies and prescribers who dispense from their offices submit prescription data to the MNPMP for all Schedules II, III, IV controlled substances; butalbital; and gabapentin dispensed in or into Minnesota. Approximately 85 percent of respondents reported that

provider use of the MNPMP stayed the same since Demonstration implementation, whereas 15 percent reported increases in MNPMP use.

Exhibit 26. Self-reported provider challenges in providing MOUD to Demonstration patients*



*Providers could select ≥1 response for this question, so the total does not add up to 25.

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

To encourage improvement of care coordination and transitions between LOCs under Milestone 6, MN DHS took actions related to the Demonstration goal of increased adherence to and retention in treatment. Milestone 6 reflects the overall outcome of the systemic changes occurring under the Demonstration. To evaluate progress toward this milestone quantitatively, we analyzed data to assess several measures, including all-cause acute care readmissions (defined as the percentage of acute inpatient stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days), ED utilization, and ED visits following discharge, among others. Data from a recent provider survey are also presented below to provide context for provider experience under the Demonstration.

Summary of Measures

For four of five measures associated with Milestone 6 (Exhibit 27), we do not observe progress toward the state's targets. Follow-ups after ED visit for AOD use or dependence increased, representing

change in the desired direction. We observed no change in ED utilization per 1,000 beneficiaries for SUD. There was an increase in readmissions and ED visits following discharge from treatment.

Exhibit 27. Summary of measures for Milestone 6

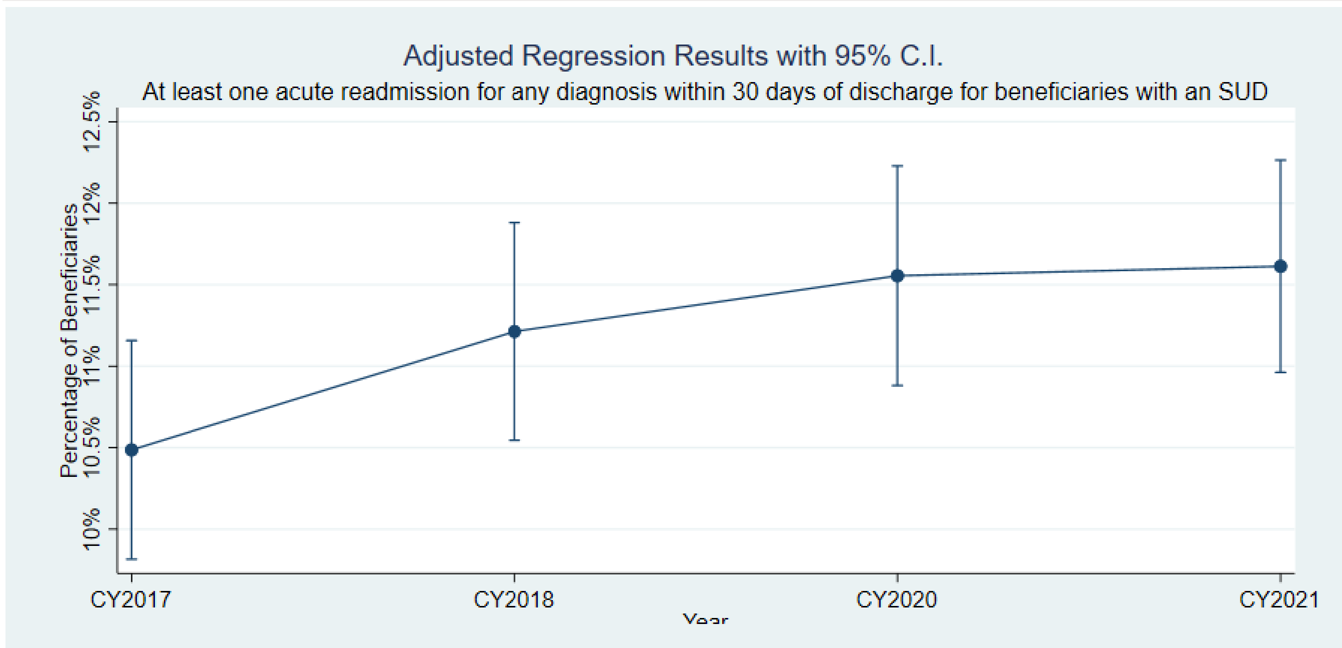
Measures Examined	State's Target	Directionality	Progress (Yes/No)
All-cause readmissions during the measurement period among beneficiaries with SUD	Decrease	Increase	No
ED utilization per 1,000 beneficiaries for SUD	Decrease	No change	No
ED visits following discharge from treatment	Decrease	Increase	No
Follow-up after ED visit for AOD use or dependence diagnosis	Increase	Increase	Yes
Follow-up after IMD stay, for persons with AOD use or dependence diagnosis	Increase	Decrease	No

The state made several efforts to improve care coordination and transitions between levels of care, such as linking beneficiaries with OUD and SUD to community-based services and support. However, despite these efforts, the Demonstration still observed an increase in readmissions among beneficiaries with an SUD (Exhibit 28). The readmission rate increased from 11.9 percent during the baseline period to 12.5 percent during the Demonstration period. CY2017 had the lowest rate of readmissions, whereas CY2021 had the highest. The proportion of beneficiaries with any readmission increased by 0.7 percentage points from the baseline period to the Demonstration period. The rate of readmission for beneficiaries with more than one stay also increased from 19.5 percent to 20.3 percent.

Individual Measure Results

Exhibit 28. All-cause readmissions among beneficiaries with an SUD, CY2017-CY2021

Hypothesis: The demonstration will decrease readmissions.
Measure: All-cause readmissions during the measurement period among beneficiaries with SUD: ≥1 acute readmission for any diagnosis within 30 days of the index discharge date for beneficiaries with an SUD
Measure steward: HEDIS measure/NCQA. This is a modification of CMS Metric 25, based on the calendar year.



Study Period	Total Hospital Stays	Total Readmissions	% Index Stays w. a Readmission	Absolute Change from Prior Year	No. Benefic. w. Index Event	% Benefic. w. Any Readmission	Absolute Change from Prior Year	No. Benefic. w. >1 Stay	Average % Stays w. Readmissions for Benefic. w. >1 Stay	Absolute Change from Prior Year	Average No. Readmissions for Those w. >1 Stay
CY2017	11,119	1,241	11.2%	No Data	7,998	10.5%	No Data	1,906	19.4%	No Data	0.61
CY2018	12,146	1,517	12.5%	+1.3%*	8,481	11.2%	+0.7	2,145	19.6%	+0.2	0.69
CY2020	11,914	1,448	12.2%	-0.3%	8,338	11.6%	+0.3	2,078	20.2%	+0.6	0.68
CY2021	13,256	1,705	12.9%	+0.7%	9,117	11.6%	0.1	2,348	20.3%	+0.1	0.70

Overall Change from 2017-2018 to 2020-2021

Type	2017-2018	2020-2021	Absolute Change	Relative Change
Readmission rate (percent of index stays with a readmission)	11.9%	12.5%	+0.6*	+5.4
Proportion of beneficiaries with any readmission	10.9%	11.6%	+0.7*	+6.4
Rate of readmission for beneficiaries with ≥1 stay	19.5%	20.3%	+0.8	+4.1

*At p<.05
Note: Includes inpatient hospital stays.

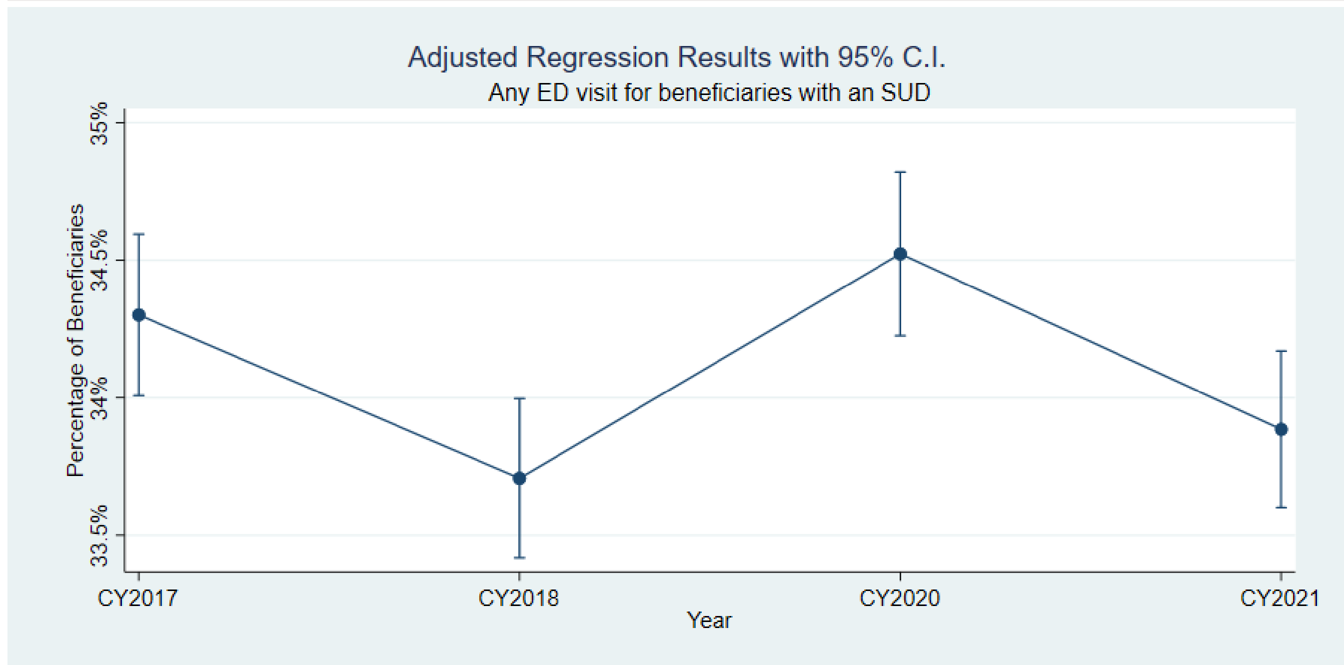
The proportion of beneficiaries with an SUD who had any ED visit (Exhibit 29) did not significantly change (0.2 percent point increase) during the Demonstration period. During the baseline period, there were 681.3 ED visits per 1,000 beneficiaries with an SUD compared to 691.2 ED visits per 1,000 beneficiaries with an SUD during the Demonstration period. During the Demonstration period, the rate per 1,000 beneficiaries decreased from 705.8 (CY2020) to 677.4 (CY2021). Approximately one-third of beneficiaries with an SUD diagnosis had any ED visit during the baseline and Demonstration periods. Beneficiaries with more than one visit had an average of 3.8 ED visits both before and during the Demonstration period.

Exhibit 29. ED utilization among beneficiaries with an SUD, CY2017-CY2021

Hypothesis: The demonstration will decrease ED utilization for beneficiaries with an SUD.

Measure: ED utilization per 1,000 beneficiaries for SUD, proportion of beneficiaries with any ED visit, and mean number of visits for those with more than one visit

Measure steward: CMS metric 23



Study Period	No. ED Visits	Total Benefic. w. an SUD	Rate/1,000 Beneficiaries	Absolute Change from Prior Year	% of Any ED Visit	Change from Prior Year	% of Benefic. w. ≥1 Visit^	Mean # ED Visits (for >1 Visit	Absolute Change from Prior Year
CY2017	67,998	98,862	687.8	No Data	34.3%	No Data	12.2%	3.9	No Data
CY2018	67,453	99,941	674.9	-12.9	33.7%	-0.6%	12.1%	3.8	-0.1
CY2020	66,810	94,660	705.8	+30.9*	34.5%	+0.8%	12.7%	3.8	0.0
CY2021	69,759	102,977	677.4	-28.4*	33.9%	-0.6%	12.2%	3.8	0.0

Overall Change from 2017-2018 to 2020-2021

Type	2017-2018	2020-2021	Absolute Change	Relative Change
Total ED visits per 1,000 beneficiaries with an SUD	681.3	691.2	9.9	0.01
Proportion of beneficiaries with any ED visit	34.0%	34.2%	0.2%	0.6%

*Indicates significant difference at p<.05 between time periods.
Notes: Includes ED visits that result in an inpatient stay.

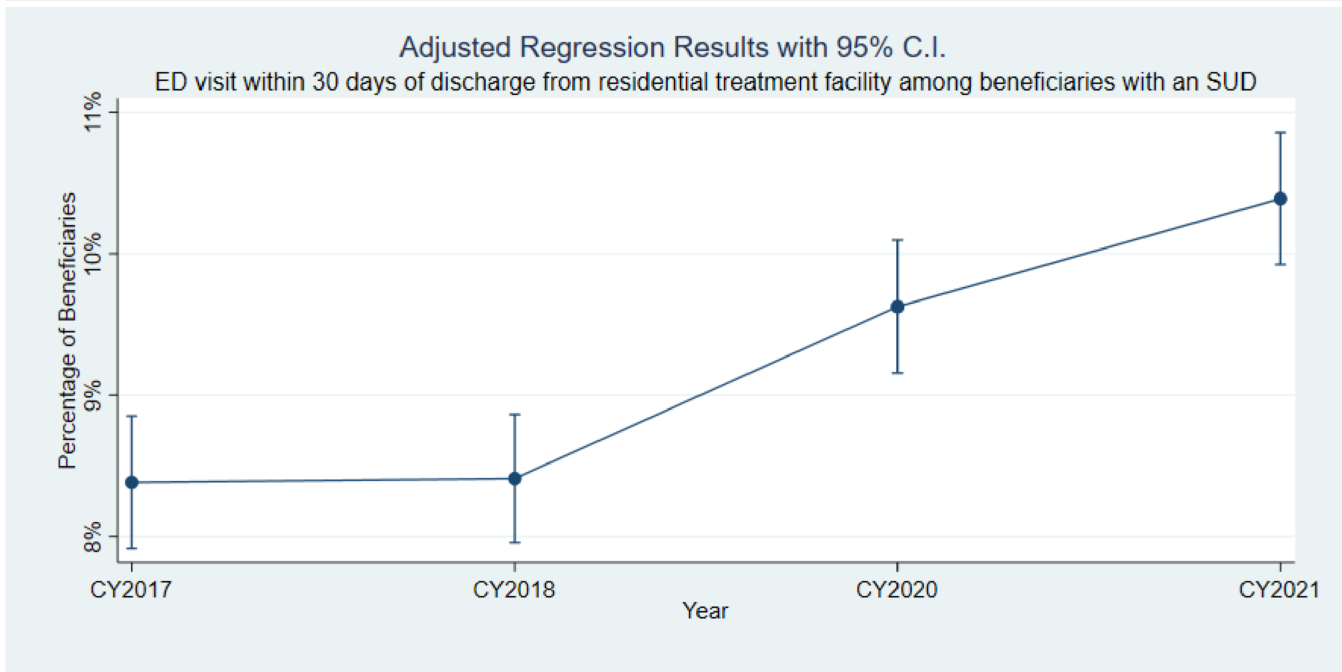
The percentage of beneficiaries with any ED visit after discharge from a residential treatment facility (for beneficiaries with an SUD) increased 1.6 percent during the Demonstration period (Exhibit 30). The rate of treatment stays with an ED visit also increased (4.1 percent) between the baseline and Demonstration periods. CY2018 had the lowest rate of ED visits (10.4 percent), whereas CY2021 had the highest rate of ED visits (15.3 percent) following a residential stay.

Exhibit 30. ED utilization within 30 days of discharge from a residential treatment facility among beneficiaries with an SUD, CY2017-CY2021

Hypothesis: The demonstration will decrease ED utilization following treatment for beneficiaries with an SUD.

Measure: Rate of ED visits within 30 days of discharge from a residential treatment facility and proportion of beneficiaries with any SUD

Measure steward: This is a modification of CMS metric 23, to measure ED visits 30 days following discharge from a residential treatment facility.



Study Period	No. ED Visits within 30 Days of Discharge from Residential Treatment Facility	Total Discharges from Residential Treatment Facility	Rate of ED Visits (% of Index Stays w. ED Visit)	Change from Prior Year	Total Benefic. w. Treatment	% of Benefic. w. ED Visit Following Discharge	Change from Prior Year
CY2017	1,733	16,319	10.6%	No Data	13,792	8.4%	No Data
CY2018	1,767	16,927	10.4%	-0.2%	14,317	8.4%	0.0%
CY2020	2,588	18,612	13.9%	3.5%*	14,196	9.6%	1.2%*
CY2021	3,333	21,820	15.3%	1.4%*	15,348	10.4%	0.8%*

Notes: If a transfer to another facility (either treatment or hospital) occurs within one day, then the discharge date would be from the new facility. If the time elapsed is >1 day (the person is newly admitted to a residential treatment facility), then the clock for the 30 days starts for the new facility.
*Indicates significant difference at p<.05 between time periods.

Overall Change from 2017-2018 to 2020-2021

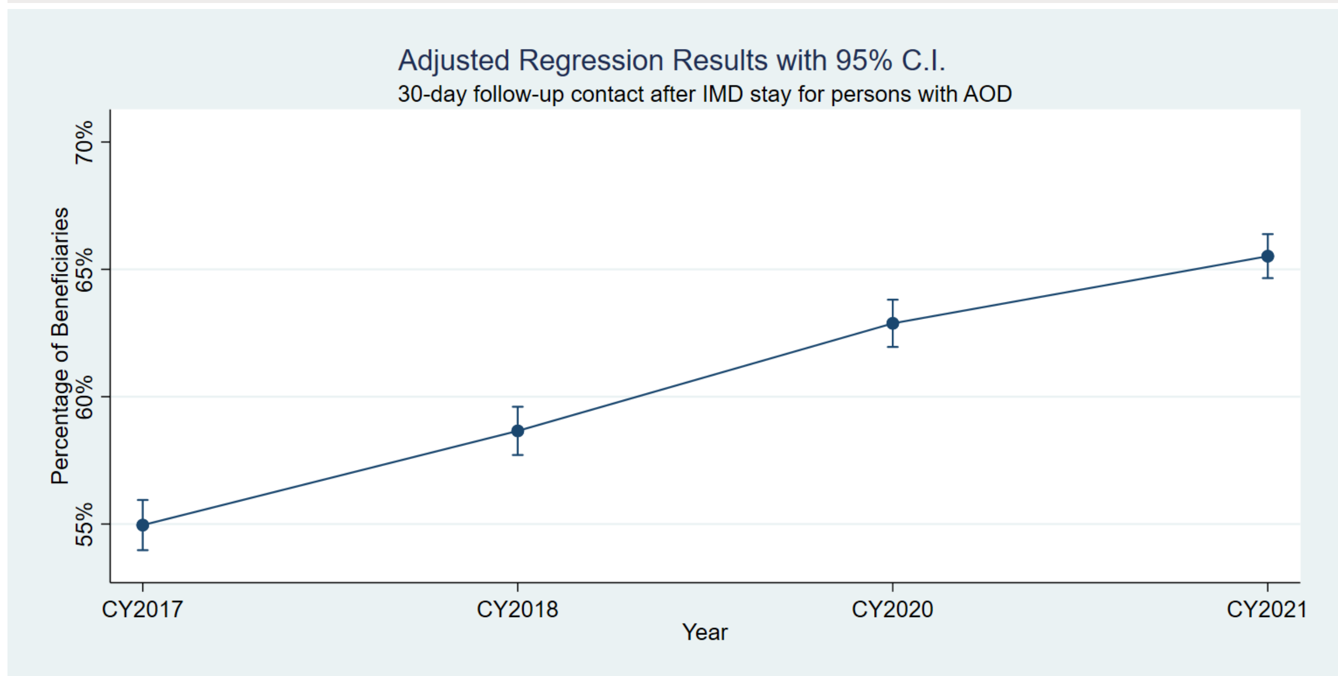
Type	2017-2018	2020-2021	Absolute Change	Relative Change
Percent of treatment stays with an ED visit	10.5%	14.6%	4.1%*	39.0%
Percent of beneficiaries with ED visit following discharge from treatment	8.4%	10.0%	1.6%*	19.0%

*Indicates significant difference at p<.05 between time periods.

There was in increase in 30-day follow-up contacts for beneficiaries with alcohol or other SUDs and an IMD stay (Exhibit 31) during the Demonstration period. Since CY2017, more than half of IMD stays had a follow-up visit within 30 days. IMD stays with a follow-up visit within 30 days increased year over year. During the Demonstration period, 63.7 percent of stays had a follow-up visit within 30 days. This represents a 7.8 percent increase from the baseline period (55.9 percent). Beneficiaries with a follow-up visit within 30 days also increased by 7.4 percent from the baseline to the Demonstration period.

Exhibit 31. Follow-up contacts for beneficiaries with alcohol or other SUD and an IMD stay, CY2017-CY2021

Hypothesis: MN DHS will increase 30-day follow-up contacts for beneficiaries with alcohol or other SUD and an IMD stay.
Measure: 30-day follow-up contact after IMD stay for persons with AOD use or dependence
Measure steward: HEDIS measure/NCQA. This is a modification of metric 17(1), modified to the subpopulation of patients with an AOD use disorder or and IMD discharge rather than ED.



Study Period	Total Follow-up Contacts in 30 Days	Total IMD Stays	% Stays w. Follow-up Visit within 30 Days	Absolute Change from Prior Year	No. Benefic. w. Alcohol or Other SUD and Discharged from an IMD	% Benefic. w. Follow-up Visit within 30 Days	Absolute Change from Prior Year
CY2017	6,404	11,825	54.2%	No Data	10,691	55.0%	No Data
CY2018	7,100	12,326	57.6%	+3.4%*	11,052	58.7%	+3.7%*
CY2020	8,126	13,111	62.0%	+4.4%*	11,025	62.9%	+4.2%*
CY2021	10,355	15,893	65.2%	+3.2%*	12,189	65.5%	+2.6%*

Overall Change from 2017-2018 to 2020-2021

Type	2017-2018	2020-2021	Absolute Change	Relative Change
Rate (percent of stays with a follow-up visit within 30 days)	55.9%	63.7%	+7.8%	+17.4%*
Percent of beneficiaries with a follow-up visit within 30 days	56.9%	64.3%	+7.4%	+16.8%*

Notes: Transfers between IMDs that occur within 1 day can be counted as 1 stay. This is a modification of metric 17(1), modified to the subpopulation of patients with an AOD use disorder or an IMD discharge rather than ED.
*Indicates significant difference at p<.05 between time periods. Only follow-up per 30-day period is counted.

There was a 2.7 percentage point decrease in the percent of ED visits for alcohol or other substance use with a follow-up contact from the baseline period (29.7 percent) to the Demonstration period (27.0 percent) (Exhibit 32). Follow-up visits were the highest in CY2018 (31.0 percent) and the lowest in CY2020 (26.7 percent). Similarly, there was also 2.8 percentage point decrease in beneficiaries with a follow-up contact within 30 days of discharge.

Exhibit 32. Follow-up contacts for beneficiaries with alcohol or other substance use disorder and an ED visit, CY2017-CY2021

Hypothesis: MN DHS will increase follow-up contacts for beneficiaries with an ED visit for alcohol or other substance use.
Measure: Follow-up after ED visit for alcohol and other drug abuse or dependence (30-day) (any follow-up and average per-beneficary rate) for beneficiaries with SUD
Measure steward: NCQA; NQF #2605; CMS Medicaid Adult Core Measure metric 17(1)
Adjusted Regression Results

Study Period	Total Follow-up Contact in 30 Days	Total ED Visits for AOD	% ED Visits w. Follow-up Contact	Absolute Change from Prior Year	No. Benefic. w. AOD Discharged from an ED	% Benefic. w. Follow-up Contact within 30 Days of Discharge	Absolute Change from Prior Year
CY2017	3,279	11,548	28.4%	No Data	9,407	29.9	No Data
CY2018	3,683	11,879	31.0%	+2.6%*	9,203	32.9	+2.9*
CY2020	2,660	9962	26.7%	-4.3%*	7,986	28.4	-4.5*
CY2021	2,962	10,859	27.3%	+0.6%*	8,795	28.9	+0.5

Overall Change from 2017-2018 to 2020-2021

Type	2017-2018	2020-2021	Absolute Change	Relative Change
Percent of ED visits with a follow-up contact	29.7	27.0	-2.7*	-9.1
Percent of beneficiaries with a follow-up contact within 30 days of discharge	31.4	28.6	-2.8*	-8.9

Notes: ED visits for beneficiaries ≥18 of age with a principal diagnosis of AOD abuse or dependence who had a follow-up visit for AOD abuse or dependence.
* Indicates significant difference at p<.05 between time periods.

Although the quantitative data show minimal progress toward the goals of this Milestone, the provider survey data reported above for Milestones 1 through 5 described the steps that providers have been taking. As a whole, these steps led to care coordination and better transitions across ASAM LOCs.

After two full years of implementation, the majority of provider survey respondents found the Demonstration “Effective” or “Very Effective” in several important ways. Fifty-four percent (13) reported effectiveness in promoting patient-centered care for OUD treatment in the state, and approximately 67 percent (16) of respondents reported effectiveness in facilitating transitions to different ASAM LOCs for OUD treatment. As described above, some providers have been able to increase capacity and build referral networks as part of the Demonstration. One provider reported, “I have been a proponent of this waiver since its inception. It is good to see more providers in the state adapt the ASAM criteria, and I believe it also benefits the clients who need our treatment services.” Others noted that an expanded continuum of care, including MOUD, and rate increases, specifically for counselors, were improving the delivery of SUD services.

However, among providers, some also felt the Demonstration was not effective at accomplishing these goals and detailed the challenges with the Demonstration’s administrative changes. One explained, “It seems like the cart was put before the horse and DHS did not take into account that during a worldwide

pandemic, increase in overdose deaths and an already slim workforce the impact that adding another system, checkbox or thing to do- would have not only has a financial impact but an emotional impact on our team." Another noted, "It provided more checkboxes and not actual interventions to create quality care. Referral agreements may harm the referral process by potentially limiting who people think they can refer to." Other providers reported more positive experiences, such as one who wrote, "The professional team at MN SUD Demonstration Waiver have been accessible, responsive, and helpful throughout this transition."

Conclusions

The findings in this interim evaluation report document that the state has made mixed progress toward the Demonstration's milestones and goals. The state continues to address the contextual and operational challenges of implementing a Demonstration during a PHE and to fully align its state policies, regulations, and statutes with the ASAM criteria.

MN DHS is focused on several changes that support progress toward the six milestones. First was the adoption the ASAM levels of care and ensuring that enrolled providers could provide or refer patients for all LOCs and assist in transitions of care during treatment. Second was establishing a system of UM to monitor access to appropriate treatment. Third was expanding access to MOUD by increasing both prescribing and referrals. The results of the provider survey indicate that providers believe that there has been significant progress in implementing these changes. As a result, respondents report that the Demonstration is achieving its goals of identification and initiation of treatment, getting patients to the appropriate LOC, and facilitating transitions to different LOCs (engagement). Most providers also report that they are able to refer their patients to all LOCs. The majority of providers also reported that they felt the Demonstration facilitated transitions to ASAM LOCs for OUD treatment and promoted patient-centered care. As reported in the MPA, there was a tension between providers and the new UM requirements. Providers in the current survey also reported this tension. All except one provider had received training on Kepro data reporting and submission, and most providers reported that UM is integrated into their workflow and that they have adequate staff capacity. Nonetheless, implementation has posed an administrative burden, and the state has responded by introducing legislation to support paperwork reduction, and MN DHS has made specific policy changes to adjust UM requirements and reduce burden.

Although most of the providers responding to our survey in early 2023 reported that the Demonstration had been effective in meeting its goals, our analysis of the quantitative data through 2021 shows a more complicated picture of the implementation. Some of the key findings concerning utilization, access, and overdose deaths include:

- Utilization of services

  - There was **a very small decline in the proportion of beneficiaries with an SUD with ambulatory care visits**. This mirrors the nationwide trend during the pandemic of the reduction in the use of outpatient ambulatory services.[xx,xxi]
  - The rate of ED visits per 1,000 beneficiaries stayed approximately the same, and the proportion of beneficiaries with at least one ED visit during the year remained approximately 34 percent. This measure is all-cause ED visits, which may include visits related to COVID-19. The ED can also be a critical point of entry into care, and evidence indicates that MOUD can be initiated following an ED visit.[xxii] The proportion of beneficiaries discharged from residential treatment who visited an ED increased in both number and percent. The number of ED visits per beneficiary (among those with more than one stay) did not change, suggesting that it is difficult to reduce ED use for this population. This measure is for all-cause ED use and may include COVID-19-related ED use.
  - **All-cause readmission rates stayed approximately the same for beneficiaries with an SUD**. Both the number of index stays and beneficiaries with any readmission increased slightly during the Demonstration. The number of beneficiaries with a readmission increased by 0.7 percent, from 10.9 percent to 11.6 percent, while the number of stays with readmission increased 0.6 percent during the Demonstration (11.9 percent to 12.5 percent). However, this includes all beneficiaries with an SUD who were admitted to the hospital regardless of the reason for the readmission, which may include COVID-19-related issues. The rate of readmissions among beneficiaries with more than one stay did not increase (remaining at approximately 20 percent of stays) despite the pandemic, suggesting that readmissions did not increase among those who experienced frequent admissions.
- Access to medication
  - The proportion of **beneficiaries with OUD who initiated a MOUD increased by nearly 13 percent** (5.8 percentage points). During the pandemic, the state undertook measures to sustain and expand access to MOUD, such as enabling telehealth services for prescriptions. Increased use of MOUD rose at similar rates in both urban and rural areas. There was a growth in the absolute number of beneficiaries receiving MOUD between the baseline and Demonstration periods (from 4,417 to 6,615). Despite an initial increase from 2017 to 2018, the proportion of beneficiaries with continuous 180-day prescription **fills for MOUD declined 3.8 percentage points** between the baseline and Demonstration years.
- Access to services
  - The proportion of **beneficiaries who engaged in treatment within 34 days of diagnosis increased 6.8 percentage points between the baseline and Demonstration years.** Timely treatment engagement increased by 0.8 percentage points between CY2017 (13.9 percent) and CY2018 (14.7 percent) and continued to increase during Demonstration CY2020 (15.4 percent) before dipping slightly in Demonstration CY2021 (15.3 percent). The total number of beneficiaries who engaged increased between CY2017 and CY2020 (from 6,941 to 8,008).

  - The proportion of **beneficiaries who initiated treatment within two weeks increased by 1.1 percentage points** (5.7 percent), and the average time to treatment remained similar in the baseline and Demonstration periods (2.3 days vs. 2.2 days).
  - There was an **increase in follow-up contacts after an IMD stay**, in both number and percent. The number of beneficiaries with AOD discharged from an IMD also increased from 10,691 in CY2017 to 12,189 in CY2021, and the percentage of beneficiaries with a follow-up within 30 days increased from 55.9 percent to 63.7 percent between the baseline and Demonstration periods, which is a relative change of 17.4 percent.
  - The **percent of beneficiaries with a follow-up contact within 30 days of discharge from an ED was lower** in the Demonstration period, declining from 31.4 percent to 28.6 percent. The lower follow-up rate following an ED visit compared to the 30-day follow-up rate after an IMD stay may reflect the pandemic-related workforce shortages of care coordination personnel and an increased number of ED visits overall.
- Overdose deaths
  - **Overdose deaths have increased** during the Demonstration period. This increase could be partly attributable to the growing prevalence of more lethal fentanyl in the circulating illicit drug supply.[xxiii]

Lessons Learned, Interpretations, and Policy Implications

Drawing conclusions regarding the impact of the Demonstration based on these results is not recommended. In light of the challenges of the COVID-19 pandemic, these results are likely atypical for the anticipated change for some measures, and comparisons with other states' trends are not possible due to the varying nature and timing of the intensity of the pandemic. In addition, these analyses only include data through 2021. In 2021, a legislative mandate passed that required all residential and WM providers to enroll in the Demonstration and meet provider standards requirements by January 1, 2024. Since that time, the number of these types of providers participating in the Demonstration has grown, and this will likely impact utilization and access across the state. In the final evaluation report, we will be able to better understand trends in the baseline and Demonstration periods using the quarterly data. In addition to the 2021 mandate, there are several factors that support the hypothesis that the results in the final evaluation report may look different:

- **Staffing.** During the pandemic, the state faced several significant barriers, including a hiring freeze, staff shortages, and staff turnover. Lower rates of ED visits and follow-up services likely reflect the shift in provider priorities to responding to COVID-19-related health care services and the availability of services.
- **Beneficiaries.** This report presents the experiences and perceptions of enrolled providers and documents the steps taken by the state to further develop the staff, systems, and processes

needed to implement the Demonstration. It does not, however, include the experiences and perceptions of the patients covered by the waiver and served by the Demonstration providers.

- **Enhanced rates.** The requirement for residential (as well as outpatient providers) along with the enhanced payment rates may lead to higher access to services for Medicaid beneficiaries at these facilities.[xxiv]
- **Implementation of Direct Access.** This development expands beneficiary choice and enables quicker referrals to access SUD services and will improve care coordination across LOCs and provider agencies. This could lead to higher rates of treatment initiation and engagement and reduce ED use.
- **MOUD prescribing.** The state anticipates an increase in the number of providers who are actively prescribing MOUD due to state-wide initiatives to expand eligibility for prescribing, as well as the removal of the requirement for a DEA "X-waiver" to prescribe buprenorphine. The final evaluation report will include a reexamination of unique prescribers of MOUD, updating the baseline PCA. The state applied for and was granted the COVID-19-modified take-home schedule for opioid treatment program (OTP)–dispensed methadone in March 2020 and implemented it as a variance under Minnesota licensing authority. With the termination of the PHE, Minnesota has issued a concurrence with the Substance Abuse and Mental Health Services Administration (SAMHSA) to continue those allowances until May 11, 2024.

Interactions with Other State Initiatives

Telehealth. The COVID-19 emergency waiver opened up all treatment services to telehealth, including audio-only services, to accommodate clients in remote locations. That waiver has ended, but the Behavioral Health Department received another waiver that allows outpatient services to be delivered via telehealth until June 2023. The continued support and use of telehealth may also contribute to improved entry into treatment, as well as the use of treatment and recovery services. A report by the MN DHS that assessed the use of telehealth among Medicaid beneficiaries before and during the pandemic (with analyses through December 2020) found that behavioral health services were used at a higher rate (30 percent vs. 19 percent for nonbehavioral health care) and that there was a larger increase in behavioral health care delivered only through telehealth vs. nonbehavioral health (17 percent vs. 3 percent) both before and after the PHE.[xxv]

Housing. To date, in Minnesota, some housing services have been provided through the Behavioral Health Fund. Beneficiaries with very high risk for relapse (ASAM Level 4 and Dimensions 5 or 6) can receive residential room and board, while those who are at high risk and non-compliant (Level 4, Dimension 4) may receive outpatient room and board. The state currently provides housing stabilization services to individuals with disabilities (including SUD) through its 1915(i) state plan amendment.[xxvi] Several states have successfully incorporated supportive housing services for individuals with SUD into their Section 1115 Demonstrations, including California, Hawaii, New Mexico, Oregon, Virginia, and Washington;[xxvii] these programs offer enhanced services in addition to case management.

Care Coordination. The state is exploring utilization of a cloud-based service such as the Omnibus Care Plan (OCP), a care coordination platform created by SAMHSA that facilitates the service coordination for recipients who are being served by multiple providers and provider networks. Service coordination between different providers and provider networks will be one of the most critical components of the Integrated Behavioral Health project, Continuum of Care/SUD reform project, 1115 SUD Waiver project, and the Housing Stabilization Services project. OCP would provide a cloud-based service coordination tool for any provider to use with other providers, the state, counties, and service recipients. The state has been undertaking an extensive redesign of case management and care coordination services in Medicaid writ large, and SUD-related needs will be considered in the design.

Prescription Drug Monitoring Program Improvements. Under the direction the Board of Pharmacy, the state is planning to enhance MNPMP functionality and interoperability, including by linking it to systems in which prescribers will be able to view electronic health records and easily link them with the MNPMP (currently, staff have to leave the electronic health record, go to the MNPMP, and return to the electronic health record). MDH applied for and received CDC Overdose Data to Action funding, a key strategy that supports the improvement of MNPMP functionality, interoperability, and provider utilization.[xxviii] Minnesota is currently connected to the interstate sharing hub PMP Inter-Connect and is presently sharing access with the Military Health System, the District of Columbia, and 40 states who wish to share access or who have authority to share access according to their laws. The MN DHS Behavioral Health Division will actively collaborate with and support the efforts of the BOP in expanding interstate data sharing agreements. In addition, MN BOP will explore the potential use of additional funding through CMS or SAMHSA to potentially expand interstate data sharing possibilities, as other states have done.

Opioid Prescribing Improvement Program (OPIP). To enhance the identification of long-term opioid use directly correlated to clinician prescribing patterns, Minnesota will continue to refine the prescriber reports. Providers whose prescribing rate is above the threshold for any of the five measures will be required to participate in the quality improvement program if they also prescribed above a certain volume of opioid analgesic prescriptions to Minnesota Medicaid and MinnesotaCare enrollees in the measurement year. DHS will work to expand prescriber enrollment and will continue to refine reporting and quality improvement processes.

Minnesota e-Health Initiative. This public collaboration is focused on accelerating the adoption and use of e-health. The Advisory Committee represents the spectrum of Minnesota's health community, including providers, payers, public health, researchers, vendors, consumer, and more. The e-Health Initiative will continue to encourage and support efforts to implement e-prescribing of controlled substances (EPCS) by providing input on e-Health Strategies for Preventing and Responding to Drug Overdose and Substance Misuse and address ongoing priority topics such as implementation of SCRIPT standards, use of diagnosis code on prescriptions, advancing medication management therapy, and improving the medication reconciliation process.

Recommendations

Recommendations provided below reflect the findings above and the research on initiatives and tools developed and implemented in other states.

Recommendations

Based on the results of this interim evaluation, Minnesota could consider the following actions:

- **Collaborating with providers** to examine what is needed to improve follow-up services, from the ED as well as any treatment services, such as improved infrastructure, more personnel, or improved health information technology to document transitions and care management services. The state could also consider incentives and penalties to focus on improving follow-up and reducing ED use.
- **Continue examining how to obtain comprehensive information on the health workforce that serves the Medicaid population.** This will enable an assessment of what percent of licensed health care workers do not serve Medicaid beneficiaries and inform efforts to increase provider participation in the program—thereby facilitating access to care and widening the referral network. This information will also help MN DHS understand how to increase recruitment and retention of providers in rural and underserved areas.
- **Consider mechanisms to monitor and assess the quality of care provided through managed care.** For example, some states (at least 17 as of 2022) have used financial incentives tied to one or more SUD care continuum performance measures to help ensure quality of care.[xxix] Similarly, Minnesota could leverage its existing requirements for MCOs regarding their participation in state-mandated performance improvement projects (PIPs) to implement a PIP focused specifically on the SUD care continuum, as was recently done in Pennsylvania.[xxx]
- **Maintain commitment to telehealth for SUD services.** A strong infrastructure for telehealth can have a role in Demonstration success by ensuring that the substance use treatment and recovery services can be multimodal and meet beneficiaries' needs.

In addition to the suggestions related to the collection of individual provider data in the PCA and MPA, there were additional measures regarding service delivery of providers participating in the Demonstration that the state can continue to look toward. For example, pending availability of codes in claims data, assessments could be classified into screenings that occurred before a diagnosis of a disorder and are thus considered early intervention, vs. follow-up assessments after a diagnosis. Similarly, we lack data on the service delivery to MCO enrollees who are treated by Demonstration providers who participate in MCO utilization review processes. MN DHS may also consider implementing a survey of organizations to capture other data that may inform MN DHS of treatment quality and adequacy.

References

[i] Minnesota Legislature. (2016). Chapter 170--S.F.No. 2378, Pub. L. No. 254B.15. Available at: https://www.revisor.mn.gov/laws/2016/0/170/.

[ii] Minnesota Legislature. (2021). Sec. 256B.0759 MN Statutes. Available at: https://www.revisor.mn.gov/statutes/cite/256B.0759.

[iii] Minnesota Management and Budget. (2019). Human Services 2020-21 Governor's revised biennial budget proposal. Available at: https://mn.gov/mmb-stat/documents/budget/2020-21-biennial-budget-books/governors-revised-march/human-services.pdf.

[iv] American Society of Addiction Medicine. (2023). The ASAM criteria. Available at: https://www.asam.org/asam-criteria/about-the-asam-criteria.

[v] Minnesota Department of Human Services. Minnesota Substance Use Disorder Section 1115 Waiver Implementation Plan. Available at: https://mn.gov/dhs/assets/sud-section-1115-waiver-implementation-plan_tcm1053-469823.pdf.

[vi] Minnesota Department of Human Services. 1115 Substance Use Disorder System Reform Demonstration 2021 Legislative Changes. Available at: 1115 Substance Use Disorder System Reform Demonstration 2021 Legislative Changes, Bulletin #21-21-01.

[vii] Minnesota Statutes 2022, Chapter 254B.151. Available at: https://www.revisor.mn.gov/statutes/cite/254B/pdf.

[viii] Centers for Disease Control and Prevention. (May 23, 2022). DOSE dashboard: Nonfatal overdose syndromic surveillance data. Available at: https://www.cdc.gov/drugoverdose/nonfatal/dashboard/index.html.

[ix] Avena, N. M., Simkus, J., Lewandowski, A., Gold, M. S., & Potenza, M. N. (2021). Substance use disorders and behavioral addictions during the COVID-19 pandemic and COVID-19-related restrictions. *Frontiers in Psychiatry, 12,* 653674. Available at: https://www.frontiersin.org/articles/10.3389/fpsyt.2021.653674/full.

[x] Hulsey, J., Mellis, A., & Kelly, B. (June 8, 2020). COVID-19 pandemic impact on patients, families & individuals in recovery from a SUD. Addiction Policy Forum. Available at: https://www.addictionpolicy.org/post/covid-19-pandemic-impact-on-patients-families-individuals-in-recovery-fromsubstance-use-disorder.

[xi] Hulsey, J., Mellis, A., & Kelly, B. (June 8, 2020). COVID-19 pandemic impact on patients, families & individuals in recovery from a SUD. Addiction Policy Forum. Available at: https://www.addictionpolicy.org/post/covid-19-pandemic-impact-on-patients-families-individuals-in-recovery-fromsubstance-use-disorder.

[xii] Saloner, B., Krawczyk, N., Solomon, K., Allen, S. T., Morris, M., Haney, K., & Sherman, S. G. (2022). Experiences with substance use disorder treatment during the COVID-19 pandemic: Findings from a multistate survey. *International Journal of Drug Policy*, *101*, 103537. Available at: https://www.sciencedirect.com/science/article/pii/S0955395921004552.

[xiii] Office of the Assistant Secretary for Planning and Evaluation (ASPE) (2022). Impact of the COVID-19 pandemic on the hospital and outpatient clinician workforce: Challenges and policy responses. Issue Brief. Available at: https://aspe.hhs.gov/sites/default/files/documents/9cc72124abd9ea25d58a22c7692dccb6/aspe-covid-workforce-report.pdf.

[xiv] Macht, C., & Schaffhauser, A. (2021). Critical condition: the health care workforce in Minnesota. Minnesota Department of Employment and Economic Development. Available at: https://mn.gov/deed/newscenter/publications/trends/december-2021/critical.jsp.

[xv] Minnesota Department of Health (2022). Minnesota's health care workforce: Pandemic-provoked workforce exits, burnout and shortages. Issue Brief. Available at: https://www.health.state.mn.us/data/workforce/docs/2022workforcebrief.pdf.

[xvi] Minnesota Department of Health. (2020). IT Project Portfolio Summary (No. 3). Available at: https://mn.gov/mnit/assets/2020-10-01_MNIT_16E-0466_Subd_2_Project_Portfolio_Report_tcm38-449899.pdf.

[xvii] Minnesota Department of Health. Drug overdose dashboard. Available at: https://www.health.state.mn.us/communities/opioids/opioid-dashboard/index.html.

[xviii] Centers for Disease Control and Prevention. SUDORS dashboard: Fatal overdose data. Available at: https://www.cdc.gov/drugoverdose/fatal/dashboard.

[xix] Tanz, L. J., Dinwiddie, A. T., Snodgrass S., O'Donnell J., Mattson C. L., & Davis N. L. A qualitative assessment of circumstances surrounding drug overdose deaths during the early stages of the COVID-19 pandemic. SUDORS Data Brief 2 (2022). Available at: https://www.cdc.gov/drugoverdose/pdf/sudors-covid-databrief-22.pdf.

[xx] Mafi, J. N., Craff, M., Vangala, S., et al. (2022). Trends in US ambulatory care patterns during the COVID-19 pandemic, 2019-2021. *JAMA*, *327*(3), 237-247. Available at: https://jamanetwork.com/journals/jama/articlepdf/2788140/jama_mafi_2022_oi_210146_1642787258.47771.pdf.

[xxi] Patel, S. Y., Mehrotra, A., Huskamp, H. A., Uscher-Pines, L., Ganguli, I., & Barnett, M. L. (2021). Variation in telemedicine use and outpatient care during the COVID-19 pandemic in the United States. *Health Affairs*, *40*(2), 349-358. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7967498/.

[xxii] Reuter, Q., Smith, G., McKinnon, J., Varley, J., Jouriles, N., & Seaberg, D. (2020). Successful medication for opioid use disorder (MOUD) program at a community hospital emergency department. *Academic Emergency Medicine*, *27*(11), 1187-1190. Available at: https://onlinelibrary.wiley.com/doi/10.1111/acem.13921.

[xxiii] Minnesota Department of Health (2022). State reports record drug overdose deaths in 2021; Increasing prevalence of fentanyl thought to be a contributing factor. News release. Available at: https://www.health.state.mn.us/news/pressrel/2022/drugod071422.html.

[xxiv] U.S. Government Accountability Office. Medicaid: States' changes to payment rates for substance use disorder services; GAO-20-260. Available at: https://www.gao.gov/products/gao-20-260.

[xxv] Minnesota Department of Human Services. Telehealth and telemedicine during the COVID-19 pandemic; 12/16/2020. Available at: https://mn.gov/dhs/assets/telemedicine-utilization-report-2020_tcm1053-458660.pdf.

[xxvi] Corporation for Supportive Housing (CSH) (2022). Policy brief: Summary of state actions on Medicaid and housing services. Available at: https://www.csh.org/resources/policy-brief-summary-of-state-actions-on-medicaid-housing-services/.

[xxvii] Corporation for Supportive Housing (CSH) (2022). Policy brief: Summary of state actions on Medicaid and housing services. Available at: https://www.csh.org/resources/policy-brief-summary-of-state-actions-on-medicaid-housing-services/.

[xxviii] CDC Overdose Data to Action. Accessed at https://www.cdc.gov/drugoverdose/od2a/funded-states.html.

[xxix] Donohue, J. M. (2022, July). Meeting the needs of Medicaid beneficiaries with substance use disorders in managed care. *JAMA Health Forum* 3(7):e221722. Available at: https://jamanetwork.com/journals/jama-health-forum/fullarticle/2793911.

[xxx] Hinton, E., Guth, M., Raphael, J., Haldar, S., et al. (2022). How the pandemic continues to shape Medicaid priorities: Results from an annual Medicaid budget survey for state fiscal years 2022 and 2023. Kaiser Family Foundation. Available at: https://www.kff.org/report-section/medicaid-budget-survey-for-state-fiscal-years-2022-and-2023-introduction/.

Official Notices

Pursuant to *Minnesota Statutes* §§ 14.101, an agency must first solicit comments from the public on the subject matter of a possible rulemaking proposal under active consideration within the agency by publishing a notice in the *State Register* at least 60 days before publication of a notice to adopt or a notice of hearing, and within 60 days of the effective date of any new statutory grant of required rulemaking.

The *State Register* also publishes other official notices of state agencies and non-state agencies, including notices of meetings and matters of public interest.

Department of Human Services

Health Care Administration

Request for Comments on the Minnesota Substance Use Disorder System Reform Section 1115 Medicaid demonstration waiver Section 1115 Medicaid Waiver Extension Request

DHS is announcing a 30-day comment period on the proposed extension of the Minnesota Substance Use Disorder (SUD) System Reform Section 1115 Medicaid demonstration waiver.

The SUD waiver was first approved by the Centers for Medicare & Medicaid Services in August 2019. The SUD waiver provides federal Medicaid funds for enrollees receiving SUD treatment in facilities that meet the federal definition of an Institution for Mental Diseases (IMDs). This federal funding supports continued access to intensive residential SUD treatment services for Minnesotans struggling with addiction. The state proposes a five-year demonstration waiver extension under section 1115(a) of the Social Security Act to test the impact of evidence-based provider referral arrangements and practices on improving health outcomes for Medicaid enrollees with substance use conditions.

The current waiver ends June 30, 2024. DHS invites public comment on the SUD waiver extension request. Comments received will be posted on the DHS website. A copy of the waiver extension request can be found at ***Federal health care waivers with public hearings and comments / Minnesota Department of Human Services (mn. gov)*** .

Written comments may be submitted to the following email mailbox: ***Section1115WaiverComments@state.mn.us***. To support making comments available to people who use screen readers, DHS requests comments be submitted in Microsoft Word format or incorporated within the email text. If you would also like to provide a signed copy of the comment letter, you may submit a second copy in Adobe PDF format. Comments must be received by October 27, 2023.

In addition to the opportunity to submit written comments during the 30-day public comment period, two public comment meetings will be held to provide comment on the waiver request directly to DHS staff. The dates and times of the two meetings are:

First Meeting – Video Conference
Date: Tuesday, October 10, 2023
Time: 11:00 a.m. to 12:00 p.m.

Second Meeting – In-person (St. Paul, MN)
Date: Thursday, October 12, 2023
Time: 11:00 a.m. to 12:00 p.m.

If you would like to attend either meeting, please send an email request to ***Section1115WaiverComments@state.mn.us*** to obtain the call/video conference information or in-person registration information. If you plan to testify during the either meeting about the SUD waiver extension, please send an email to ***Section1115WaiverComments@state.mn.us*** indicating that you will testify. All comments and testimony will be recorded and will be shared publicly as part of the waiver extension request.

Minnesota Substance Use Disorder (SUD) System Reform Waiver Extension – Comment Period

From: Minnesota Department of Human Services <Minnesota_DHS@public.govdelivery.com>

Subject: Minnesota Substance Use Disorder (SUD) System Reform Waiver Extension – Comment Period

The Minnesota Department of Human Services (DHS) plans to submit a waiver extension request to the Center for Medicare & Medicaid Services (CMS) for approval to continue the Minnesota Substance Use Disorder (SUD) System Reform Waiver.

The SUD waiver was first approved by CMS in August 2019. The SUD waiver provides federal Medicaid funds for enrollees receiving SUD treatment in facilities that meet the federal definition of an Institution for Mental Diseases (IMDs). This federal funding supports continued access to intensive residential SUD treatment services for Minnesotans struggling with addiction. The current waiver ends June 30, 2024, and DHS is proposing a five-year demonstration waiver extension under section 1115(a) of the Social Security Act. The demonstration waiver is an important component of the state's larger reform effort to address the opioid crisis as well as the health care delivery system for Medicaid enrollees who need SUD treatment and services.

A draft of the SUD waiver extension request is posted on DHS' federal waiver web page. The web page also includes information about opportunities to comment, including two scheduled hearings. Written comments are also accepted if they are submitted to Section1115WaiverComments@state.mn.us by October 27, 2023.

Having trouble viewing this email? View it as a Web page.

Stay connected

Minnesota Department of Human Services

Subscriber services:
Manage subscriptions | Help

This email was sent to Email Address using GovDelivery Communications Cloud on behalf of: Minnesota Department of Human Services · 540 Cedar St. · Saint Paul, MN 55101

Minnesota Department of Human Services
Health Care Administration
540 Cedar Street
PO Box 64983
St Paul, MN 55164-0983

September 25, 2023

Re: Minnesota's Substance Use Disorder System Refrom demonstration waiver extension request

Dear Tribal Leader,

The Department of Human Services (DHS) is announcing a 30-day comment period on the Substance Use and Disorder System Reform (SUD) waiver extension request. The SUD waiver was initially approved by the Centers for Medicare & Medicaid Services on July 1, 2019 under Section 1115(a) of the Social Security Act, and the waiver expires on June 30 2024. DHS is requesting that the Centers for Medicare & Medicaid services approve a five-year extension of the SUD waiver pursuant to authority under state law.

The SUD waiver provides federal Medicaid funds for beneficiaries receiving substance use disorder treatment in facilities that meet the federal definition of an Institution for Mental Diseases (IMDs) and supports continued access to intensive residential SUD treatment services for Minnesotans struggling with addiction. DHS provided information about the SUD waiver extension request at the quarterly Tribal and Urban Health Directors meetings held this year in March, May, and August. It was also raised at the American Indian Advisory Council (AIAC) held on March 16, 2023.

The SUD waiver extension request is available for review on the DHS website. The website includes information about how to submit comments via email or through public meetings. We request that feedback be provided by October 27, 2023. Should you have questions about the SUD extension request, please contact Michelle Long of my staff directly at michelle.long@state.mn.us. Thank you.

Sincerely,

Patrick Hultman
Deputy State Medicaid Director

Attachment E

Comments Received by the State During the 30-day Public Notice Period

Table A provides the public comments received during the waiver hearing that was held virtually on October 10, 2023. Comments and questions were entered electronically by participants and are recorded below as submitted. DHS staff read and responded to each question during the hearing. The final state responses are provided in this attachment.

Subsequent pages of this attachment contain written comments received during the public comment period and DHS' responses.

Table A

Name/Affiliation	Question as Submitted	State Response
Grayce Lemon, Allina	Is the proposed 5 year extension an extension of funding or enrollment?	The planned five-year extension provides authority for Minnesota to continue to receive Federal Financial Participation (FFP) for Substance Use Disorder (SUD) services provided in Institutions for Mental Diseases (IMD).
Dale Dobrin, Doctors for Early Childhood	does the demo include attention to sud in mothers and babies?	DHS submits quarterly and annual data to the Centers for Medicare & Medicaid Services (CMS), and is required to report on a subpopulation of Medicaid beneficiaries who are or were pregnant in the past year and who have a Medicaid claim for SUD services.
Dale Dobrin, Doctors for Early Childhood	clarification: and IMD includes residenttial as well as non residential treatment?	Only residential programs meet the federal requirements to be designated as an IMD.
Dale Dobrin, Doctors for Early Childhood	and how many IMDs exist in MN?...just SUD.	There are 90 IMDs in Minnesota that provide SUD services.
Dawn Laudenbach, CentraCare	Will there be a carve out for complexity enhancements for SUD services such as our current cooccurring complexity?	There are currently no plans to create a carve out for rate enhancements due to complexity of service needs. DHS is currently conducting a rate study with a report due to the state legislature in January 2024. Any changes to the current rate methodology are subject to legislative and federal Medicaid state plan approvals.
Dale Dobrin, Doctors for Early Childhood	since care coordination enhances connections between those in need and services, is there ar opportunity to pay for additional care coord	Yes. To meet the ASAM requirements, DHS' published standards that include increased requirements for treatment coordination as well as patient referral arrangement agreements and program outreach plans. The program outreach plan must include how the provider will coordinate with inpatient acute-care hospitals, including emergency departments, hospital outpatient clinics, urgent care centers, residential crisis settings, medical

	needed to follow up ED and in patient services?	detoxification inpatient facilities and ambulatory detoxification providers in the area served by the provider to help transition individuals from emergency department or hospital settings and minimize the time between assessment and treatment. Providers that attest to meeting these additional requirements are eligible for enhanced payments.

From: Lance Egley <lcegley@paulbunyan.net>
Sent: Thursday, October 12, 2023 12:29 PM
To: MN_DHS_Section1115WaiverComments <Section1115WaiverComments@state.mn.us>
Subject: Written Comments on Minnesota 1115 Waiver Renewal Application

You don't often get email from lcegley@paulbunyan.net. Learn why this is important

This message may be from an external email source.
Do not select links or open attachments unless verified. Report all suspicious emails to Minnesota IT Services Security Operations Center.

Minnesota 1115 Waiver Renewal Application Comments

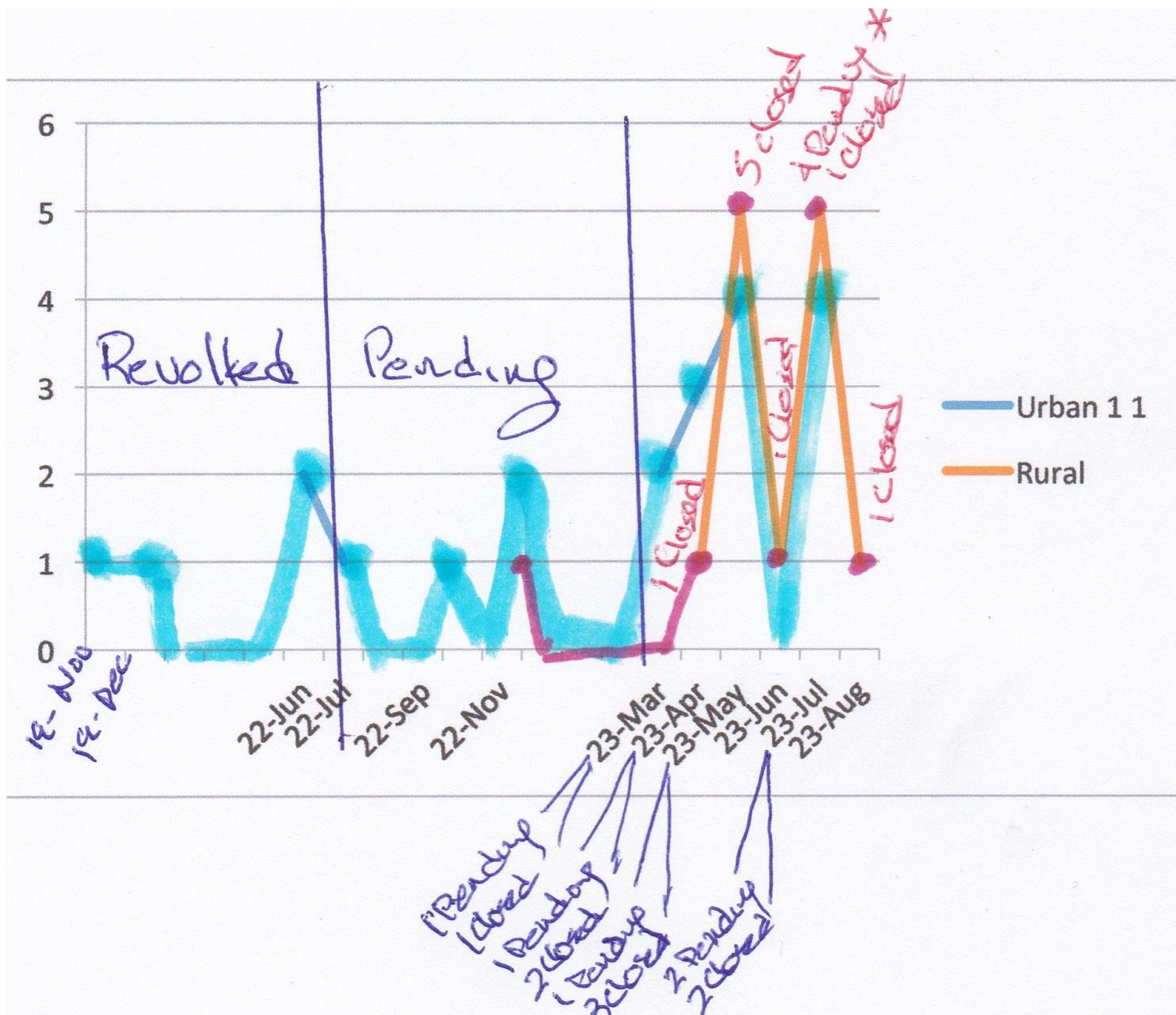
Federal 1115 Waiver Reviewers:

I have worked over 20 years in SUD treatment. I received a post-doc in the Organization and Financing of Mental Health Services from University of California, Berkeley. I taught SUD courses at and coordinate the minor leading to the LADC at Bemidji State university, trained providers throughout the State of Minnesota, trained staff at Red Lake Nation Chemical Health Programs for 19 years, served over a decade on the Board of a large provider professional association, and participated in various community inputs to DHS planning efforts over the past 8 years. I am currently co-chair of the Paperwork Reduction and Systems Improvement Steering Committee with providers and DHS as participants.

Extension of the waiver is desirable, but several features of the application need further attention.

SUD Workforce Crisis in Minnesota

There is a shortage of providers and of licensed alcohol and drug counselors (LADCs) in the State of Minnesota that is reaching extreme levels. In addition, there are signs that providers are closing and few LADCs are coming into the field than in the past. Recent data from the Licensing Division shows the following provider closures.



Revoked Licenses represent programs closed by the Licensing Division. Pending means closed pending reopening, whereas "closed" alone means the program terminated its own license and would have to reapply from scratch should it changes its mind and want to open again. Closed programs have no plan to reopen.

Also, a recent MNCASE meeting of educators of LADCs say enrollment in courses is notably declining. This trend of reduced capacity in comparison to need for LADC's over time in Minnesota is verified by Minnesota Department of Health annual surveys of Licensed Professionals. A Minnesota Department of Health Study in cooperation with the economic development department found LADC's that were leaving the field before retirement age, with the primary reason being excessive paperwork and regulation. Also included was conflict with other staff, which accelerates when LADC's and providers generally are overworked and understaffed.

The decision in the Waiver to require additional LADC certification starting 1/1/25 for ASAM other than, and in addition to, the LADC requirements already in place by the independent Minnesota Board of Behavioral Health, will increase the LADC workforce shortage. This start, the same date as all the remaining providers (outpatient) are required to join the waiver, invites both more program closures and more LADCs leaving the field of SUD treatment. The Waiver also intends to add the 2.1 and 2.5

ASAM levels of care at this same date. Addition of these levels of care will not directly impact other services, but because all the other providers will need to create agreements with at least one program in each of these new levels of care, it will severely burden providers at a time when they are already stressed by staff shortages, inadequate reimbursement, and rapid change. At least one residential provider has already informed me that DHS electronic "help" on enrolling in the 1115 Waiver had so many bad links and irrelevant connections that she was going to close her program. The program was only saved when she reported this experience directly to DHS and then DHS staff hand-walked her through the Application. What happens to less assertive providers? I know of another medium-intensity residential facility which did close, knowing that the medium-intensity rate would be discontinued and not knowing what could take its place.

No doubt the 1115 Waiver continuation will expand the level of care choices available for clients. The question is, "Will implementing it greatly reduce the capacity of the entire provider system to deal with the volume of clients in need?"

Loopholes in Standards

It is not clear that DHS is being effective in enforcing standards on the MCOs with which it contracts. We have been told that DHS can only include in the contract those items that are in statute. This would exclude many implementation applications by both DHS and its Licensing Division. There does not seem to be any review by DHS as to whether the contracted MCOs are meeting ASAM standards and for one of the 9 MCOs contracted with the state there is widespread believe among providers that it does not, denying care without adequate justification.

In addition, although Care Coordination can be expected to enhance continuation with other levels of care or aftercare support needed by clients, the decision to no longer support medium intensity residential treatment rates because it is not a level in ASAM works in the opposite direction by reducing the available transitional housing that is safe and sober. The SUD Division director has stated that DHS recognizes this problem and hopes to offset it with more sustainable higher level low-intensity treatment rates. Those rates are not yet evident.

Although Direct Access has potential to speed access to treatment, many clients do not experience this. If a client is not on MA before the SUD issue is presented at an assessment, even if qualified for MA, Counties who authorize MA, and also authorize State Behavioral Health Fund payment qualification for those who meet only State income requirements, delay access by debating county of residence or demanding excessive documentation of county of residence or income that cannot be provided in a timely fashion. This is an especial problem for admissions to Withdrawal Management or to detox as timeliness may be lifesaving, but timeliness is also relevant to all admissions where client motivation can fluctuate rapidly.

Open-ended Commitments in the Proposal

As we cannot know what the ASAM 4th Edition will require, providers face an unknown change in the immediate future. This is especially difficult to cope with because at the same time full integration of providers into the 1115 Waiver is in progress, the ASAM criteria themselves are new, and Direct Access implementation is just beginning to be worked out.

The Application states that culturally specific providers must comply with national standards. I am not aware of any national standards for "culturally appropriate services." Certainly, for American Indian Tribes, each of which is a unique culture, it is hard to see how there can be a national standard.

The expression that providers are required to "facilitate access to MAT" is undefined in the Application. This is important. Simply requiring providers to admit to treatment clients who are on MAT is a limited objective. Requiring providers to transport clients to MAT dosing, often daily, can be prohibitively expensive, especially in Northern Minnesota where the nearest methadone dosing can be 150 miles away for North Central Minnesota (Bemidji), or even 250 miles for the most remote NW corner of the State.

There is no indication what DHS might be doing with plans for "streamlining residential requirements" to ease the burden of changes including the requirements of the 1115 Waiver.

Recommending opioid MAT standards be legally required should not occur until after through vetting with providers. To my knowledge, this has not been done.

Proper Credits

The reference to various mapping resources should credit providers for and the Paperwork Reduction and Systems Implementation Action Teams they have formed for all the mappings except the DHS High Level Mapping.

I hope that in the final approval process the Minnesota 1115 Waiver Renewal Application will be amended to address many of these concerns.

Yours,

Lance Egley, Ph.D., L.A.D.C., L.I.C.S.W., C.A.D.C. III

From: Hultman, Patrick N (DHS)
To: Lance Egley
Subject: Your Comments RE: Minnesota"s SUD Waiver
Date: Wednesday, November 15, 2023 4:52:00 PM
Attachments: image002.png
image003.png
image004.png

Good Afternoon,

Thank you for your correspondence dated October 12, 2023 in response to the state's request for comments on the state's Medicaid waiver extension that provides continued federal support for Minnesota's substance use disorder (SUD) treatment system. If approved by the Centers for Medicare & Medicaid Services (CMS}, this waiver extension supports continued access to high quality, clinically appropriate SUD treatment for Minnesotans.

The Department shares your concerns regarding the ongoing SUD treatment workforce shortage, and is engaged with state leaders to collaborate on potential solutions. We are actively working on these issues with the Office of Rural Health and Primary Care at the Minnesota Department of Health and staff with the Results First Initiative at Minnesota Management and Budget. The state also carefully tracks trends in service utilization as required under this Medicaid demonstration project. We also understand the concern from providers regarding the utilization review processes employed by the state's contracted managed care organizations. The Department holds monthly meetings with representatives from the managed care organizations and we understand that the health plans are using the ASAM criteria to conduct utilization review. We encourage you to remain in contact with Department staff with any specific concerns you have regarding managed care organizations.

We also appreciate your comment about the state's policy regarding access to medication assisted treatment services, now referred to as Medications for Opioid Use Disorder (MOUD), and concerns about accessing MOUD services in rural Minnesota. States participating in this federal demonstration must ensure that Medicaid beneficiaries have access to MOUD services. To address concerns regarding administration of MOUD in rural areas, Opioid Treatment Programs (OTP) may request a federal exemption allowing stable patients to receive up to 28 days of take-home doses of the patient's medication for opioid use disorder to be administered in a residential program.

Thank you for your continued partnership and your ongoing support for the goals of this demonstration. Agency leadership in the Behavioral Health, Housing, and Deaf and Hard of Hearing services administration will follow up with you directly regarding items in your letter that are outside the scope of this demonstration. Your comments will be included in the waiver application submitted to CMS. The Minnesota Department of Human Services will inform stakeholders when the waiver request has been approved or denied by CMS through its web site and email lists.

Patrick Hultman
Pronouns: (he/him/his)
Deputy Medicaid Director | Health Care Administration
Minnesota Department of Human Services
O: 651-431-4311
mn.gov/dhs

Patrick Hultman

Pronouns: (he/him/his)
Deputy Medicaid Director | Health Care Administration
Minnesota Department of Human Services
O: 651-431-4311
mn.gov/dhs

To: Michelle Long, MN DHS--Federal Relations
From: Brian Zirbes, MARRCH Executive Director
Subject: Response to Section 1115 Waiver Demonstration Extension Request
Date: 10/27/23

On behalf of the Minnesota Association of Resources for Recovery and Chemical Health, its Board of Governors, its members, and thousands of Substance Use Disorder (SUD) professionals providing treatment in Minnesota, we appreciate the opportunity to provide feedback regarding the 1115 Demonstration Extension Request. MARRCH sees the extension of the 1115 Waiver as vital to stability for the SUD system in MN. Providers have put in an extraordinary effort over the last few years to learn about the American Society of Addiction Medicine (ASAM) levels of care, incorporate systemic changes, train staff, and provide ongoing oversight to ensure compliance with this national standard. Providers need assurances of continuity as there are significant workforce issues at play resulting in staff burnout and a dwindling pipeline of people entering the SUD field as their profession. We have broken down our feedback to respond to each section of the extension request. We look forward to continued collaboration in building a system of care in MN that is evidence based and meets SUD needs for Minnesotans in a timely manner.

Section I Feedback:

- MARRCH would like to acknowledge the movement DHS and its selected vendor made in moving from 100% of claims needing to be submitted to 10-15% for residential and non-residential respectively. The initial requirement added significant burden to providers without any benefit.
- The 1115 Waiver continuation will expand the level of care choices available for clients in MN. Will continued expansion greatly reduce the capacity of the entire provider system to deal with the volume of clients in need? Asking for more from an already strained system may have adverse effects.
- Providers need consistent, in-depth, and side by side training opportunities at low to no cost. Resources and support for the absence of staff when training is needed.
- The timing of the required changes needs to take into account the current change fatigue. Ample notice, guidance, instruction, and support for change is also needed.

Section II Feedback:

- The concept of a national Culturally and Linguistically Appropriate Services (CLAS) standard may not consider the differences amongst cultural groups. Certainly, for American Indian Tribes, each of which is a different culture, it is hard to see how there can be a national standard.

- There needs to be more detail on how offering the full continuum of ASAM levels of care is expected to improve identification of the need for and access to culturally responsive services.
- The overdose death rates for people of color in MN is alarming and needs a robust and detailed plan to address. Providers stand ready to be a part of the solution, we just need support, direction, and autonomy to act.

Section IV Feedback:

- How does DHS ensure the contracted Managed Care Organizations (MCOs) are meeting ASAM standards? Please elaborate on how this is being met.
- Although Direct Access has potential to speed access to treatment, many clients do not experience this.
    - If a client is not on MA (but qualifies for MA) before the SUD issue is presented at an assessment, counties can delay access by debating county of residence by demanding excessive documentation of residence or income.
    - This is a problem for admissions to Withdrawal Management as timeliness may be lifesaving, but relevant to all admissions where client motivation can fluctuate rapidly.
- The expression that providers are required to “facilitate access to MAT” is undefined in the Application. Simply requiring providers to admit to treatment clients who are on MAT is a fairly limited objective. Requiring providers to transport clients to MAT dosing, often daily can be prohibitively expensive, especially in Northern Minnesota where the nearest methadone dosing can be 150 miles away for North Central Minnesota (Bemidji), or even 250 miles for the most remote corner of the State.
- The recent MCO networking sessions with DHS and each of the 9 MCOs has been a good start. Providers consistently raise concerns about variations in requirements between clients funded by MA versus those by an MCO. These varying requirements add an additional burden to providers. Getting billing issues resolved, challenges with unclear expectations on clinical documentation, and shorter lengths of stays being approved are consistent issues experienced by providers. DHS as the contracting authority with MCOs needs to take a firmer stance with MCOs in ensuring they are not creating undue barriers for providers which hinders access to SUD services for enrollees. There needs to be more consistency in the Utilization Review process across Kepro and all MCOs.

Section V Feedback:

- Why does milestone 4 not include quantifiable numbers, but rather anecdotal? The report indicates it's because of a lack of the ability of the state to report on individuals. How will DHS address this?
- Milestone 6 of the evaluation is not favorable, what will DHS do to put more efforts into this?

Section VI Feedback:

- Why is the Fee For Service (FFS) expenditure so much more than Managed Care, when FFS makes up about 10% of all Medicaid members?
- The 1115 enrollment rate increase from 15% to 25% was a MARRCH led initiative to re-align reimbursements with costs. Even with this increase, providers have noted the rates are still not sufficient. This has been made evident by the draft rate recommendations recently released by the Outpatient Rate Methodology vendor, Burnes & Associates/Health Management Associates.

General Feedback:
Highlighting the decreases in effectiveness and numbers, as well as the plans to address, should be more apparent in the extension request. MARRCH looks forward to being a collaborative partner with DHS in addressing these concerns in this extension request.

DEPARTMENT OF HUMAN SERVICES

November 15, 2023

Brian Zirbes
Executive Director, MARRCH
1601 Utica Avenue South
Minneapolis, MN 55416

Dear Mr. Zirbes

Thank you for your correspondence dated October 27, 2023 in response to the state's request for comments on the state's Medicaid waiver extension that provides continued federal support for Minnesota's substance use disorder (SUD) treatment system. If approved by the Centers for Medicare & Medicaid Services (CMS}, this waiver extension supports continued access to high quality, clinically appropriate SUD treatment for Minnesotans.

We share your concern regarding provider capacity and welcome your ongoing engagement in the Department's efforts to monitor and evaluate whether provider capacity is sufficient to meet the demand for services. Your letter also identified the continued need for ongoing training and support as the state fully adopts nationally recognized standards for SUD treatment. We understand the challenge of adopting new provider standards and remain committed to providing ongoing training and technical assistance at no cost to the provider community as we have done since the standards were published in 2020.

We also appreciate your comment about the state's policy regarding access to medication assisted treatment services, now referred to as Medications for Opioid Use Disorder (MOUD), and concerns about accessing MOUD services in rural Minnesota. States participating in this federal demonstration must ensure that Medicaid beneficiaries have access to MOUD services. To address concerns regarding administration of MOUD in rural areas, Opioid Treatment Programs (OTP) may request a federal exemption allowing stable patients to receive up to 28 days of take-home doses of the patient's medication for opioid use disorder to be administered in a residential program.

Thank you for your continued partnership and your ongoing support for the goals of this demonstration. Agency leadership in the Behavioral Health, Housing, and Deaf and Hard of Hearing services administration will follow up with you directly regarding items in your letter that are outside the scope of this demonstration. Your comments were included in the waiver application submitted to CMS. The Minnesota Department of Human Services will inform stakeholders when the waiver request has been approved or denied by CMS through its web site and email lists.

Sincerely,

Julie Marquardt
Interim State Medicaid Director

540 Cedar Street, Post Office Box 64983, St. Paul, MN 55164-0355

An equal opportunity and veteran-friendly employer

From: Monique Bourgeois <Monique.Bourgeois@nuway.org>
Sent: Wednesday, October 25, 2023 12:26 PM
To: MN_DHS_Section1115WaiverComments <Section1115WaiverComments@state.mn.us>
Subject: Public Comment submission SUD demonstration waiver

You don't often get email from monique.bourgeois@nuway.org. Learn why this is important

This message may be from an external email source.
Do not select links or open attachments unless verified. Report all suspicious emails to Minnesota IT Services Security Operations Center.

Here are my public comments related to the SUD demonstration waiver (1115) by MN DHS:

- DHS extension request will be immediately out of date with the release of ASAM 4.0. For example, PHP is no longer supported in ASAM 4.0.
- How utilization management conducted through the MCOs should be streamlined and consistent to ensure no additional burdens a put upon the providers to meet an individual MCOs requirements.

Monique Bourgeois, MPNA, LADC
Chief Community Relations Officer
she/her/hers

Administrative Offices
2217 Nicollet Avenue S
Minneapolis, MN 55404
P: 651-964-3680
F: 612-767-0301
nuway.org

CONFIDENTIAL COMMUNICATION. The information contained in this e-mail and any attachments are confidential or otherwise protected from disclosure and is for the intended use of the designated

recipients. The use, distribution, or re-transmittal by an unintended recipient is prohibited. If you have received this communication in error, please delete this material without copying it and immediately notify the sender so that our address may be corrected. DO NOT FORWARD THIS COMMUNICATION WITHOUT PERMISSION.

From: Hultman, Patrick N (DHS)
To: monique.bourgeois@nuway.org
Subject: Your Comments RE: Minnesota"s SUD demonstration
Date: Wednesday, November 15, 2023 4:59:00 PM
Attachments: image002.png
image003.png
image004.png

Good Afternoon,

Thank you for your correspondence dated October 25, 2023 in response to the state's request for comments on the state’s Medicaid waiver extension that provides continued federal support for Minnesota's substance use disorder (SUD) treatment system. If approved by the Centers for Medicare & Medicaid Services (CMS), this waiver extension supports continued access to high quality, clinically appropriate SUD treatment for Minnesotans.

We appreciate your comment regarding the state’s adoption of the most up to date standards issued by the American Society of Addiction Medicine (ASAM) for the treatment of SUD. The Department intends to align the standards for SUD treatment services in Minnesota with the 4th edition of the ASAM standards, and will support changes in state law necessary to adopt the forthcoming changes. We also understand the concern from providers regarding the utilization review processes employed by the state’s contracted managed care organizations. The Department holds monthly meetings with representatives from the managed care organizations and we understand that the health plans are using the ASAM criteria to conduct utilization review. We encourage you to remain in contact with Department staff with any specific concerns you have regarding managed care organizations.

Thank you for your continued partnership and your ongoing support for the goals of this demonstration. Your comments will be included in the waiver application submitted to CMS. The Minnesota Department of Human Services will inform stakeholders when the waiver request has been approved or denied by CMS through its web site and email lists.

Patrick Hultman
Pronouns: (he/him/his)
Deputy Medicaid Director | Health Care Administration
Minnesota Department of Human Services
O: 651-431-4311
mn.gov/dhs

Granite Falls Campus
660 18th St | PO Box 116
Granite Falls, MN 56241
PH: 320.564.4911
FAX: 320.564.3122

Marshall Campus
1220 Birch Street
Marshall, MN 56258
PH: 507.532.3008
FAX: 507.532.3058

Willmar Campus
309 7TH Street NW
Willmar, MN 56201
PH: 320.214.7744
FAX: 320.235.0642

Redwood Falls Outpatient
334 South Jefferson Street
Redwood Falls, MN 56283
PH: 507.637.8783
FAX: 507.532.3058

October 30, 2023

Project Turnabout
660 18th St
Granite Falls, MN 56241
mpaulson@projectturnabout.org

To whom it may concern,

As the Chief Executive Officer of a full Continuum of Care, Project Turnabout Centers for Addiction Recovery located in Southwest Minnesota, I would strongly support the extension of the 1115 Waiver being led by the Minnesota Department of Human Services.

As one of the largest providers who has been a part of the 1115 Waiver since the start in 2018, we are confident in the direction that DHS is leading this new phase. The Waiver requires all providers to offer a full continuum, whether it is through their own program or contracting with other facilities. This has strengthened the state's behavioral health care system by improving access to substance use disorder treatment across Minnesota. By taking additional steps and incorporating ASAM into the full continuum of care, this too, will improve the quality of services our patients receive.

I would highly encourage the extension of the 1115 Waiver be put through.

Sincerely,

Marti Paulson *CARN, MSOP*
Executive Director/CEO
Project Turnabout

www.ProjectTurnabout.org

Full lives for people with disabilities

October 25, 2023

RE: Minnesota 1115 Waiver Extension

Vinland National Center is an ASAM 3.3 level of care (Clinically Managed Population-Specific High-Intensity Residential Program). We have been involved in the Minnesota 1115 Demonstration Waiver since 2018 and are one of the eight original "Early Adopters." As such, our exposure to this waiver has allowed us to see results and changes within the state Substance Use Disorder system. Listed below are our observations.

Direct Access - has allowed people with SUD's a more efficient entry into treatment by eliminating an outside assessor's involvement and permits qualified personnel to determine the appropriate ASAM client placement. Because Vinland serves clients from all over the state of Minnesota, referents utilizing the ASAM SUD placement criteria can identify those individuals that have cognitive deficits and may be best served in our program or would do better in another program. It allows to the client to receive the appropriate services throughout their treatment services.

Continuum of Care - with more providers participating in the 1115 waiver and utilizing the ASAM criteria there are additional options for people with SUD. Clients are commonly referred from high intensity to a lower level of care. While in treatment, work with that client can establish a continuum of care once they completely leave treatment. This may include Peer Recovery specialists and communities, as well as other community support groups. Establishing longevity in treatment continuum is a positive, evidence-based practice.

Patient Referral Arrangement Agreements - as the only ASAM 3.3 level of care in the state, Vinland has Patient Referral Arrangement Agreements with over 120 residential provider locations. It has been extremely beneficial to have these agreements since it opens up opportunities for an enhanced continuum of care throughout the state. Many of these PRAA providers were not "known" to our staff and it has allowed for new referrals to happen. Knowing that the PRAA providers are practicing the same ASAM criteria that our clients were exposed to while in treatment at Vinland has also benefited our SUD clients post discharge. Utilizing evidence-based treatment by providers participating in the 1115 demonstration is a more consistent method to service delive1y.

Program Outreach Plan - Vinland approaches our outreach plan as a collaboration between ourselves and "others." The others include treatment providers, court systems, CCBHC's, hospitals, urgent care centers, medical,

3675 Ihduhapi Road, PO Box 308, Loretto, MN 55357

Phone 763.479.3555 Fax 763.479.2605 www.vinlandcenter.org

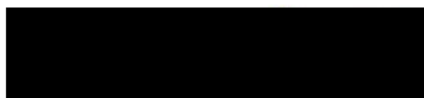
detoxification facilities, native tribes, primary care and mental health facilities, and all SUD-related conferences. This allows education about SUD to a variety of systems that provide behavioral health services and allows transitions between levels of care to an appropriate provider.

Medication Assisted Treatment - since MAT is a requirement of participation in the 1115 demonstration, it has greatly increased availability for SUD clients to have access to this option.

Physical and Mental Health - is a barrier to the success of individuals with SUD. By implementing the requirements that all providers have access to both Medical and Mental Health services it reduces some of those barriers. Logically it should also reduce utilization of higher-level hospital-based care.

In addition to the items listed above, the MN DHS SUD Reform and Redesign team has consistently worked with providers participating in the 1115 waiver. Provider knowledge and input were considered part of the process of the initial and ongoing implementation. Application of the ASAM criteria across all aspects of treatment has resulted in a more uniformed system of delivery of services. It has also provided more evidence-based services to individuals seeking SUD services.

Regards,



Mary Roehl
Executive Director
763-479-4521
mroehl@vinlandcenter.org