



# 1115 SUD System Reform Demonstration: enrollment

Department of Human Services

## Topics

Background – Kristen Godwin

Overview – Jen Sather

Licensing Requirements – Kristi Strang

1115 Level of Care Requirements & application – Julie Jacobson, Lisa Luckhardt, Jen Sather

Provider Eligibility & Compliance (PEC) & Assurance Statement – Paul Schenck

Billing & utilization management – Lisa Luckhardt

Thank you & questions

# What is an 1115 Demonstration?

- 2015 & 2017- Centers for Medicare and Medicaid Services (CMS) announced section 1115(a) demonstrations to combat opioid crisis
  - Federal authority under the Social Security Act
- “[G]ive states additional flexibility to design and improve their programs, is to demonstrate and evaluate state-specific policy approaches to better serving Medicaid populations”
- Guided by state statutes & under contract with Centers for Medicare & Medicaid Services (CMS)

# Federal goals & objectives

- Increased rates of identification, initiation and engagement in treatment
- Increased adherence to, and retention in, treatment
- Reductions in overdose deaths, particularly those due to opioids
  - Medication Assisted Treatment (MAT) Policy Statement on webpage
- Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD...through improved access to more appropriate services available through the continuum of care;
- Fewer readmissions to the same or higher level of care for readmissions that are preventable or medically inappropriate
- Improved access to care for physical health conditions

# 1115 Demonstration goals & objectives



Create a clinical, person-centered and outcome-driven continuum of care aligned with American Society of Addiction Medicine (ASAM) criteria



Expand state Medical Assistance (MA) coverage to Institutions for Mental Disease (IMDs)

# Required 1115 Demonstration enrollment

- SUD providers required to enroll in the 1115 Demonstration by January 1, 2024:
  - Residential treatment programs licensed by the MN Department of Human Services (DHS) and enrolled in Minnesota Health Care Programs (MHCP)
  - Withdrawal management programs licensed by DHS and enrolled in MHCP
  - Out-of-state residential SUD providers enrolled in MHCP
- Failure to do so will result in un-enrollment from MHCP
- Outpatient SUD providers and tribally licensed providers may elect to participate.
- According to [Minnesota Section 256B.0759 Subd. 2.](#)

# 1115 Demonstration enrollment overview

1. Get all necessary licensure from DHS Licensing

2. Get all necessary Patient Referral Arrangement Agreements

3. Attend Virtual Office Hours

4. Choose level(s) of care for application

5. Update relevant policies & procedures with Level of Care Requirements

6. Submit application to 1115 mailbox

7. 1115 Team begins review process

8. Submit Assurance Statement after 1115 Team approval

# 245G.20 Requirements

- Providers interested in obtaining the co-occurring add-on should submit the following documentation to [dhs.mhcdlicensing@state.mn.us](mailto:dhs.mhcdlicensing@state.mn.us) that demonstrates the following:
  - Continuing access to a medical provider with appropriate expertise in prescribing psychotropic medication; (Submit a contract or signed agreement);
  - A mental health professional available for staff member supervision and consultation; (Submit the license of the MHP); and
  - An assessment process that determines appropriate group size, structure, and content considering the special needs of a client with a co-occurring disorder.
- We are encouraging providers who do not yet have this add-on to the license, to submit as soon as possible, but no later than October 31, 2023 to ensure you meet the deadline to enroll.



# Virtual Office Hours

- Weekly question & answer time for all clinical and enrollment questions
  - Thursdays 2:00-3:00 p.m.
  - Link is available on the 1115 webpage
- Recommend attending after obtaining all licensing requirements and before writing policies & procedures
- Drop-in anytime throughout
  - Attend as frequently as you need

# Choosing a Level of Care - outpatient

- Licensed to provide non-residential treatment
- 1.0 Outpatient
  - 0-8 skilled treatment service hours per week
- 2.1 Intensive Outpatient (IOP)
  - 9-19 skilled treatment service hours per week
  - Can provide more than 19 hours with documentation indicating 2.5 Partial Hospitalization would be necessary if available

# Choosing a Level of Care - residential

- 3.1 Clinically Managed Low-Intensity Residential
  - Licensed to provide low or medium intensity residential treatment
- 3.3 Clinically Managed Population Specific High-Intensity Residential
  - Licensed to provide high intensity residential treatment & designated as disability responsive
- 3.5 Clinically Management High-Intensity Residential
  - Licensed to provide high intensity residential treatment

# Choosing a Level of Care – withdrawal management

- [Minnesota Statute Chapter 245F](#) licensure
- 3.7 Withdrawal Management
  - Licensed as medically monitored program
- 3.2 Withdrawal Management
  - Licensed as clinically managed program

# Patient Referral Arrangement Agreements (PRAAs)

- Each provider must complete a PRAA for all levels of care not offered
- Purpose: encourage providers to refer within the Demonstration & build continuum of care
- Client choice comes first—doesn't limit referral sources

- Submit completed PRAAs with completed application
  - Available on the 1115 webpage “How to Enroll” tab
- List of providers on “Approved Locations” tab of 1115 webpage
  - Vinland National Center is the only 3.3 provider in Minnesota

DHS-7309-ENG

<b>Patient Referral Arrangement Agreement</b>
Patient Referral Arrangement Agreement between _____ and _____
This form serves to document the formal patient referral arrangements between participating demonstration providers to offer levels of care not provided by (enter name of originating provider) _____ as required in MS section <a href="#">256B.0759</a> , subdivision 3, paragraph (b), clause (2) or paragraph (c), clause (2)
We, as representatives of the above named providers, attest that our organizations will enter into a formal patient referral arrangement for the levels of care identified below.
<input type="checkbox"/> <b>Level 1.0 Outpatient Treatment Services</b> <input type="checkbox"/> <b>Level 2.1 Intensive Outpatient Treatment Services</b> <input type="checkbox"/> <b>Level 3.1 Clinically Managed Low-Intensity Residential Treatment Services</b> <input type="checkbox"/> <b>Level 3.2 Clinically Managed Residential Withdrawal Management</b> <input type="checkbox"/> <b>Level 3.3 Clinically Managed Population-Specific High-Intensity Residential Treatment Services</b> <input type="checkbox"/> <b>Level 3.5 Clinically Managed High-Intensity Residential Treatment Services</b> <input type="checkbox"/> <b>Level 3.7 Medically Monitored Inpatient Withdrawal Management</b>
<p style="text-align: center;"><b><u>Assurance of Client Choice</u></b></p> Each party acknowledges that all clients have the freedom to choose (request) a provider and level of care up to and including the level of care recommended. Neither party has received an inducement nor other consideration in exchange for entering this agreement, nothing within this agreement requires or is intended to require payment, each party remains separate and independent.
<p style="text-align: center;"><b><u>Term and Termination</u></b></p> This agreement may be terminated at any point, by either party, by giving notice to the other entity. Termination of the agreement will require the originating provider to secure a new agreement with a provider that will offer the level(s) of care not provided by the originating provider.
<p style="text-align: center;"><b><u>Privacy and Confidentiality of Consumer Information</u></b></p> Care will be coordinated in a manner that complies with privacy and confidentiality requirements. Each party will request consumers consent for disclosure of their health information, in accordance with state and federal law. Each party will follow consumer preferences for shared protected health information. This section shall survive termination of this agreement.
<b>Signatures</b>
Originating Provider: _____ Date: _____
Referral Provider: _____ Date: _____

# Level of Care Requirements policies & procedures

- Providers must develop and/or update written program policies and procedures describing how the Level of Care Requirements will be met
  - Similar to licensing process & updating policies & procedures
- Most requirements are to document “access and availability of” services
  - Policies & procedures should describe how programs are meeting clients needs in required time frames
  - Not requiring all services to be on staff

# Program Outreach Plan

- Develop and maintain a program outreach plan
  - Must review and update annually
- Must include how the provider will ensure seamless transitions across the continuum of care
  - How will the provider will coordinate different types of health care and community services?
  - Examples: early intervention treatment services, Certified Community Behavioral Health Clinics (CCBHC), hospitals, emergency departments, primary care and mental health settings, etc.



# Assessment & Placement Grid

- Assessment summaries must include documentation of whether or not the client's placement is aligned with the level of care recommendation in the 1115 Assessment and Placement Grid.
  - Include clinical rationale for why a level of care being provided to the client differs from the level of care recommended
- [Assessment and Placement Grid](#) required documentation for utilization management through Kepro

# Example Assessment & Placement Grid

ASAM Criteria Level of Care – Other Treatment and Recovery Services																																														
ASAM Criteria Level of Care	ASAM Level	Dimension 1 Substance Use, Acute Intoxication and/or Withdrawal Potential					Dimension 2 Biomedical Condition and Complications					Dimension 3 Emotional, Behavioral, or Cognitive Condition and Complications					Dimension 4* Readiness to Change					Dimension 5* Relapse, Continued Use, or Continued Problem Potential					Dimension 6* Recovery/Living Environment																			
		0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4	0	1	2	3	4															
Outpatient Services	1																																													
Intensive Outpatient Services	2.1																																													
Partial Hospitalization >= 20 hours	2.5	Service currently unavailable																																												
Clinically Managed Low-Intensity Res. Services	3.1																																													
Clinically Managed population specific, High-Int Res. Ser.	3.3																																													
Clinically Managed Med (youth) & High (adult) – Int Res. Ser.	3.5																																													

Recommend inpatient mental health services

Level of Care	Adults	Adolescents
1.0 Outpatient program	8 hours skilled treatment services	6 hours skilled treatment services
2.1 Intensive Outpatient Program	9-19 hours skilled treatment services	6-19 hours skilled treatment services
3.1 Clinically Managed Low-Intensity Residential	At least 5 hours of skilled treatment, peer recovery, and treatment coordination	
3.3 Clinically Managed Population-Specific High-Intensity Residential	At least 30 hours of skilled treatment services, peer recovery and treatment coordination provided to individuals with a TBI or cognitive impairment.	
3.5 Clinically Managed High-Intensity Residential	At least 30 hours of skilled treatment services, peer recovery and treatment coordination provided to individuals. 24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full therapeutic community.	



# Psychiatric & medical consultation

- 1.0 Outpatient & 2.1 IOP
  - must have access to and document the availability of psychiatric and medical consultation services within 24 hours by telephone.
- 2.1 IOP
  - must have access to and document the availability of psychiatric and other medical consultation to the client within 72 hours in person
- 3.1, 3.3, & 3.5
  - Have the ability to administer medications or assist with the self-administration of medications according to the requirements of section 245G.08, subdivision 5.
  - Have telephone or in-person medical consultation available 24 hours a day, 7 days a week.

# Medication-assisted treatment (MAT) policy

- DHS supports and encourages the use of all three FDA approved MAT medications as part of an evidence-based person-centered approach to treating opioid use disorder(OUD).
- Decision to continue or taper off medication is between patient and their provider
- SUPPORT Act State Plan option requirements:
  - Follows reliable, evidence-based practices
  - Offers at least 2 forms of medication-assisted treatment for substance use disorders on site, including, in the case of medication-assisted treatment for opioid use disorder, at least 1 antagonist and 1 partial agonist.
- Thank you to our partners for collaborating on this very important requirement

# Using the enrollment application

- Available on the [1115 webpage “How to Enroll” tab](#) or on [eDocs \(DHS-7325\)](#)
- Recommend saving it on computer to edit
  - Have to use Microsoft Edge, Internet Explorer, or Firefox to download
- Auto populates requirements by the selected levels of care
- In the red boxes (right column) cite relevant policy & procedure for each requirement
- Apply for multiple locations if policies & procedures are largely the same

# Populating the enrollment application

\* Required field

*PROVIDER NAME			*NPI
*SERVICE LOCATION ADDRESS			*CITY
	*STATE	*ZIP CODE	
*CONTACT NAME		*EMAIL ADDRESS	*PHONE NUMBER
*PATIENT REFERRAL ARRANGEMENT AGREEMENT CONTACT NAME		*EMAIL ADDRESS	*PHONE NUMBER

LEVEL(S) OF CARE AT THIS LOCATION

<input type="checkbox"/> Level 1.0: Outpatient	<input type="checkbox"/> Level 3.3: Clinically Managed Population-Specific High-Intensity Residential
<input type="checkbox"/> Level 2.1 Intensive Outpatient	<input type="checkbox"/> Level 3.5: Clinically Managed High-Intensity Residential
<input type="checkbox"/> Level 3.1: Clinically Managed Low-Intensity Residential	<input type="checkbox"/> Level 3.7: Medically Monitored Inpatient Withdrawal Management
<input type="checkbox"/> Level 3.2: Clinically Managed Residential Withdrawal Management	

[Add location](#)

## IV. TREATMENT SERVICES, CONSULTATION AND REFERRAL

1115 Demonstration Requirement	Provide a description of how the program is currently meeting the requirement.  If the requirement is not currently being met, describe the provider's plan for implementing the requirement and enter the date the program will have the requirement implemented in the column to the right.	Date the requirement will be implemented.  (N/A if requirement is already met)
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## V. ASSESSMENT AND PLACEMENT

1115 Demonstration Requirement	Provide a description of how the program is currently meeting the requirement.  If the requirement is not currently being met, describe the provider's plan for implementing the requirement and enter the date the program will have the requirement implemented in the column to the right.	Date the requirement will be implemented.  (N/A if requirement is already met)
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## VI. INDIVIDUAL TREATMENT PLAN

1115 Demonstration Requirement	Provide a description of how the program is currently meeting the requirement.  If the requirement is not currently being met, describe the provider's plan for implementing the requirement and enter the date the program will have the requirement implemented in the column to the right.	Date the requirement will be implemented.  (N/A if requirement is already met)
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## VII. TREATMENT COORDINATION

1115 Demonstration Requirement	Provide a description of how the program is currently meeting the requirement.  If the requirement is not currently being met, describe the provider's plan for implementing the requirement and enter the date the program will have the requirement implemented in the column to the right.	Date the requirement will be implemented.  (N/A if requirement is already met)
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## VII. DOCUMENTATION OF TREATMENT SERVICES; TREATMENT PLAN REVIEW

1115 Demonstration Requirement	Provide a description of how the program is currently meeting the requirement.  If the requirement is not currently being met, describe the provider's plan for implementing the requirement and enter the date the program will have the requirement implemented in the column to the right.	Date the requirement will be implemented.  (N/A if requirement is already met)
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# Populating the enrollment application – 3.1 selected

providers create referral agreements.

\* Required field

*PROVIDER NAME			*NPI
*SERVICE LOCATION ADDRESS			*CITY
	*STATE	*ZIP CODE	
*CONTACT NAME	*EMAIL ADDRESS	*PHONE NUMBER	
*PATIENT REFERRAL ARRANGEMENT AGREEMENT CONTACT NAME	*EMAIL ADDRESS	*PHONE NUMBER	
LEVEL(S) OF CARE AT THIS LOCATION			
<input type="checkbox"/> Level 1.0: Outpatient	<input type="checkbox"/> Level 3.3: Clinically Managed Population-Specific High-Intensity Residential		
<input type="checkbox"/> Level 2.1 Intensive Outpatient	<input type="checkbox"/> Level 3.5: Clinically Managed High-Intensity Residential		
<input checked="" type="checkbox"/> Level 3.1: Clinically Managed Low-Intensity Residential	<input type="checkbox"/> Level 3.7: Medically Monitored Inpatient Withdrawal Management		
<input type="checkbox"/> Level 3.2: Clinically Managed Residential Withdrawal Management			

[Add location](#)

## VI. INDIVIDUAL TREATMENT PLAN

<b>1115 Demonstration Requirement</b>	Provide a description of how the program is currently meeting the requirement.  If the requirement is not currently being met, describe the provider's plan for implementing the requirement and enter the date the program will have the requirement implemented in the column to the right.
Enrolled demonstration providers licensed under chapter 245G or other applicable standards must meet the following additional requirements:	
(a) The treatment plan must include: (1) a goal for transition planning considering factors such as proximity to an individual's support network including but not limited to, family members, employment, counseling and other services near an individual's place of residence.	
(2) how cultural and socioeconomic factors affecting the patient's access to services are being addressed when needed;	
(b) A treatment plan for an adolescent client must include maintenance strategy goals and methods that address relapse prevention and strengthening of protective factors.	

# Application materials

- Submit application and supporting documentation to 1115 mailbox, [1115demonstration.dhs@state.mn.us](mailto:1115demonstration.dhs@state.mn.us)
- Include:
  - Signed, dated, & completed enrollment application
  - Relevant policies & procedures
  - PRAAs
  - MAT Policy (residential providers)



# Application review process

- 1115 Team will reply when application is received
  - Be sure to unencrypt emails
  - If you haven't received confirmation within 5 business days send a separate follow-up
- After review 1115 team sends follow-up communications:
  - Incomplete—missing licensing requirements, PRAAs, or all of policies & procedures
  - Meeting with 1115 Team—missing 4 or more policies & procedure items
  - Request for More Information (RFMI)—missing less than 4 or more policies & procedures

# Application resubmissions

- Active applications will be prioritized over new submissions
  - Incomplete applications will not be prioritized
  - 1115 Team will follow-up on RFMI letters— no responses will be moved to inactive status
- Resubmitted inactive applications will not be prioritized over new submissions

# MHCP Enrollment and Assurance Statement

- After BHD approval submit Assurance Statement with BHD Approval to Enroll Letter
  - Via fax or Enrollment Record Request in the [MPSE Portal](#)
  - Assurance Statement is on the 1115 webpage & eDocs (DHS-7323)
    - Edocs are on the [DHS website](#) in the upper right corner of the page
- Provider Eligibility and Compliance processes documents within 30 days of receipt
  - Resubmissions take additional 30 days

# Assurance Statement



MINNESOTA HEALTH CARE PROGRAMS (MHCP)

DHS-7323-ENG

8-21

## 1115 Substance Use Disorder (SUD) System Reform Demonstration Project Provider Assurance Statement

### Provider information

PROVIDER NAME		NPI	
SERVICE LOCATION ADDRESS			
CITY		STATE	ZIP CODE
CONTACT NAME	OFFICE PHONE NUMBER	OFFICE FAX NUMBER	

This Assurance Statement is an addendum to the provider's Minnesota Health Care Programs (MHCP) Provider Agreement (DHS-4138). Signing this form assures the Department of Human Services (DHS) that the provider holds the appropriate licensure, or meets other applicable standards to participate in Minnesota's 1115 SUD System Reform Federal Demonstration (Project No. 11-W-00320/5) under the authority of section 1115(a) of the Social Security Act as it is defined under [Minnesota Statutes 256B.0759](#).

By initialing each level of care the provider will be offering and by signing this form, a participating demonstration provider agrees to the following terms and conditions:

- Meet the standards identified for each level of care offered as published in the [1115 Level of Care Requirements \(DHS-7326\) \(PDF\)](#) within the timelines identified on the provider's [1115 Substance Use Disorder System Reform Enrollment Checklist \(DHS-7325\) \(PDF\)](#).
- Document client's level of care placement determination using the medical review agent's 1115 Demonstration Assessment and Placement Grid. A link to the grid can be found under the Utilization Management heading on the [Substance Use Disorder \(SUD\)](#) section of the Minnesota Health Care Programs Provider Manual.

After we receive this completed assurance statement along with a copy of your approval letter from the Behavioral Health Division (BHD), MHCP Provider Eligibility and Compliance will update your record with the effective date that BHD has indicated.

### Level of Care

I, a representative of the named provider, attest that our organization will provide the levels of care initialed according to the applicable requirements. (Initial only the levels of care that your organization provides. Electronic initials accepted.):

<input type="checkbox"/> Level 1.0 Outpatient Treatment Services	<b>Initial approved levels of care</b>
<input type="checkbox"/> Level 2.1 Intensive Outpatient Treatment Services	
<input type="checkbox"/> Level 3.1 Clinically Managed Low-Intensity Residential Treatment Services	
<input type="checkbox"/> Level 3.2 Clinically Managed Residential Withdrawal Management	
<input type="checkbox"/> Level 3.3 Clinically Managed Population-Specific High-Intensity Residential Treatment Services	
<input type="checkbox"/> Level 3.5 Clinically Managed High-Intensity Residential Treatment Services	
<input type="checkbox"/> Level 3.7 Medically Monitored Inpatient Withdrawal Management	

### Opt Out

If you no longer provide a level of care, or if you would like to opt out of the 1115 SUD Demonstration entirely, enter the date when this change should be made effective in the appropriate box.

### Level of Care

Level 1.0 Outpatient Treatment Services	END DATE
Level 2.1 Intensive Outpatient Treatment Services	END DATE
Level 3.1 Clinically Managed Low-Intensity Residential Treatment Services	END DATE
Level 3.2 Clinically Managed Residential Withdrawal Management	END DATE
Level 3.3 Clinically Managed Population-Specific High-Intensity Residential Treatment Services	END DATE
Level 3.5 Clinically Managed High-Intensity Residential Treatment Services	END DATE
Level 3.7 Medically Monitored Inpatient Withdrawal Management	END DATE

An administrator, manager, director or other person authorized to sign must initial each applicable level of care, write the name and title of the person signing and sign this assurance statement. You must disclose this person to us on the [Disclosure of Ownership and Control Interest of an Entity \(DHS-5259\) \(PDF\)](#) or in the Owners and Authorized Persons section of the [Minnesota Provider Screening and Enrollment \(MPSE\) Portal](#).

By initialing each level of care to be provided and signing this form, I attest to the accuracy of all information on this form.

Check if signing electronically:

- I am signing this form electronically. My name as typed in the signature field is my legally binding signature. I understand that my electronic signature has the same legal effect and can be enforced in the same way as a handwritten signature. (Minnesota Statutes 325L.02(h), 325L.05 and 325L.08)

AUTHORIZED OFFICER NAME (please print)	AUTHORIZED OFFICER TITLE	
AUTHORIZED OFFICER SIGNATURE	DATE	

Keep a copy of this signed assurance statement for your records and submit the original form either through the online [Minnesota Provider Screening and Enrollment \(MPSE\) Portal](#) or fax to Provider Eligibility and Compliance at 651-431-7504.

# Billing & utilization management

- Current rate enhancements:
  - Residential services receive 15% over the base rate
  - Outpatient services receive 10% over the base rate
  - Additional 10% increases approved by CMS
- Review the billing overview webinar for resources and procedures
- After enrollment be sure to start utilization management process
  - Required component of the 1115 Demonstration

# Thank You!

1115 SUD System Reform Demonstration Team

[1115demonstration.dhs@state.mn.us](mailto:1115demonstration.dhs@state.mn.us)