

## **Attachment D**

# **Minnesota Substance Use Disorder Section 1115 Waiver Implementation Plan**

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## Introduction

Preliminary statewide data show a decrease in overall drug overdose deaths in Minnesota, with deaths dropping 17% from 733 in 2017 to 607 in 2018. This reduction was primarily driven by a decrease in heroin deaths and deaths that involved prescription opioids.<sup>1</sup> While these reductions are promising, overdose rates remain at historic highs and demonstrate the need for additional work to prevent and treat of substance use disorder<sup>2</sup>.

Despite the progress in reducing opiate overdose deaths overall, deaths related to synthetic opioids, primarily illicitly manufactured fentanyl, continue to increase<sup>1</sup>. Opioids and other drugs have been especially harmful in tribal communities and communities of color in Minnesota. In 2017, American Indian Minnesotans were six times more likely to die from a drug overdose than white Minnesotans, and African American Minnesotans were two times more likely to die from a drug overdose than white Minnesotans. These rates of disparity—between American Indians/whites and African Americans/whites—are among the highest in the United States.

To address this crisis, Minnesota is pursuing multiple approaches across its agencies, including this demonstration project, to ensure people who need treatment get high-quality, effective services as quickly as possible across the state. In 2016, Minnesota enacted legislation that directed the Minnesota Department of Human Services (DHS) to seek all necessary federal authority to transform the Medicaid and publicly-funded delivery systems for SUD treatment to one that is more accessible and integrated with the larger health care provider system ([Minn. Stat. § 254B.15](#)).

Under this demonstration, Minnesota plans to test a new way to strengthen the state's behavioral health care system by improving access to the American Society for Addiction Medicine (ASAM) levels of care<sup>i</sup>. The state will do this through new federal Medicaid funding opportunities for SUD services provided to patients within intensive residential settings (i.e. Institutions for Mental Disease (IMDs)) that have established referral arrangements with other SUD providers to create a continuum of care network. The waiver also seeks to increase the use of evidence-based placement assessment criteria and matching individual risk with the appropriate ASAM level of care<sup>i</sup> to ensure beneficiaries receive the treatment they need.

This waiver will establish a network of providers interested in providing the comprehensive continuum of ASAM levels of care<sup>i</sup> to individuals in need of SUD treatment. Providers in Minnesota have expressed interest and commitment in participating in this demonstration and the state plans to implement the demonstration to create statewide access to a comprehensive ASAM-based continuum of care for SUD treatment services. Another important component of

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<sup>1</sup> All opioid deaths declined 22% from 422 in 2017 to 331 in 2018. There was a 32% decrease in prescription opioid-involved deaths from 195 in 2017 to 134 in 2018. Heroin overdose deaths decreased 23% from 111 in 2017 to 85 in 2018.

<sup>2</sup> Minnesota Department of Health. July 9, 2018. *Preliminary 2018 data show decline in opioid deaths*. News Release

this demonstration is the inclusion of the state's six Certified Community Behavioral Health Clinics (CCBHCs) in the SUD provider network.

This Implementation Plan (plan) provides the detail necessary to operationalize Minnesota's vision and goals for improving the outcomes of Minnesota Medicaid enrollees who are suffering from addiction. The plan is organized by the six key milestones identified by CMS. Minnesota has developed cross-agency teams that are responsible for completing the action items in each milestone.

State law enacted by the 2019 Minnesota Legislature provides a framework for the broader implementation of the demonstration statewide over time, including clarifying state law, providing resources for implementation, and creating incentives for participating providers. The legislation codifies required service standards for participating providers that are consistent with ASAM criteria and provides funding necessary to issue provider agreements, conduct a waiver evaluation, provide technical assistance, and develop and implement a utilization review process.<sup>1</sup>

Upon waiver approval, Minnesota SUD providers may elect to participate and will enroll as demonstration project providers. Providers electing to participate in the demonstration will be required to establish and maintain formal patient referral arrangements to ensure access to the ASAM levels of care defined by the state. In October 2020, the state plans to publish service standards and staffing requirements for participating providers that are consistent with ASAM criteria in the provider manual.<sup>1</sup> Participating providers will receive training and technical assistance on the ASAM criteria and the program modifications needed to assure that service delivery models align with these standards.<sup>1</sup> Payment rates for participating providers will be increased to support their transition to the ASAM-based standards.

## **Alignment with CMS Goals and Objectives**

Minnesota is committed to providing a full continuum of care for people with opioid use disorder (OUD) and other SUDs, and to implementing evidence-based solutions for expanding access and improving outcomes for beneficiaries in the most cost-effective manner possible. Toward that end, Minnesota's SUD Implementation Plan is designed to achieve the following goals:

1. Increased rates of identification, initiation and engagement in treatment for OUD and other SUDs;
2. Increased adherence to, and retention in, treatment for OUD and other SUDs;
3. Reductions in overdose deaths, particularly those due to opioids;
4. Reduced utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment when the utilization is preventable or medically inappropriate, through improved access to more appropriate services available through the continuum of care;

5. Fewer readmissions to the same or higher level of care for readmissions that are preventable or medically inappropriate; and
6. Improved access to care for physical health conditions among beneficiaries with SUDs.

As such, this implementation plan is organized based on the 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 level of care, including medication-assisted treatment (MAT);
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and
6. Improved care coordination and transitions between levels of care.

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

### **CMS Specifications:**

Coverage of a) outpatient, b) intensive outpatient services, c) medication assisted treatment (MAT) including medications as well as counseling and other services, d) intensive levels of care in residential and inpatient settings, and e) medically supervised withdrawal management.

### **Minnesota's Response:**

Minnesota currently has robust coverage of SUD treatment services under the Medicaid state plan. The state plan includes coverage of outpatient services, counseling, withdrawal management, intensive levels of care in residential and inpatient settings, and MAT. A state plan amendment to cover Screening, Brief Intervention, and Referral to Treatment (SBIRT) is currently pending with CMS. MAT is currently provided in conjunction with outpatient and residential treatment services, but will be expanded under the waiver. Most recently, the legislature expanded the SUD treatment services covered under the state plan to include a comprehensive assessment, treatment coordination, peer recovery and support services and residential withdrawal management. As noted above, participating residential and outpatient SUD service providers enrolled in the demonstration will transition with the goal of being fully compliant with the ASAM-based standards by June 30, 2021. Table 1 below identifies each level of care as defined by the ASAM criteria<sup>1</sup>, the service and service description, whether the service is currently covered and the authority used to cover it, and any changes that are being proposed under the state plan for this waiver.

**Table 1. Minnesota Coverage of SUD Treatment Services**

ASAM Level of Care	Service	Description	Current Coverage	Future Coverage Under Medicaid State Plan
0.5	Early Intervention	Assessment and educational services for individuals who are at risk of developing a SUD. Services may include SBIRT and driving under the influence/while intoxicated programs.	State Plan Attachment 3.1-A/B, Item 13.b. Screening Services; Attachment 4.19-B; Attachment 3.1-A/B, Item 5.a. Physicians' Services	State law enacted by the 2019 legislature expands SBIRT to allow all qualified providers to deliver the service and establishes minimum treatment services for positive screens. A State Plan amendment is pending.
1.0	Outpatient Services (OP)	Outpatient treatment (usually less than 9 hours a week), including counseling, evaluations, and interventions.	State Pan Attachment 3.1-A/B, Item 13.d. Individual and group therapy; Attachment 4.19-B	Continuation of current state plan coverage while moving toward ASAM-based compliance which is targeted for June 2021.
2.1	Intensive Outpatient Services (IOP)	9-19 hours of structured programming per week (counseling and education about addiction-related and mental health problems).	Service not available.	Minnesota will submit a state plan amendment and begin coverage of this service by July 1, 2022.
3.1	Clinically Managed Low-Intensity Residential Services	24-hour supportive living environment; at least 5 hours of low-intensity treatment per week.	State Plan Attachment 3.1-A/B, Item 13.d Individual and group therapy; Attachment 4.19-B Low intensity for adults only.	Continuation of current state plan coverage while moving toward ASAM-based compliance which is targeted for June 2021.
3.3	Clinically Managed population specific, High Intensity Residential Services	24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu for those with	State Plan Attachment 3.1-A/B, Item 13.d. Individual and group therapy; Attachment 4.19-B	Continuation of current state plan coverage while moving toward ASAM-based compliance which is targeted for June 2021.

ASAM Level of Care	Service	Description	Current Coverage	Future Coverage Under Medicaid State Plan
		cognitive or other impairments.		
3.5	Clinically Managed Medium (Youth) & High (Adult)-Intensity Residential Services	24-hour living environment, more high-intensity treatment (level 3.7 without intensive medical and nursing component).	State Plan Attachment 3.1-A/B, Item 13.d. Individual and group therapy; Attachment 4.19-B	Continuation of current state plan coverage while moving toward ASAM-based compliance which is targeted for June 2021.
3.7	Medically Monitored Intensive Inpatient Services	24-hour professionally directed evaluation, observation, medical monitoring, and addiction treatment in an inpatient setting (usually hospital-based).	Service not available.	The state has no plan to offer this level of care.
4.0	Medically Managed Intensive Inpatient Services	24-hour inpatient treatment requiring the full resources of an acute care or psychiatric hospital.	Service not available.	The state has no plan to offer this level of care.
1-WM	Ambulatory Withdrawal Management without Extended On-Site Monitoring	Mild withdrawal with daily or less than daily outpatient supervision.	. Service not available.	The state has no plan to offer this level of care.
2-WM	Ambulatory Withdrawal Management with Extended On-Site Monitoring	Moderate withdrawal with all-day withdrawal management support and supervision; at night, has supportive family or supportive living situation.	Currently provided by CCBHCs only.	Continuation of current CCBHC coverage under state plan authority or the 223 demonstration after July 1, 2020.

ASAM Level of Care	Service	Description	Current Coverage	Future Coverage Under Medicaid State Plan
3.2-WM	Clinically Managed Residential Services Withdrawal Management	Moderate withdrawal but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.	State Plan Attachment 3.1-A/B. Attachment 4.19-B Withdrawal Management Services	Continuation of current state plan coverage effective as of July 1, 2019.
3.7-WM	Medically Monitored Inpatient Withdrawal Management	Severe withdrawal and needs 24-hour nursing care and physician visits as necessary; unlikely to complete withdrawal management without medical, nursing monitoring (usually hospital- based).	State Plan Attachment 3.1-A/B. Attachment 4.19-B Withdrawal Management Services	Continuation of current state plan coverage effective as of July 1, 2019.
Recovery Support	Recovery Support	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.	State Plan Attachment 3.1-A/B, Item 13.d; Attachment 4.19-B Peer Recovery Support Services	Continuation of current state plan coverage.
OTS	Opioid Treatment Services (OTS) for persons experiencing an OUD	Pharmacological (opioid agonist, partial agonist, & antagonist medications) and counseling services provided in either an Opioid Treatment Program (OTP) or Office- based setting (OBOT).	State Plan Attachment 3.1-A, item 13.d. Medication Assisted Therapy	Continuation of current state plan coverage. SUD treatment providers are required to make arrangements for all services indicated in each beneficiary's treatment plan including MAT.



As outlined in Table 1 above, all of the services currently covered under the state plan will continue to be covered while moving towards ASAM-based compliance during the demonstration period. The state will work closely with the provider community to ensure that they are prepared to implement the ASAM-based criteria by June 2021.

The following section summarizes the service coverage changes that will be made under the state plan, as well as changes to the provider manual that will be disseminated through provider training and credentialing and released over the next 12-24 months.

### **Level of Care 0.5: Early Intervention – Screening, Brief Intervention, and Referral to Treatment (SBIRT)**

**Current State:** The state plan provides coverage for screening and physician services.

**Future State:** 2019 legislation allows all qualified providers – including primary care clinics, hospitals, and other medical or school settings – to conduct SBIRT screenings. The legislation also authorizes an initial set of treatment services for beneficiaries whose SBIRT result is positive. These initial services include up to four hours of individual or group SUD treatment, two hours of SUD care coordination, and two hours of SUD peer support services provided by qualified individuals. A state plan amendment that includes SBIRT is pending. The state will make changes to the provider manual as necessary.

### **Level of Care 2.1: Intensive Outpatient**

**Current State:** Current coverage of outpatient services does not meet ASAM standards for intensive outpatient coverage.

**Future State:** Minnesota will seek legislative authority to add intensive outpatient treatment to the state plan for coverage starting in July 2022. The state will issue provider requirements and service standards consistent with ASAM level 2.1

#### **Actions Needed to Achieve Milestone #1 Across All Service Levels**

<b>Action Needed</b>	<b>Timeline</b>
Implement training and technical assistance to align providers with ASAM-based standards	July 2020; ongoing
Publish ASAM-based service standards and staffing requirements in MHCP provider manual	October 2020
Target for providers to reach ASAM-based compliance	June 2021
Begin state plan coverage of Intensive Outpatient treatment	July 2022

**CMS Specifications:**

- Implementation of requirement that providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools, e.g., the ASAM criteria<sup>i</sup> or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines; and
- Implementation of a utilization management approach such that a) beneficiaries have access to SUD services at the appropriate level of care, b) interventions are appropriate for the diagnosis and level of care, and c) there is an independent process for reviewing placement in residential treatment settings.

**Minnesota's Response:**

Minnesota currently uses evidence-based placement criteria that is based on the ASAM six dimensions of multidimensional assessment<sup>i</sup>. The state will assess where its current evidence-based assessment policies need to be more closely aligned, with the ASAM placement criteria<sup>i</sup>.

Additionally, Minnesota will develop an independent utilization review process over the next two years to ensure that beneficiaries have access to the necessary levels of care, that interventions are appropriate for the level of care needed, and that there is an independent process for reviewing appropriate placement in residential treatment settings. In addition, the state will ensure that the continuum of care extends beyond the intensive inpatient and outpatient treatment settings in order to promote sustained and long-term recovery and minimize readmissions.

**A. Patient Placement Assessment**

**Current State:** All 87 Minnesota counties, 11 American Indian Tribes, and eight managed care organizations (MCOs) are required to conduct an assessment that incorporates the six dimensions of the ASAM placement criteria<sup>i</sup> to assess the SUD treatment needs of beneficiaries. Findings from the assessment must be documented in an assessment and placement summary that includes a risk rating for each of the six dimensions, a narrative summary supporting the risk descriptions, a determination of whether the client has a SUD, and information relevant to treatment services planning that is recorded using the following six dimensions:

- Dimension 1: Acute intoxication/withdrawal potential; the client's ability to cope with withdrawal symptoms and current state of intoxication;
- Dimension 2: Biomedical conditions and complications; the degree to which any physical disorder of the client would interfere with treatment for substance use, and the client's ability to tolerate any related discomfort. The license holder must determine the impact of continued chemical use on the unborn child, if the client is pregnant;
- Dimension 3: Emotional, behavioral, and cognitive conditions and complications; the degree to which any condition or complication is likely to interfere with treatment for substance use or with functioning in significant life areas; and the likelihood of harm to self or others;

- Dimension 4: Readiness for change; the support necessary to keep the client involved in treatment service;
- Dimension 5: Relapse, continued use, and continued problem potential; the degree to which the client recognizes relapse issues and has the skills to prevent relapse of either substance use or mental health problems; and
- Dimension 6: Recovery environment; whether the areas of the client's life are supportive of or antagonistic to treatment participation and recovery.

These dimensions are further defined in [Minnesota Rules, part 9530.6622](#).

Although Minnesota's SUD assessment requirements utilize risk ratings according to the six ASAM dimensions<sup>i</sup> the resulting placement recommendations do not currently align with the ASAM levels of care<sup>i</sup>. A client's placement falls into two categories: outpatient care (with any necessary MAT) or inpatient care. The inpatient levels of care are described in more detail under Milestone 3.

Comprehensive Assessment: SUD treatment providers may also conduct a comprehensive assessment of the client's SUD to determine the appropriate level of treatment using the criteria described above. All assessments be completed within three calendar days after service initiation for a residential program or during the initial session for all other programs. If the comprehensive assessment is not completed during the initial session, the client-centered reason for the delay and planned completion date must be documented in the client's file. If available, the alcohol and drug counselor may use current information provided by a referring agency or other source as a supplement. ([Minnesota Statutes, section 245G.05](#))

Assessment Summary: Alcohol and drug counselors must complete an assessment summary within three calendar days after service initiation. If the comprehensive assessment is used to authorize the treatment service, the alcohol and drug counselor must prepare an assessment summary on the same date the comprehensive assessment is completed. If the comprehensive assessment and assessment summary are to authorize treatment services, the assessor must determine appropriate service options for the client using the six ASAM dimensions<sup>i</sup> and document the recommendations. ([Minnesota Statutes, section 245G.05](#))

Initial Services Plan: Providers must complete an initial services plan on the day of service initiation. The plan must address the client's immediate health and safety concerns, identify the needs to be addressed in the first treatment session, and make treatment suggestions for the client during the time between intake and completion of the individual treatment plan. The initial services plan must include a determination of whether a client is a vulnerable adult, as defined in regulation. Adult clients of a residential program are defined as vulnerable adults. An individual abuse prevention plan is required for clients who meet the definition of a vulnerable adult. ([Minnesota Statutes, section 245G.04](#))

Minnesota's Certified Community Behavioral Health Clinics (CCBHCs) provide integrated care in an outpatient setting and will become part of the ASAM continuum of care<sup>i</sup> established within this waiver demonstration. Not only are CCBHCs required to provide integrated mental health

and SUD treatment, they must complete primary care screenings and utilize care coordination to ensure clients are receiving coordinated medical care. The [CCBHC federal criteria](#) require both an initial evaluation and comprehensive evaluation as well as an integrated treatment plan. In Minnesota, the state-specific standards for CCBHCs require the use of the ASAM six dimensions<sup>i</sup> as an architecture for assessment, treatment planning and documentation of progress. The initial and comprehensive evaluations include risk ratings for all six dimensions and utilize the current SUD placement criteria as described above. Once a CCBHC client enters SUD treatment at a CCBHC clinic, the CCBHC follows the same requirements in state law as all other SUD treatment providers.

**Future State:** SUD assessments will continue to be based on the ASAM six dimensions of multidimensional assessment.<sup>i</sup> Minnesota will update patient placement criteria to align with the ASAM levels of care by June 2021. Minnesota plans to work with the provider community to more closely align with ASAM patient placement criteria by matching patients' risk ratings directly with the ASAM levels of care instead of to the current Minnesota levels of care, which are more general (outpatient services or inpatient care).<sup>i</sup> This will be helpful in completing placement assessments and ensuring that clients have access to the most appropriate services at the right time.

All providers who conduct assessments must be a qualified provider and trained in the ASAM dimensions and levels of care.<sup>i</sup> Minnesota will expand training and technical assistance opportunities for providers over the next 12 to 24 months. To enhance and strengthen the use of ASAM criteria, new provider manuals will be released, refresher training will be developed for, and technical assistance will be provided to, staff that are conducting assessments and to SUD treatment providers within the 12 to 24 months following the waiver approval.<sup>i</sup> The state will align its multi-dimensional assessment tool with ASAM's placement criteria and require participating providers to make treatment recommendations accordingly.

## **B. Utilization Management**

**Current State:** Current utilization management practices consist of licensing review audits. Every two years, or more frequently as needed, licensing site visits are conducted and a random sample of client files are reviewed to ensure that documentation meets the statutory requirements as defined in state law. Determination of medical necessity, completion of the ASAM Six Dimensions of multidimensional assessment, and the placement recommendations must be made by an alcohol and drug counselor. Licensing audits include a review of the comprehensive assessment, assessment summary, treatment plan and weekly treatment plan reviews to ensure that clients are receiving treatment as identified in the treatment plan.<sup>i</sup> While licensing reviews account for some of the utilization management practices, Minnesota does not currently have a standardized utilization management review process for clients who receive SUD services through the fee-for-service (FFS) delivery system.

Approximately 60 percent of Medicaid enrollees receiving SUD treatment are enrolled in a managed care organization (MCO). MCO contracts include language that MCOs cannot require prior authorization before beginning treatment – so once an assessment has been conducted,

treatment can begin. However, each MCO has different utilization review policies and procedures. For residential treatment stays, MCOs authorize a set number of initial days covered and then request concurrent or continued stay information for approval of continued placement. MCOs conduct post-payment review of outpatient SUD services to verify medical necessity, appropriateness of care, over and under-utilization of services, and evaluation of service delivery and outcomes.

The certification for CCBHCs is contingent on each clinic maintaining a license under Minnesota Statutes, section 245G for their outpatient SUD treatment services. Licensing staff review client files to ensure documentation is complete and that services are being delivered according to the treatment plan. Additionally, the certification process and ongoing monitoring for CCBHCs includes utilization management to ensure the proper integration of SUD treatment with mental health and social services.

**Future State:** Minnesota intends to develop a comprehensive, independent utilization review process over the next two years to ensure that beneficiaries served in FFS MA have access to the necessary levels of care, that interventions are appropriate for the diagnosis, and that there is an independent process for reviewing placement in residential treatment settings. The state issued a Request for Information (RFI) in September 2019 to solicit feedback from organizations that conduct utilization management for SUD services. DHS is using this feedback to develop a Request for Proposal (RFP) to contract with an independent utilization review agent to conduct concurrent and post payment review of SUD treatment services. The vendor chosen for this project will review whether the level of treatment meets medical necessity standards including whether the service is appropriate for the beneficiary’s condition, the service intensity is supported by clinical data or rationale, and that the treatment duration is appropriate. DHS has a goal of executing this contract by January, 2021 and implementing the utilization review process by July 2021. To the extent possible, DHS will ensure that the standards for utilization management in FFS align with the practices of MCOs.

### Actions Needed to Achieve Milestone #2

Action Needed	Timeline
Begin process of updating MCO contracts to define participating providers	December 2019
Implement training and technical assistance to align providers with ASAM-based standards	July 2020; ongoing
Update MCO contracts to align utilization management practices with ASAM-based placement criteria	September 2020 (for January 2021 contract initiation)
Begin utilization management process that includes an independent utilization review process for residential placements	July 2021
Communicate changes to providers	Ongoing

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

**CMS Specifications:**

- Implementation of residential treatment provider qualifications in licensure requirements, policy manuals, managed care contracts, or other guidance. Qualifications should meet the program standards in the ASAM Criteria<sup>i</sup> or other nationally recognized, evidence-based SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings
- Implementation of state process for reviewing residential treatment providers to assure compliance with these standards
- Requirement that residential treatment facilities offer MAT on-site or facilitate access off-site

**Minnesota's Response:**

Minnesota Statutes, sections [245G](#) and [254B.05](#) outline the current state requirements for licensed treatment facilities and provider eligibility requirements. DHS analysis of ASAM requirements indicates that Minnesota's SUD treatment providers meet a majority of ASAM standards, but the state will be working with providers over the next 12 to 18 months to ensure full alignment with the ASAM-based standards developed by the state.

**A. Implementation of Residential Treatment Provider Qualifications (in Licensure Requirements, Policy Manuals, Managed Care Contracts, or Other Guidance)**

**Current State:** The DHS Division of Licensing enforces standards to protect the health, safety, rights, and well-being of children and adults in residential substance use disorder treatment facilities. The division provides oversight, processes variances to licensing rules, provides technical assistance, conducts investigations of reported licensing violations, issues corrections orders and, if appropriate, recommends fines and conditional licenses or other licensing actions. Regulatory methods are defined in Minnesota Statutes, Chapter 245A. 09, Subdivision 7, paragraph (e) unless otherwise specified in statute, and the commissioner may conduct routine inspections every two years. Minnesota Statutes, chapter 245G details licensing standards for SUD treatment providers that are residential and non-residential including opioid treatment programs.

Licensors and/or investigators inspections may range from a full inspection (physical plant inspection, policy and procedure review, resident files, and personnel files) to a targeted reviewer investigation. Licensing inspections are conducted utilizing a checklist depicting regulations and documenting if license holder is in compliance. Depending on the inspection, if a license holder has failed to comply with an applicable law or rule, the commissioner may issue a correction order, conditional license, or sanction. When issuing a conditional license or sanction, the nature, chronicity, or severity of the violation of law or rule and the effect of the violation on the health, safety, or rights of persons served by the program is considered.

License holders are subject to statutory requirements under Minnesota Statutes, chapter 245G.

The Licensing Division verifies compliance with statutory requirements that detail the following:

- Treatment service requirements;
- Service initiation and termination policies;
- Client documentation and record keeping requirements including client assessment, treatment and discharge planning, medication orders, and personnel records;
- Staff requirements and qualifications;
- Operational and personnel policies;
- Client rights, including the process for filing grievances;
- Emergency procedures, including definitions of circumstances, processes, and contact information; and
- Evaluation, including the requirement that providers must participate in data reporting to the state.

**Future State:** DHS is comparing current residential treatment facility requirements with the ASAM residential levels of care<sup>i</sup> and defining the enhanced expectations for residential treatment facilities. The areas for which initial differences have been identified involve medical policies for specific levels of service and the involvement of credentialed medical staff. Staff with the DHS Behavioral Health Division and the Division of Licensing will develop updated SUD treatment service requirements, assessment and placement criteria, and staffing requirements that are consistent with ASAM standards<sup>i</sup> and publish them in the provider manual by October 2020.

## **B. Implementation of State Process for Reviewing Residential Treatment Providers Compliance with Standards**

**Current State:** Minnesota outlines its provider requirements in Minnesota Statutes, chapter 245G, which details SUD licensure requirements. The DHS Licensing Division is responsible for reviewing provider applications and attestations of both provider qualifications and meeting service requirements. Licensing visits include, but are not limited to review of client files, documentation, staff files, client interviews and staff interviews. The interval for these reviews is every two years, and more frequently if reviewing a complaint.

DHS has taken steps to ensure provider compliance with standards, primarily through billing validation and provider audits, but the state also conducts licensing program monitoring visits. Medicaid managed care health plans also conduct provider audits. Any time there is a question or concern about licensing, the DHS Managed Care Division investigates and/or conducts an audit.

**Future State:** The DHS Behavioral Health Division has drafted standards in alignment with the ASAM criteria for each of the critical levels of care that will be implemented during this demonstration. To enroll in the demonstration, providers will be required to submit an enrollment checklist. The enrollment checklist will require providers to identify which standards that their programs do not currently meet and explain how they will implement the additional standards required for each level of care and the date in which they will have these additional requirements implemented; to be no later than June 30, 2021. The Division of

Licensing provide oversight of SUD providers in accordance with current state standards. DHS will pursue legislation in 2021 clarifying the agency authority to provide oversight and administer sanctions based on the updated standards beginning in July of 2021.

**C. Implementation of Requirement that Residential Treatment Facilities Offer MAT Onsite or Facilitate Access Offsite**

As discussed in Milestones 4 and 5, Minnesota has engaged in efforts to promote and expand MAT services across the state. Currently there are 17 opioid treatment programs (OTP) operating in the state and in recent years there has been an increase in the number of tribally licensed programs that offer MAT services. Current SUD placement guidelines outlined in Minnesota Rules, part [9530.6622](#), and structured similarly to ASAM's six dimensions<sup>i</sup>, require placing authorities to refer a client with an OUD and a risk rating of two (2) or more in dimension 5 to an OTP. Minnesota has also expanded the availability of MAT by authorizing mid-level nurse practitioners and physician assistants to dispense medications used to treat OUD. This allowance, in addition to information the state has regarding practitioners utilizing the Drug Addiction Treatment Act of 2000's waiver to increase patient prescribing capacity to 275, has increased the capacity for MAT across the state. Minnesota is also supporting expansion of MAT access through grant funded initiatives (outlined in Milestone 5), which include use of Project ECHO to engage a range of provider environments and professionals – from the prescribers, to social service staff, to licensed alcohol and drug abuse counselors, to clinic administrators and beyond. Through this process, Minnesota is working to expand access to MAT and improve quality of services across the state.

There is currently no general requirement in Minnesota that residential treatment facilities offer MAT on site or facilitate access off site. However, the state is in the process of implementing a new provision as part of its agreements with all participating providers that MAT must be offered as part of the continuum of care and that providers have at least one medical professional with prescribing authority within their networks. State law requires participating residential providers to offer MAT services or facilitate MAT access offsite where clinically appropriate.

**Actions Needed to Achieve Milestone #3**

Action Needed	Timeline
Providers electing to participate provide verification of formal referral arrangements to ensure access to each of the ASAM levels of care <sup>i</sup>	January 2020 ongoing
Implement training and technical assistance to align providers with ASAM-based standards	July 2020; ongoing
Update MCO contracts to reflect residential provider requirement changes	September 2020 (for January 2021 contract initiation)
Publish ASAM-based service standards and staffing requirements in MHCP provider manual	October 2020
Develop residential treatment provider review process and initiate ongoing monitoring process	June 2021



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

### CMS Specifications:

Completion of assessment of the availability of Medicaid enrolled providers accepting new patients at the critical levels of care throughout the state including those that offer MAT.

### Minnesota's Response:

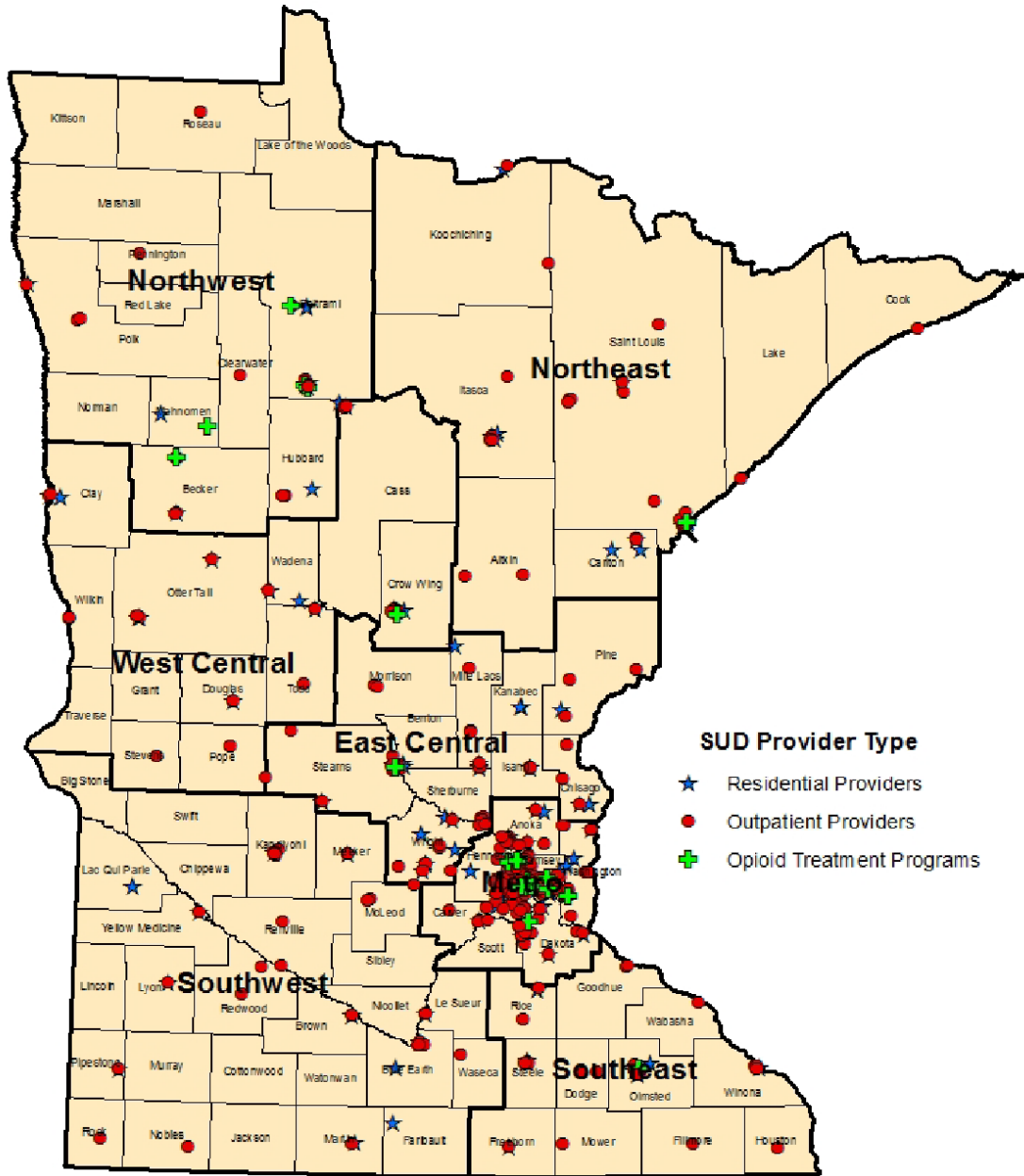
The state has approximately 415 licensed programs providing SUD treatment services in Minnesota – 145 of which are located in rural areas. Treatment settings include free-standing for-profit and not-for-profit organizations, hospitals, tribal governments and state-operated treatment services. Approximately 175 of these programs provide integrated, co-occurring services, and others coordinate mental health services via partnerships with community resources. There are currently 23 Minnesota counties with no state licensed SUD providers.

The state is aware that there is a demand for broader access to MAT. The state has found that there are several providers not yet prescribing buprenorphine in office based settings. DHS administers grants funding technical assistance to physicians, nurse practitioners, and physician assistants who wish to apply for a waiver to prescribe buprenorphine. These activities include immersive mentoring with clinics prescribing in office settings.

**Current state:** In order to link people to services with real time availability, Minnesota funds an online tool called Fast Tracker. Fast Tracker's platform allows providers to consistently update whether they are accepting new clients, enabling users to search for available mental health and SUD services. Minnesota will be utilizing data from this platform in the Monitoring Protocol and demonstration evaluation as a means to monitor for provider capacity. DHS is working with Managed Care Organizations to promote the use of the Fast Tracker system to assist MCOs in making SUD placements.

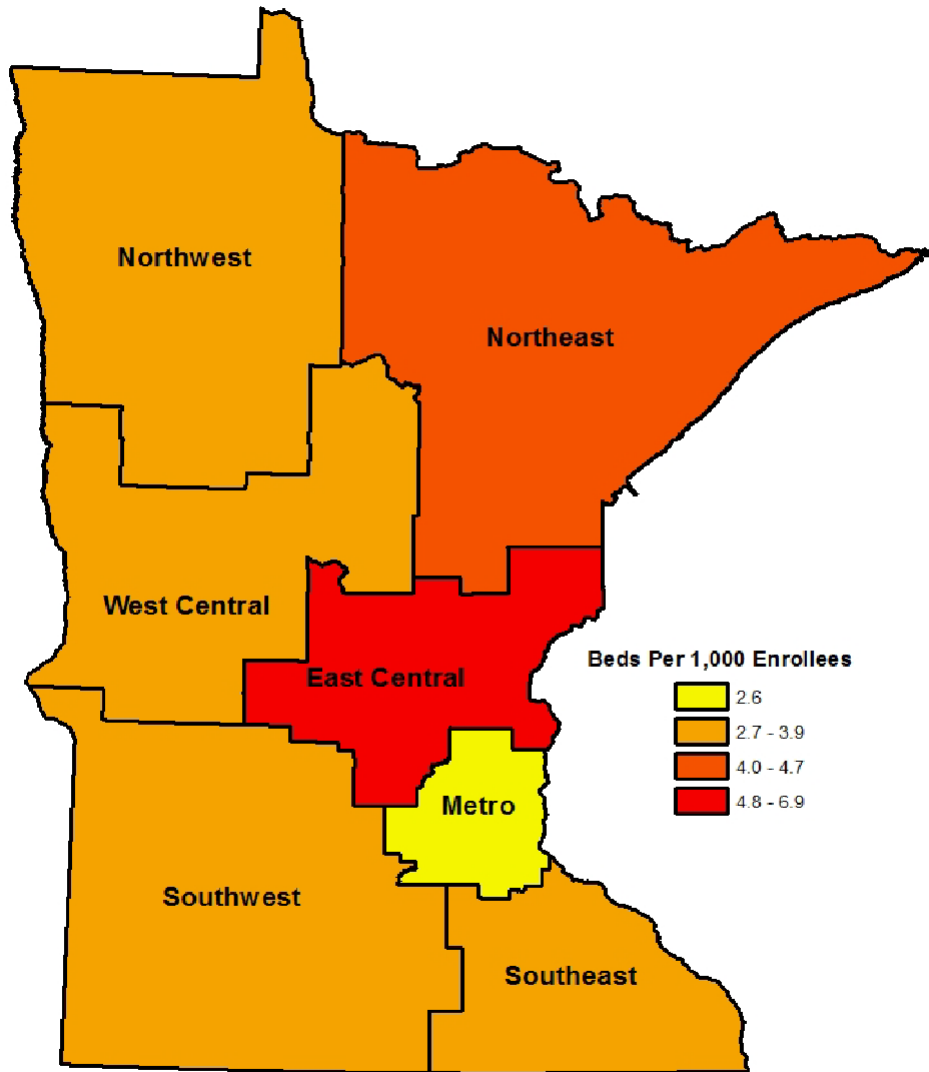
Below is a series of maps showing SUD treatment capacity in Minnesota for three different levels of care in seven regions of the state. The first map shows the location of "active" SUD treatment providers in Minnesota. To be included as an active provider, a SUD treatment provider must have provided at least one SUD treatment service to people eligible for publicly-funded treatment between July 2017 and June 2018. Three additional maps merge provider data with Medicaid enrollment data to create a provider-to-enrollee ratio. Minnesota will use these ratios to monitor trends in SUD treatment provider availability at the enrollee level.

**SUD Treatment Providers Serving Medicaid Enrollees in FY2018**



Source: Minnesota Department of Human Services, BHD (5/8/2018)

**Residential SUD Treatment Beds per 1,000  
Medicaid Enrollees: SFY2018**

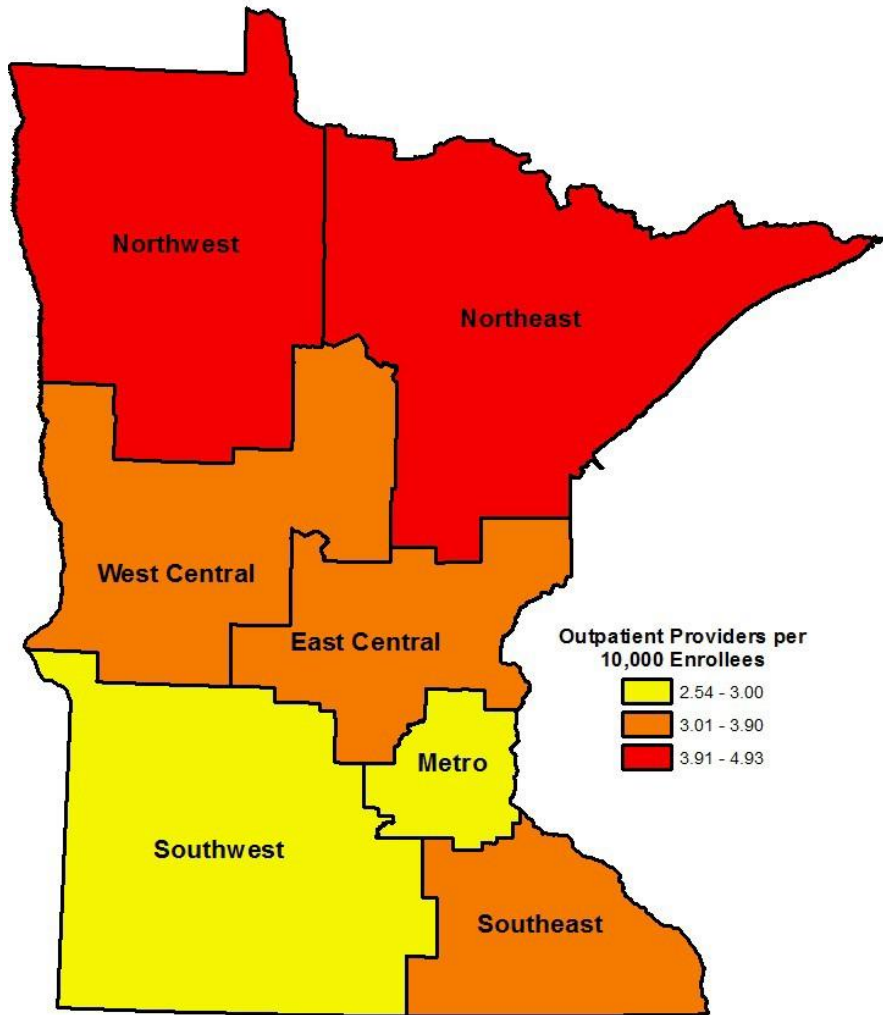


Source: Minnesota Department of Human Services, BHD (5/8/2019)

Regions	# of MA Enrollees	# of residential beds	Ratio of residential beds per 1000 MA enrollees	# of MA enrollees that received this level of care
Northwest	51,619	198	3.8	1103 (2.1%)
Northeast	70,955	332	4.7	1546 (2.2%)
West Central	73,076	284	3.9	1156 (1.6%)
East Central	115,314	796	6.9	1343 (1.2%)
Southwest	105,680	376	3.6	1197 (1.1%)
Southeast	90,428	309	3.4	1242 (1.4%)
Metro	586,142	1498	2.6	6481 (1.1%)

Source: Minnesota Department of Human Services, BHD (5/8/2019)

**Outpatient SUD Treatment Providers per 10,000 Medicaid Enrollees: FY2018**

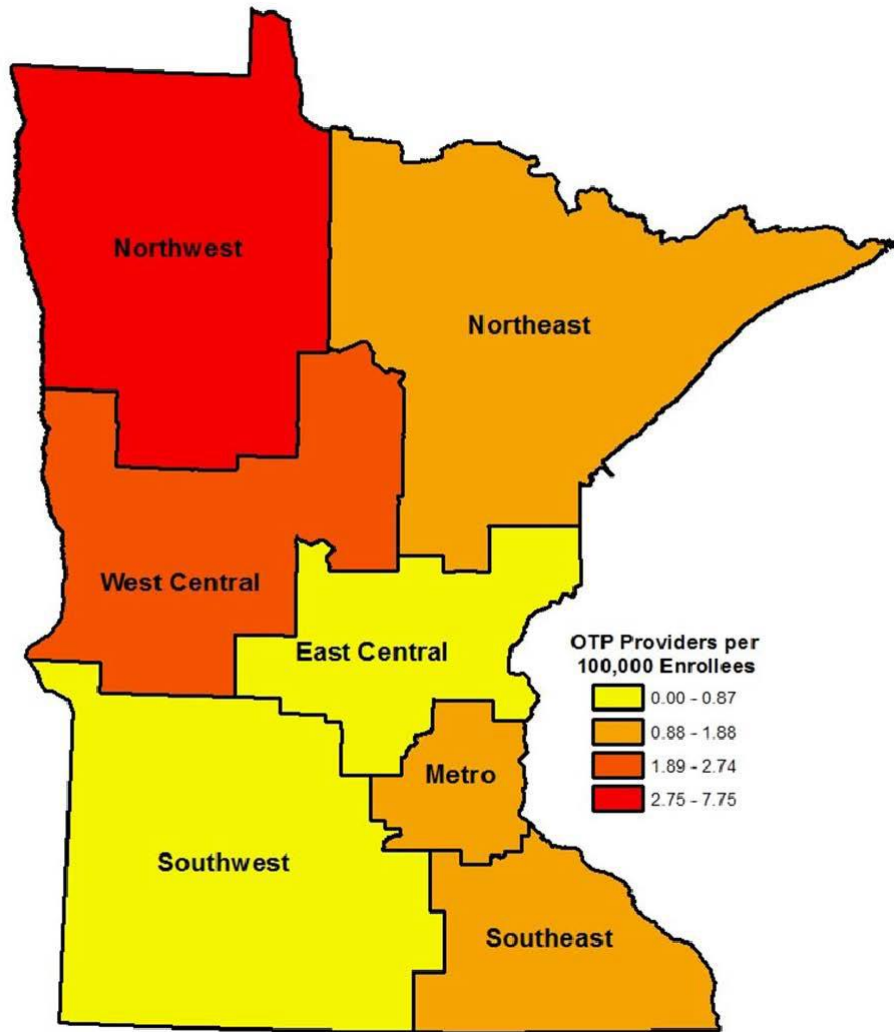


Source: Minnesota Department of Human Services, BHD (5/8/2019)

Regions	# of MA Enrollees	# of active providers of outpatient SUD services	Ratio of active providers per 10,000 MA enrollees	# of MA enrollees that received this level of care
Northwest	51,619	21	4.07	1138 (2.2%)
Northeast	70,955	35	4.93	1808 (2.5%)
West Central	73,076	24	3.28	1074 (1.5%)
East Central	115,314	43	3.73	2287 (2.0%)
Southwest	105,680	30	2.84	1334 (1.3%)
Southeast	90,428	28	3.1	1257 (1.4%)
Metro	586,142	149	2.54	9861 (1.7%)

Source: Minnesota Department of Human Services, BHD (5/8/2019)

Opioid Treatment Programs per 100,000  
Medicaid Enrollees: FY2018



Source: Minnesota Department of Human Services, BHD (5/8/2019)

Regions	# of MA Enrollees	# of active providers of OTP clinics	Ratio of active providers per 100,000 MA enrollees	# of MA enrollees that received this level of care
Northwest	51,619	4	7.75	471 (0.9%)
Northeast	70,955	1	1.41	744 (1.0%)
West Central	73,076	2	2.74	247 (0.3%)
East Central	115,314	1	0.87	520 (0.5%)
Southwest	105,680	0	0	83 (0.1%)
Southeast	90,428	1	1.11	259 (0.3%)
Metro	586,142	11	1.88	4532 (0.8%)

Source: Minnesota Department of Human Services, BHD (5/8/2019)

**Future State:** Minnesota is currently implementing statutory changes required through the Substance Use Disorder Reform Act enacted in July 2017. There is an expectation that these reforms and the implementation of this waiver will expand access to the full SUD continuum of care for Medicaid beneficiaries. Minnesota is committed to the ongoing monitoring of SUD treatment services by furthering the state's data and analytics studies as they relate to statewide interactions between provider capacity and beneficiary access so that the state may respond to the complex SUD needs of its Medicaid population.

A critical step in this process is expanding access to intensive outpatient SUD treatment. Minnesota's state plan includes coverage of outpatient services, and providers already offer the 9-19 hours of outpatient treatment specified under ASAM level 2.1. DHS will add intensive outpatient treatment to the state plan effective July 1, 2022 and include provider and service standards consistent with ASAM level 2.1. The Department is confident that this service will be available to beneficiaries in many areas across the state.

To support this commitment, and as part of the waiver implementation, Minnesota will develop proposed future state measures to ensure sufficient provider capacity at, and beneficiary access to, ASAM critical levels of care<sup>1</sup> in partnership with the state's contracted vendor for the independent evaluation of the overall demonstration. The state is currently in the contracting process with a vendor to develop and implement the provider capacity assessment and create a baseline set of measures to assess the State's capacity to provide each critical level of care and where gaps of care may exist in the state. Upon identifying those gaps, the state can begin to develop measures to build capacity at those levels of care where the gaps exist.

### *Workforce Development Efforts*

The state is currently undertaking several efforts to expand the SUD provider workforce across the state. The 2017 legislation included additional provider types to include recovery community organizations (RCO), counties, and licensed individuals in private practice. Within this legislation, RCOs may become eligible vendors to provide peer support services. Counties may become eligible vendors to provide comprehensive assessments and treatment coordination. Qualified licensed professionals in private practice may become eligible vendors to provide SUD treatment services.

The Minnesota Department of Health (MDH) Office of Rural Health and Primary Care supports the SUD workforce in multiple ways. The office:

- Collects health professional licensing data and publishes [reports](#) with analysis of the workforce.
- Funds [loan forgiveness awards](#) to mental health professionals, which includes professionals providing SUD services in rural and underserved urban areas.
- Funds [grants](#) to expand clinical training for Mental Health Professional educational programs, particularly those who send students to rural and underserved areas.
- Funds grants to FQHCs.

- Funds [grants](#) to safety net clinics that provide care to underserved populations throughout the state, including SUD services.
- Funds [grants](#) to clinics that serve American Indian communities not living on a Reservation. Projects often include SUD services.
- Funds [grants](#) to mental health safety net clinics, many of which provide SUD services.
- Develops policy recommendations through the Governor-appointed [Rural Health Advisory Committee](#), which has added behavioral health to this year's work plan.
- Participates formally in consortia for multiple HRSA-funded grant projects to address the opioid epidemic, known as the Rural Communities Opioid Response Program (RCORP).
- Provides technical assistance to National Health Service Corps (NHSC) participants and sites, which includes mental health professionals, and new funding earmarked for SUD providers.
- Provides technical assistance to safety net clinics and hospitals looking to maximize reimbursement, sustain workforce, and build partnerships to integrate care across sectors.
- Promotes promising models and best practices from communities that are integrating care.

In addition, recent contract amendments with two RCOs funded through state grant dollars required the RCOs to partner with underrepresented communities in two parts of the state – Rochester and the Twin Cities Metro area – to train and coach up to 20 members from within those underrepresented communities to become culturally-responsive Peer Recovery Specialists.

**MAT-Specific Efforts:** Minnesota has engaged in efforts to promote and expand MAT services across the state. Currently there are 17 Opioid Treatment Programs operating in the state and in recent years there has been an increase in the number of tribally licensed programs that offer MAT services. Current SUD placement guidelines outlined in Minnesota Rules, part 9530.6622, and structured similarly to ASAM's six dimensions<sup>1</sup>, require placing authorities to refer a client with an OUD and a risk rating of two or more in dimension 5 to an OTP. Minnesota has also expanded the availability of MAT by authorizing mid-level nurse practitioners and physician assistants to dispense medications used to treat OUD. This allowance, in addition to information the state has regarding practitioners utilizing the Drug Addiction Treatment Act of 2000's waiver to increase patient prescribing capacity to 275, has increased the capacity for MAT across the state. Further grant funded MAT-expansion activities, including the use of Project ECHO, are described in detail in Milestone 5.

The expansion of telemedicine for mental health services is a priority for DHS. There are efforts across the state to increase broadband access, which will facilitate further telemedicine services the state will be undertaking additional efforts to provide technical assistance to providers on the use of and billing for telemedicine services as they expand.

### Summary of Actions Needed to Achieve Milestone #4

Action Needed	Timeline
Providers electing to participate provide verification of agreement to submit pertinent data for assessment measures	January 2020, ongoing
Assess provider capacity at critical levels of care and plan a response to address gaps where identified, including for MAT	January 2021
Baseline measurements collected for provider capacity assessment	July 2020

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

#### CMS Specifications:

- Implementation of opiate 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.

#### Minnesota's Response:

Minnesota has numerous efforts underway to address opioid abuse and OUDs. In 2018, Governor Dayton released the [Minnesota Opioid Action Plan](#), which provides a comprehensive summary of the state's current and planned actions related to:

- Prevention;
- Emergency Response;
- Treatment and Recovery; and
- Law Enforcement.

Minnesota's efforts that are most relevant to Milestone #5 are summarized below.

#### A. Implementation of Opioid Prescribing Guidelines Along with other Interventions to Prevent Opioid Abuse

##### Opioid Prescribing Guidelines

The 2015 Minnesota Legislature established an opioid prescribing improvement program at DHS. The program includes three components: 1) statewide opioid prescribing guidelines for acute, post-acute and chronic pain; 2) a state prescriber education campaign; and 3) a quality improvement program within the state's Medicaid and MinnesotaCare programs.



The program includes an opioid prescribing workgroup, an advisory group composed of consumers, health care and mental health professionals, law enforcement, and MCO representatives. In 2018, the workgroup released Minnesota’s opioid prescribing guidelines for acute pain, post-acute pain, and chronic pain to be used by all providers and payers. The guidelines provide a framework for safe and thoughtful opioid prescribing for pain management. Three following key principles guided the creation of the Minnesota opioid prescribing guidelines:

- Prescribe the lowest effective dose and duration of opioids for acute pain.
- The post-acute pain period is the critical timeframe to prevent chronic opioid use.
- Providers should avoid initiating chronic opioid therapy for new chronic pain patients, and carefully manage those who remain on opioid medications.

### **Pharmacy Management**

Sound opioid prescribing in Medicaid is supported in the following ways:

- Prior authorization is required for opioid prescription exceeding 90 morphine milligram equivalents (MME) per day. This is a reduction from the threshold previously set at 120 MME per day.
- The initial fill of an opiate prescription is limited to no more than a seven-day supply. The new limit applies to all claims where the member does not have a paid claim for the same drug, or a similar drug containing the same active ingredient(s), in the previous 90 days.
- Minimum early refill threshold for opioids is set at 85 percent for FFS plans. Managed care plans have the option of setting the threshold at a higher level (e.g., 90percent).
- Policies and procedures are established to address opioid policy exceptions for members with specific conditions (e.g., cancer diagnosis, palliative care etc.).
- Universal Pharmacy Policy Workgroup (UPPW) is a group composed of pharmacy policy experts from managed care plans and the state that will develop a universal pharmacy policy for high risk and controlled substance medications including opiates. Members of the UPPW must be pharmacists or physicians licensed by the state or individuals with significant pharmacy policy expertise. The workgroup is chaired by state staff. Policies regarding utilization of opioids (maximum daily limits, early refill threshold, etc.) are consistent across all managed care and FFS plans.
- Opiate utilization, alone or in combination with other high-risk medications, is reviewed periodically by the Drug Utilization Review Board.

### **Provider Education**

DHS uses a number of vehicles to educate providers on prescribing guidelines, including:

- DHS recently released [‘Flip the script,’](#) a provider education campaign aimed to improve opioid prescribing practices. ‘Flip the script’ provides opioid prescribers with videos, fact sheets, and podcasts that cover the opioid prescribing guidelines, pain

assessment guidelines, and tips to engage in difficult conversations with patients about opioids. These guidelines contain extensive content on tapering and the importance of identifying OUD and referral for OUD treatment as well as non-pharmacologic treatment as discussed here: <https://mn.gov/dhs/opip/opioid-guidelines/factors-in-treatment/non-opioid-non-pharmacologic-treatment.jsp>

- DHS funds three Project ECHO videoconference knowledge-sharing networks focused on opioid prescribing and treatment of opioid use disorder across Minnesota (CHI St. Gabriel's Health, Hennepin Healthcare System, and Wayside Recovery Center). DHS anticipates expanding Project ECHO in the coming months with federal State Opioid Response funding (see description below).

### Quality Improvement Program

Minnesota is developing a quality improvement program, which will include thresholds for terminating providers from the program. As part of this program, beginning in 2019, DHS will provide opioid prescribing reports to all health care providers who prescribe opioids for pain management and treat people enrolled in Medicaid and MinnesotaCare. These reports will compare a prescriber's opioid prescribing rates to the average rates of their specialty group. The data within the reports will come from DHS administrative claims and encounter data, eligibility data, and provider enrollment data.

The opioid prescribing workgroup developed the following seven measures of opioid prescribing to be applied at the individual provider level:

1. Rate of prescribing an index opioid prescription (index opioid prescription is the first opioid prescription after a period of 90 days of opioid naiveté).
2. Rate of prescribing an index opioid prescription over the recommended dose (100 cumulative MME for non-surgical provider specialties; 200 cumulative MME for surgical specialties).
3. Rate of prescribing more than 700 cumulative MME during the acute and post-acute pain period.
4. Rate of prescribing chronic opioid analgesic therapy.
5. Rate of prescribing high-dose ( $\geq 90$  MME/day) chronic opioid analgesic therapy.
6. Rate of prescribing concomitant opioid and benzodiazepine therapy.
7. Percent of patients on chronic opioid analgesic therapy who receive opioids from three or more providers.

Additionally, Minnesota has an [opioid dashboard](#), which is a one-stop shop for all statewide data related to opioid use, misuse, and overdose death prevention. It includes indicators about opioid overdose death, nonfatal overdose, use, misuse, substance use disorder, prescribing practices, supply, diversion, harm reduction, co-occurring conditions, and social determinants of health. The Opioid Dashboard integrates numerous sources of data and makes it more transparent and available to the entire state. It allows for data-driven decision-making and shares information about upstream actions and promising practices.

## Other Interventions

### *Fatality Review, Data and Analysis*

This component provides funding for overdose fatality reviews, a systematic process that enables the state and local communities to understand the circumstances of these preventable deaths and identify strategies to prevent future overdoses. Nine states have recently authorized the fatality review process to examine and understand drug overdose fatalities. Overdose fatalities are not unpredictable and random. An in-depth, multi-disciplinary review of each fatality can identify failures or oversights in medical care, gaps in community services (e.g. access to mental health or medical treatment, coordination between service providers, including emergency medical services), the need for changes to state laws or government practices, or emerging causes of death (i.e. new synthetic opioids or drugs in the community). Minnesota Department of Health (MDH) staff will support and develop overdose fatality reviews across Minnesota. MDH will partner with tribal governments, counties, local public health, law enforcement, health care providers, other state agencies, and other community groups. MDH staff will lead some reviews; however, part of their responsibility will be to train partners across the state to lead fatality reviews at the local level. Most of the requested funding will support the work of the fatality reviews through grants awarded at the community level (\$1.3 million in FY20 and \$1.4 million in FY21).

### *Federal/State Opioid Response (SOR) Grant*

In September 2018, the U.S. Department of Health and Human Services awarded more than \$17 million to Minnesota to expand services and supports and use population-specific approaches to reach isolated and vulnerable communities. Services will be implemented to expand access to prevention, treatment and recovery support for hard-to-serve populations such as pregnant and parenting women, culturally-specific populations (such as Native American, African American, Chicano/Latino, or Asian), and individuals re-entering communities from the criminal justice system. Collectively, SOR grantees will expand the availability of MAT by increasing the number of OBOT providers serving targeted hard-to-serve individuals with OUD and high acuity levels in terms of mental health and medical comorbidities, and increase the number of waived prescribers in primary care so individuals with OUD who enter any of our 400+ state licensed SUD treatment programs have access to MAT with behavioral therapies.

Activities are expected to include:

- Expand MAT and improve recovery resources;
- Grow opioid-specific services for people leaving incarceration;
- Offer more opioid use disorder training; and
- Build the opioid use disorder workforce.

DHS is currently in contract negotiations with potential grantees for awarding these grants.

### *Federal/State Targeted Response (STR) Grants for Collaborative Treatment Efforts*

Minnesota received more than \$10 million in federal grants over two years to help establish more collaborative treatment efforts statewide. The goal of this grant is to encourage collaborative care between opioid treatment programs, health care clinics, care coordinators, and county and tribal entities. Grants focus on increasing provider capacity to identify and treat opioid addiction (including neonatal cases) and improving access to Naloxone to treat opioid overdoses. STR grants were implemented with a focus on reaching Minnesota communities experiencing significant disparities, including American Indian and African American Minnesotans. Minnesota has long recognized the importance and effectiveness of MAT for pregnant women and new mothers, therefore STR funds were also used to increase capacity reaching pregnant women. Minnesota's STR has been granted a one-year, no-cost extension for grantees with remaining funds, which were less than half of the original STR grantees. Below are more detailed descriptions of two Minnesota STR funded activities. Overall, Minnesota granted funds to more than 43 initiatives through the STR grants.

#### *Integrated Care for High Risk Pregnancies (ICHRP) Initiative*

STR funds were directed to existing Integrated Care for High Risk Pregnancies (ICHRP) Initiative grantees (see description below) to adopt an advocacy/case management model of supportive recovery-based intervention for women with opiate use disorder. The model is based on core aspects of the Parent Child Assistance Program (PCAP), an evidence-based approach cited by the Association of Maternal and Child Health Programs as a Best Practice. PCAP's primary aims are to assist mothers in obtaining drug treatment, staying in recovery, and resolving myriad complex problems related to their substance abuse; to assure that the children are in safe, stable home environments; and to prevent the births of future alcohol- and drug-exposed children. Mothers are enrolled during pregnancy or up to six months postpartum. Culturally specific intervention activities are undertaken by paraprofessional case managers who have successfully overcome difficult personal, family, or community life circumstances similar to those experienced by their clients. The case managers conduct regular home visits, connect families with services, and coordinate services among a multidisciplinary network of community providers.

#### *Minnesota's Opioid-focused Project ECHO*

STR funds were used to launch a Minnesota Project ECHO focused on building knowledge, capacity and quality of services among prescribers, social services, behavioral health treatment providers and administrators in clinic and other provider settings. Three organizations are contracted to serve as ECHO hubs: (1) The Division of Addiction Medicine at Hennepin County Medical Center (HCMC), also known as Hennepin Healthcare; (2) CHI St. Gabriel's Health; and (3) Wayside Recovery Center. The hubs engage Minnesota's medical and substance use recovery communities in a series of learning collaboratives via videoconference "clinics" focusing on evidence-based assessment and management of patients with opioid use disorders and associated comorbidities. The teaching faculty and audience are multidisciplinary and work together to discuss patient needs within the context of effective, patient-centric models of health care delivery. Hub professionals assist community providers in the stabilization of their patients through education, consultation, and direct care with the ultimate goal of empowering

general medical and substance use treatment practices to bring quality evidence-based care to their patients.

Thus far, the Minnesota Project ECHO project has successfully broadcast over 100 ECHO sessions. Hennepin Healthcare ECHO staff partnered with Minnesota Hospital Association to create a 2-day Buprenorphine Boot Camp, supported by Wayside Recovery Center and CHI St Gabriel's Health, to kick start their clinical teams' efforts to prescribe buprenorphine for opioid use disorder. One hundred eighty participants from 32 clinics, including 50 providers registered to get DATA-2000 waivers and another 33 who are already waived attended the event. As part of STR funding, Hennepin Health is also providing technical assistance and buprenorphine waiver training as necessary to primary care providers to become certified to provide MAT. The Hennepin Medical Center Opioid ECHO lead physician currently mentors 14 providers (nine physicians, three nurse practitioners, and two physician assistants) related to buprenorphine prescribing. All of them are actively prescribing buprenorphine for opioid use disorder. Through the STR funding this same physician co-facilitated a Half & Half buprenorphine waiver training for 69 providers (April 2018 and Feb 2019). In addition, Minnesota's Opioid ECHO hubs are contributing to national research by participating in an ECHO Institute study of the impact of Opioid ECHO on health and healthcare based on Medicaid claims data to evaluate the impact of Opioid ECHO on provider processes, patient outcomes and costs.

#### *Opioid Overdose Prevention Pilot Projects*

In 2017, MDH received a one-time appropriation of \$1 million to replicate the overdose prevention efforts of St. Gabriel's Hospital in Little Falls, MN. MDH awarded funding to eight communities and tribal nations. The Governor's 2019 budget proposal expanded the work occurring in the first eight communities for an additional year to allow them to assess the effectiveness and sustainability of their work. The funds also support similar drug overdose prevention grants to eight new communities for two years. Each year, the program would allow eight communities to "graduate" and eight new intervention communities would initiate prevention work (\$1.3 million in FY 20 and \$2.3 million each year thereafter).

Each community implements six major activities to reduce opioid use or abuse and reduce rates of opioid addiction:

1. Establishing multidisciplinary controlled substance care teams that may consist of physicians, pharmacists, social workers, nurse care coordinators, and mental health professionals;
2. Delivering health care services and care coordination, through controlled substance care teams, to reduce the inappropriate use of opioids by patients and rates of opioid addiction;
3. Addressing any unmet social service needs that create barriers to managing pain effectively and obtaining optimal health outcomes;
4. Providing prescriber and dispenser education and assistance to reduce the inappropriate prescribing and dispensing of opioids;

5. Promoting the adoption of best practices related to opioid disposal and reducing opportunities for illegal access to opioids; and
6. Engaging partners outside of the health care system, including schools, law enforcement, and social services to address root causes of opioid abuse and addiction at the community level.

#### *Legislation to Move to Client-Centered Model*

The 2017 Minnesota Legislature enacted new reforms to Minnesota's SUD treatment system to move from an acute, episodic-based system to a client-centered model of care, with an emphasis on managing SUD as a chronic disease. These changes remove barriers that have prevented Minnesotans on Medicaid from accessing substance abuse treatment. The reform package allows patients to more quickly access services, and adds important services like withdrawal management, treatment coordination and peer support.

#### *Medication-Assisted Treatment (MAT) for Opioids*

As discussed in Milestones 3, 4, and throughout this section, Minnesota has engaged in efforts to promote and expand MAT services across the state. Currently there are 17 Opioid Treatment Programs (OTP) operating in the state and in recent years there has been an increase in the number of tribally licensed programs that offer MAT services. Current SUD placement guidelines outlined in Minnesota Rules 9530.6622, and structured similarly to ASAM's six dimensions<sup>i</sup>, require placing authorities to refer a client with an OUD and a risk rating of two or more to an OTP. Minnesota has also expanded the availability of MAT by authorizing mid-level nurse practitioners and physician assistants to dispense medications used to treat OUD. This allowance, in addition to information the state has regarding practitioners utilizing the Drug Addiction Treatment Act of 2000's waiver to increase patient prescribing capacity to 275, has increased the capacity for MAT across the state.

Many of the activities discussed in this section are supporting expansion of MAT access through federally funded STR, SOR and MAT Expansion grants and additional state funding. Launched through Minnesota's STR grants in 2017, Minnesota is using Project ECHO to educate and engage a range of provider environments and professionals about MAT--from the prescribers, to social service staff, to licensed alcohol and drug abuse counselors, to clinic administrators and beyond (see STR summary language above). Through this process, Minnesota is working to expand access to MAT and improve quality of services across the state.

The 2017 Minnesota Legislature provided \$825,000 for health care providers to purchase direct injectable drugs to treat opioid addiction. The Minnesota Department of Corrections is also developing a strategic plan to expand access to MAT for the criminal justice-system. DHS has also received a \$6 million SAMHSA MAT expansion grant. The project is a partnership with the Red Lake Nation, the White Earth Tribal Government, and Fairview Medical Center. The first two organizations are targeting Native American communities, while the latter is targeting African American communities.

### *Federal Strategic Prevention Framework for Prescription Drugs*

In 2016, Minnesota received a \$1.5 million federal grant over five years to prevent and reduce opioid abuse and reduce opioid overdoses. The grant requires that state agencies: 1) design, implement, enhance, and evaluate primary prevention efforts using evidence-based methods; 2) work with pharmaceutical and medical communities on risks of overprescribing; and 3) raise community awareness and bring opioid abuse prevention activities and education to schools, communities, parents, prescribers, and their patients.

### *Integrated Care for High-Risk Pregnancies*

In 2015, the Legislature directed DHS to implement a state-funded pilot grant program—called the Integrated Care for High Risk Pregnancies (ICHRP) Initiative—to improve birth outcomes for high-risk women by addressing opioid use and low birth rate (Minnesota Statute § 256B.79). ICHRP targets pregnant women who are Medicaid enrollees and who are at significantly elevated risk for adverse outcomes of pregnancy. Adverse outcomes include low birth weight, prematurity, maternal opiate addiction, and other reportable prenatal substance abuse. Half of the funds were awarded to five tribes to address opioid-exposed pregnancies. The grant supports planning, system development and integration of medical, chemical dependency and social services, incorporates screening, collaborative care planning, referral, and follow up for behavioral and social risks, and encourages use of community-based paraprofessionals such as peer recovery support workers, doulas and community health workers. In 2019 the Legislature continued the ICHRP grant program. It is anticipated that the pilot may inform future policy development to sustain these efforts in Medicaid.

### *Minnesota Residential Treatment for Pregnant and Postpartum Women (PPW)*

The PPW program is designed to expand and enhance women’s pregnant and postpartum SUD services across the continuum of care (prevention, treatment and recovery) for women, children and families who receive treatment for SUDs. The PPW focuses on low-income women, age 18 and over, who are pregnant or postpartum, and their minor children, age 17 and under, who have limited access to quality health services including traditionally underserved populations, especially racial and ethnic minority women.

In Minnesota, these underserved populations with the largest disparities include American Indian women, African American women and women receiving treatment services in rural areas. The MN PPW supports evidence-based parenting and treatment models, including trauma-specific services in a trauma-informed context. New and existing grants, through curricula and treatment program services, collaborations, and a required PPW evaluation will measure outcomes specific to the identified target populations with the highest disparities in our state.

### *Limiting Opioid Prescriptions and Improving Warning Efforts*

In 2017, Governor Dayton and the Legislature passed a law requiring opiate prescriptions to contain a label that says “Caution: Opioid: Risk of overdose and addiction.” The bill also limits

opiates to a four-day supply for certain situations of dental or ophthalmic pain but provides health care providers discretion if he/she determines that a larger quantity is needed.

#### *Pharmacy Drop-Off Sites*

In 2016, the Legislature passed and the Governor signed legislation allowing any Minnesota pharmacy to be a drop-off site for unused prescriptions, including opioids.

#### *Opioid Stewardship Fund and Advisory Council*

In 2019, the Legislature created an opioid stewardship fund, funded by fees collected by the Board of Pharmacy, to address rising rates of opioid use through grant programs. The new law establishes an opioid stewardship advisory council to develop and oversee a comprehensive and effective statewide effort to address the impacts of the opioid crisis. The council will be tasked with reviewing local, state, and federal initiatives and funding related to prevention and education, treatment, and services for individuals and families experiencing and affected by opioid abuse and promote innovation and capacity building to address the opioid addiction and overdose epidemic. It will help ensure that opioid stewardship funding aligns with existing state and federal funding in order to achieve the greatest impact and support a coordinate state effort to address the opioid addiction and overdose epidemic.

#### *Culturally Specific Prevention Grants*

This grant program addresses the overdose disparities in Minnesota and strives to identify and interrupt the root causes of the overdose epidemic. MDH will distribute grants to organizations working directly with urban American Indians and Minnesota's 11 tribal nations. The community organizations and tribal nations will implement components of the Menomonie Project, a whole health initiative designed by the Menomonie Nation (Wisconsin) that has resulted in clear reductions in overdose death and hospitalizations. The Menomonie Project emphasizes high school graduation rates, employment, reclaiming language, prescribing practices, social services, and family supports (\$2.4 million in FY20 and \$4.5 million each year thereafter).

#### *Know the Dangers Website*

Minnesota launched a website – [www.knowthedangers.com](http://www.knowthedangers.com) – to educate the public about opioid facts and how to get help for yourself or someone you know.

### **B. Expanded Coverage of, and Access to, Naloxone for Overdose Reversal**

Minnesota has numerous efforts under way to improve access to Naloxone, including:

- The Minnesota opioid prescribing guidelines recommend that providers of opioids consider co-prescribing naloxone to individuals vulnerable for opioid overdose or to their loved ones.



- The Minnesota Board of Pharmacy (BOP) developed the Opioid Antagonist (Naloxone) Protocol which allows participating pharmacies to issue a legally valid prescription for naloxone and then to dispense it.
- MDH provides funding to regions to purchase Naloxone and to provide training to first responders – including state troopers, sheriffs, local law enforcement, tribal police, fire, and EMS – across the entire state. Often, our first responders have opportunities to save lives and can do so when equipped with training (so ensure proper administration of either the injectable or inhalation Naloxone) and are provided with at least two doses of Naloxone per first responder (\$1 million each year).
- Through the federal STR grants, organizations are expanding distribution efforts in Greater Minnesota and in tribal communities. DHS issued grants that support organizations and communities with the greatest need, including Brainerd, the Iron Range, White Earth, Duluth and St. Louis County, and St. Cloud. (The grants also support expanded access in the Twin Cities metropolitan area.)
- DHS funded three community-based organizations to provide naloxone distribution and training across Minnesota to syringe services programs, businesses, and individuals under the STR funding. DHS is currently working on negotiating contracts with existing and new grantees for naloxone distribution and training.
- MDH recently hired a Statewide Naloxone Coordinator to increase pharmacy participation in the Opioid Antagonist Protocol and ensure a thorough, coordinated response among various naloxone training and distribution initiatives across Minnesota.

Additionally, in 2014, the Minnesota Legislature enacted a law allowing for more widespread distribution and administration of Naloxone to reduce or prevent opioid overdoses. The law protects first responders and certain licensed health care professionals from civil liability or criminal prosecution for administering opioid antagonists to a person experiencing an opioid overdose.

### **C. Strategies to Increase Utilization and Improve Functionality of Prescription Drug Monitoring Programs**

By law, all controlled substance prescribers and pharmacists in Minnesota must enroll in the Minnesota Prescription Monitoring Program (MNPMP) and maintain a user account. However, at this time, prescribers are not required to use the MNPMP. Under [245G.22 Subdivision 16](#), upon admission to a methadone clinic outpatient treatment program, the medical director (or a delegate) must check the MNPMP and continue to do so at least quarterly. If MNPMP data shows there are multiple prescribers or multiple prescriptions for controlled substances, the MNPMP must be checked monthly. Additionally, the Board of Pharmacy sends alerts to

prescribers and pharmacies about individuals who, based on PMP data, may be “doctor shopping”.

In October 2018, the MNPMP was queried 695,715 times compared to 89,893 queries in October 2017, an increase of 673.9 percent year-over-year.<sup>3</sup> Minnesota, including all of the state’s health licensing boards, is working to increase the number of providers and pharmacies who use the MNPMP. Additionally, the MNPMP allows for interstate data sharing with 38 states utilizing PMP InterConnect.

The state uses a NarxCare and PMP AWARe software solution to aggregate and analyze prescription information from MNPMP and present visual, graphical and advanced analytic insights, and machine learning risk scores to help physicians, pharmacists and care teams provide better patient safety and outcomes. NarxCare also provides clinical tools and resources that support patients’ needs, including connectivity to treatment options, when appropriate.

Minnesota 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 then go back to the electronic health record). MDH is applying for CDC Overdose Data to Action funding, a key strategy of which is to support the improvement of MNPMP functionality, interoperability, and provider utilization.

### Summary of Actions Needed to Achieve Milestone #5

Action Needed	Timeline
Continue to support the use of the MNPMP when prescribing, and the use of the Prescribing Guidelines	Ongoing By December 2020, opioid prescribers over predetermined prescribing thresholds will be required to use and document use of the PDMP as part of the prescribing improvement program.
Identify opportunities for expanding MNPMP functionality and use	Ongoing
Increase the use of MNPMP by providers and pharmacists	Ongoing

<sup>3</sup>Total queries include prescribers, pharmacists, delegates, and administrative users granted access according to Minnesota Statutes 152.126. In September 2018 one statewide pharmacy chain and one health system integrated a one-click feature to view a MNPMP report from within their pharmacy dispensing system and electronic health record system via Appriss Health’s PMP Gateway managed service. Previous months reflect system direct queries only.

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

### **CMS Specifications:**

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.

### **Minnesota's Response:**

Minnesota is working to ensure that there is a full continuum of care in place in order to effectively serve beneficiaries with SUDs. The state is in the process of implementing new services provider requirements to ensure residential and inpatient providers link beneficiaries, especially those with OUDs, to community-based services and supports at each point in the care continuum. Virtually all of the activities described as the "current state" below will also carry forward to the future state.

**Current State:** Minnesota has enacted updated state laws defining treatment coordination provider qualifications ([245G.11, Subdivision 7](#)), a new care coordination service called "SUD treatment coordination" ([245G.07, Subdivision. 1\(6\)](#)), and outlined requirements for treatment planning services and reviews ([245G.06, Subdivision. 3](#)). Together these three elements have established the foundation for a successful continuum of care. When a beneficiary enters treatment, an individual treatment plan is required, and as a part of that plan, the provider must include resources to refer the client when the client's needs are to be addressed concurrently by another provider (245G.06). In addition, the provider must document treatment coordination activities in the weekly treatment plan review. The review includes the date, the type and amount of each treatment service, including treatment coordination activities, and the client's response. Treatment coordination activities occur throughout the client's treatment, when the decision is made to transition to a new level of care and when a discharge summary is completed. The discharge summary includes "continuing care recommendations, including transitions between more or less intense services, or more frequent to less frequent services, and referrals made with specific attention to continuity of care for mental health, as needed" (245G.06 subd. 4). The DHS Licensing Division monitors the requirements for licensed treatment providers.

Adults or adolescents eligible for Medicaid who have a SUD diagnosis and need treatment services are also eligible for SUD treatment coordination. Treatment coordination may be provided by a SUD-licensed treatment facility, a county/tribe, or a licensed individual who has specific knowledge in SUD and who meets the qualifications identified in 245G.11 subdivision 4. An individual is qualified to provide SUD treatment coordination if they meet the staff qualifications as a treatment coordination provider under 245G.11, Subdivision 7; and:

1. Is skilled in the process of identifying and assessing a wide range of client needs;

2. Is knowledgeable about local community resources and how to use those resources for the benefit of the client;
3. Has successfully completed 30 hours of training on care coordination for an individual with substance use disorder; and
4. Has either a bachelor's degree in one of the behavioral sciences or related fields; or current certification as an alcohol and drug counselor, level I, by the Upper Midwest Indian Council on Addictive Disorders; and has at least 2,000 hours of supervised experience working with individuals with substance use disorder.

SUD treatment coordinators must receive at least one hour of supervision regarding individual service delivery from an alcohol and drug counselor or a mental health professional who has substance use treatment and assessments within the scope of their practice, on a monthly basis.

SUD treatment coordinators must also:

1. Provide assistance in coordination with significant others to help in the treatment planning process whenever possible;
2. Provide assistance in coordination with, and follow up for, medical services as identified in the treatment plan;
3. Facilitate referrals to SUD services as indicated by a client's medical provider, comprehensive assessment, or treatment plan;
4. Facilitate referrals to economic assistance, social services, housing resources, and prenatal care according to the client's needs;
5. Provide life skills advocacy and support accessing treatment follow-up, disease management, and education services, including referral and linkages to long-term services and supports as needed; and
6. Document the provision of treatment coordination services in the client's file.

SUD treatment coordinators are required to assist people in making appointments, getting to appointments, and following through on recommended treatment (e.g. filling prescriptions, etc.). SUD treatment coordinators are also required to assist people in obtaining public benefits such as cash benefits, food support, and subsidized housing. Lastly, SUD treatment coordinators are expected to assist people with navigating between SUD levels of care based on their medical necessity and choice.

SUD treatment coordination is available to any person deemed eligible through a comprehensive assessment. Some people will receive treatment coordination while receiving residential or outpatient SUD treatment. Licensed treatment facilities all are required to provide treatment coordination per 245G.07. Residential treatment providers are expected to provide this service as a part of the per diem payment. A person receiving SUD treatment coordination services can receive other Medicaid care coordination or case management services as appropriate. The expectation is that the SUD treatment coordinator will

communicate with other care coordinators or case managers to ensure duplication and errors regarding care coordination responsibilities are avoided.

#### *Certified Community Behavioral Health Clinics*

Care coordination is the linchpin of the CCBHC model of care. CCBHCs are required to coordinate care across settings and providers to ensure seamless transitions for people across the full spectrum of health and social services, including acute and chronic medical needs and behavioral health needs. As providers of outpatient SUD services within the continuums of care described in this waiver, the CCBHCs can provide SUD treatment coordination or CCBHC care coordination as people's level of care needs increase and decrease throughout care.

**Future State:** Minnesota is in the process of establishing provider requirements for participating SUD providers and anticipates publishing final guidance by October 2020. These requirements will emphasize the importance of treatment coordination to support the transitions between appropriate levels of care during treatment, and at the end of the treatment process. The preliminary requirement for providers seeking to participate will be referral agreements attesting to the residential providers' ability to coordinate treatment within all of the ASAM levels of care<sup>i</sup> thereby supporting the providers' ability to conduct treatment coordination and promote long-term recovery. [To help ensure seamless transitions for people across a full spectrum of health and social services, participating providers will be required to provide peer recovery support services to assist beneficiaries and facilitate access to the additional services they need. In addition to requiring that providers offer peer recovery support services, the state will establish within its utilization management practices, a requirement that utilization reviews include oversight of treatment coordination and peer recover support services and the provider's follow through on client referrals.](#)

Minnesota's SUD providers must provide discharge planning including documentation of continuing care recommendations including any ongoing behavioral health treatment (245G.06 subd. 4). Minnesota's 1115 Policy Team (mentioned in Milestone 3), which includes individuals from the licensing division who currently monitor for this requirement, will develop standards for enhancing and aligning the discharge plan requirements with ASAM criteria<sup>i</sup> and publish these standards in the provider manual by October 2020. Minnesota's policy leads for SUD treatment coordination are also developing further guidance on ASAM- based treatment coordination standards for 1115 waiver providers.

Development of these standards is part of the broader growth of Minnesota's SUD treatment efforts and its support of the 1115 waiver implementation for residential and non-residential providers by June, 2021. Current and future work includes engagement with relevant business areas to facilitate updates to Minnesota's provider manual and necessary system changes, stakeholder engagement, identifying roles and responsibilities of providers of treatment coordination above and beyond what is identified in statute to avoid duplication of services, other development of training necessary for providers, ongoing communication and training with designated pilot participants and coordination with managed care organizations.

The state is also exploring utilization of a cloud based service such as the Omnibus Care Plan (OCP), which is a care coordination platform created by SAMHSA that facilitates the service coordination for recipients who are being served by multiple disparate providers and provider networks. Service coordination between disparate providers and provider networks is going to 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. Omnibus Care Plan would provide a cloud-based service coordination tool for any provider to use with other providers, the state, counties, and service recipients. Finally, the state has been undertaking an extensive redesign of case management and care coordination services in Medicaid writ large, and the SUD-related needs will be considered in the design.

### Summary of Actions Needed to Achieve Milestone #6

Action Needed	Timeline
Providers electing to participate provide verification of formal referral arrangements to ensure access to each of the ASAM levels of care <sup>i</sup>	January 2020; ongoing
Implement training and technical assistance to align providers with ASAM-based standards.	July 2020; ongoing
Update MCO contracts to reflect any necessary residential provider requirement changes	September 2020 (for January 2021 contract initiation)
Publish ASAM-based service standards and staffing requirements in MHCP provider manual	October 2020
Develop residential treatment provider review process and initiate ongoing monitoring process	June 2021
Communicate changes to providers	Ongoing

<sup>i</sup> Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Miller, eds. The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. 3rd ed. Carson City, NV: The Change Companies; 2013. Copyright 2013 by the American Society of Addiction Medicine.

## **Minnesota Substance Use Disorder System Reform Section 1115 Demonstration**

### **Health Information Technology (IT) Plan**

#### **Section I**

##### **Part 1: Implementation of Strategies to Increase Utilization and Improve Functionality of PDMP**

##### **Minnesota Prescription Monitoring Program**

The Minnesota Prescription Monitoring Program (PMP) was established in 2009 to promote public health and welfare by detecting abuse, misuse and diversion of controlled substance prescriptions.

The Minnesota Board of Pharmacy administers and oversees the operation of the PMP program and has selected Appriss Health to develop a data base that collects and stores prescribing and dispensing data.

Appriss Health's prescription drug monitoring program, PMP AWARe, is a web-based program that facilitates the collection, analysis and reporting of information on the dispensing of controlled substances.

Minnesota law requires that pharmacies and prescribers who dispense from their offices submit prescription data to the PMP system for all Scheduled II, III, IV and V controlled substances, butalbital and gabapentin dispensed in or into Minnesota. Minnesota licensed prescribers and pharmacists, and their delegated staff may be authorized to access information from the PMP database. This protected health information is collected and stored securely.

Additionally, Minnesota law mandated the Board of Pharmacy to appoint an advisory task force, made up of representatives from health related licensing boards, other state agencies, professional associations and members of the public. The Task Force advises the Board on the development and operation of the PMP including, but not limited to:

- (1) technical standards for electronic prescription drug reporting;
- (2) proper analysis and interpretation of prescription monitoring data;
- (3) an evaluation process for the program; and
- (4) criteria for the unsolicited provision of prescription monitoring data by the board to prescribers and dispensers.

As noted, the PMP is administered and overseen by the Minnesota Board of Pharmacy. As such, the Minnesota Department of Human Services (DHS) has limited influence over the PMP. DHS will continue to work with the Minnesota Board of Pharmacy and its advisory task force to identify opportunities to align the capabilities of the PMP with the SUD Health IT Plan requirements.

##### **Interstate Data Sharing**

Minnesota participates in an interstate PMP data exchange system, which allows permissible users in other states access to Minnesota PMP data. Conversely, other states allow Minnesota permissible users access to their data. This is accomplished using a secure method called the PMP InterConnect. There are

currently 42 states or jurisdictions exchanging data with the Minnesota PMP.

**Table 1: Strategies to Increase Utilization and Improve Functionality of Minnesota’s PDMP**

Milestone Criteria	Current State	Future State	Summary of Actions Needed
<p><b>Criterion 1:</b> Enhanced interstate data sharing in order to better track patient specific prescription data</p>	<p>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.</p>	<p>The Minnesota Board of Pharmacy (BOP) will pursue ongoing efforts at interconnecting with Oregon, Utah, Georgia, New Hampshire, Vermont, Puerto Rico, Guam, California, Nebraska and Missouri. Additional interstate data sharing opportunities will be investigated as they are recognized, with the intent that Minnesota is connected with all states in efforts to track patient-specific prescribing data. The Minnesota Department of Human Services’ Behavioral Health Division will actively collaborate with and support the efforts of the BOP in expanding interstate data sharing agreements.</p>	<p>This is dependent on the laws of each of the partner states and their technical capabilities. Currently, California and Oregon have no authority to share, Missouri is county based, thus some barriers with authority on their side, and Nebraska permits all licensed medical providers to access their data, which is an outlier in the PDMP community, making it challenging to allow two-way sharing. As statutory changes take place, the states and territories will be added as partners. Monitoring Progress: MN BOP, Controlled Substances Reporting, Director. In addition, MN BOP will explore the potential use of additional funding through CMS or SAMHSA in 2020, in order to potentially expand interstate data sharing possibilities, as other states have done.</p>



Milestone Criteria	Current State	Future State	Summary of Actions Needed
<p><b>Criterion 2:</b> Enhanced “ease of use” for prescribers and other state and federal stakeholders</p>	<p>At present, Minnesota health care providers and prescribers have the opportunity to leverage electronic health records that are integrated with access to the PMP database to make safer prescribing decisions easier.</p> <p>Currently we have 46 healthcare entities and pharmacies that have signed up with Appriss Health to use PMP</p> <p>Gateway Services (the software program that integrates access to the PMP database into the clinical workflow), and another 10 are awaiting approval.</p>	<p>The MN BOP will explore the potential of conducting randomized controlled trials to determine the return on investment for statewide integration of access to the PMP report via the electronic health record systems. This study will be conducted beginning in 2020 with estimated completion by 2021.</p> <p>Minnesota will continue to promote integration to access the PMP database within the clinical workflow to bring up the number of clinics offering this service.</p>	<p>MN BOP, Controlled Substances Reporting Section, Director; MN Management and Budget, Impact Evaluation Unit Manager; Researchers as assigned by funding partner (J-Pal).</p> <p>Milestones:            Planning phase to be completed by 7/31/2020. Start of integration activities no later than 8/1/2020, RCT to begin between no later than 8/1/2020 and continue through 9/30/2021.            Monitoring Progress: MN BOP, Controlled Substances Reporting Section, Director.</p> <p>Responsible:            MN BOP, Controlled Substances Reporting Section, Director. Seeking sustainable funding to offer statewide services. Initial funding has been established and will last until 9/30/2021.            Progress Monitoring: MN Board of Pharmacy, Controlled Substances Reporting Section, Director.</p>

Milestone Criteria	Current State	Future State	Summary of Actions Needed
<p><b>Criterion 3:</b> Enhanced connectivity between the state’s PDMP and any statewide, regional or local health information exchange</p>	<p>There is no current connectivity between the PMP and any state or local health information exchange (HIE). Connectivity between the PMP and state or local HIEs is not allowed under state law.</p> <p>In the meantime, the PMP is governed by the MN PMP Advisory Task Force, whose purpose is to advise the <a href="#">MN Board of Pharmacy</a> , as they will continue to do, on the development and operation of the prescription monitoring program, including, but not limited to:</p> <ul style="list-style-type: none"> <li>Technical standards for electronic prescription drug reporting;</li> <li>Proper analysis and interpretation of prescription monitoring data.</li> <li>Evaluation process for the program;</li> <li>Criteria for the unsolicited provision of prescription monitoring data by the board to</li> </ul>	<p>In order to increase the efficiency and effectiveness of use of the PMP, Minnesota Board of Pharmacy (BOP) has embarked on a path to improve interoperability of PMP information and content. The end goal is to provide all MN authorized healthcare entities – ambulatory care units, acute care facilities, emergency care units, pharmacies, and others – the ability to integrate access to MN PMP information into their Health IT systems, be they Electronic Medical Records (EMRs), Electronic Health Records (EHRs), Health Information Exchanges or Pharmacy Management Systems. The integrated solution will allow users to access the same information that is available in the MN PMP within their clinical workflows, including patient prescription history, summary information, and clinical risk indicators.</p>	<p>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 PMP and state or local HIEs. Regardless, collaboration between BOP, DHS, 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.</p>

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<p>prescribers and dispensers.</p> <p>The task force is governed under <a href="#">MN Statutes Chapter 152.126, Subd. 3</a></p>		
<p><b>Criterion 4:</b>Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns</p>	<p>Minnesota law requires DHS to provide individualized opioid prescribing reports to all health care providers who prescribe opioids for pain management and treat MinnesotaCare or Medicaid enrollees. The reports provide data to prescribers on their prescribing patterns and those of their anonymized peers. The data provided in the reports is from Medicaid and MinnesotaCare administrative claims data. The reports do not use data from the PMP. The goal of sharing this data with providers is to support quality improvement. The first reports went out to prescribers in July 2019. Minnesota is</p>	<p>Minnesota will continue to refine the reports to meet the needs of the state-mandated Opioid Prescribing Improvement Program (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. The reports present the comparative rates in bar graphs, and the quality improvement threshold is clearly</p>	<p>MN BOP is in the process of securing a contract with APPRISS Health for their PMP Gateway product using grant funds from the Department of Justice, Bureau of Justice Assistance which will pay for roughly 1 year of PMP Gateway Service. In addition, the BOP holds an interagency agreement with the MN Department of Health, using funds from their Center for Disease Control (CDC), Opioid Data to Action (OD2A) grant, to off-set a quarter of the cost of the annual service agreement.</p> <p>Legislative approval would be required to allow DHS staff access to prescriber audit trail information from the PMP.</p>

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<p>utilizing the MN- ITS mailbox to send the reports to prescribers that have registered to receive the communication through the web-based HIPPA compliant system. Providers who have not signed up for the MN-ITS mailbox will receive the notice through the U.S. Postal Service for the first year.</p> <p>Governor Dayton and the Minnesota Legislature established the Opioid Prescribing Improvement Program in 2015 to reduce opioid dependency and misuse in Minnesota related to opioid prescriptions. The <a href="#">Opioid Prescribing Work Group</a> will convene through 2021 to advance the program, which includes the goal of working collaboratively with the Minnesota medical community.</p> <p>In 2019, Governor Tim Walz signed the Opiate Epidemic Response into law.</p>	<p>marked in each graph. Prescribers will receive additional information about participating in the quality improvement review. Participation in the quality improvement program is based on the follow-up set of reports, which will be released in 2020. The follow-up set of reports will provide updated data and prescribing rates reflecting the time after receipt of this first report. DHS will work to expand prescriber enrollment and will continue to refine reporting and quality improvement processes.</p>	

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<p>The bill secures sustainable funding to fight the opioid crisis. The Opiate Epidemic Response bill establishes the Opioid Epidemic Response Advisory Council to develop and implement a comprehensive and effective statewide effort to address the opioid addiction and overdose epidemic in Minnesota.</p> <p>The State Government Opioid Oversight Project (SOOP) is several MN state agencies working together at every level — from prevention, to emergency response, to treatment — in order to eliminate duplication of efforts, align work and leverage resources.</p> <p>The Opioid Prescribing Workgroup published prescribing guidelines for acute, post-acute and chronic pain prescribing protocols for our Medicaid recipients. Efforts include: The Minnesota Department of Health’s (MDH) Data</p>		

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<p>driven prevention initiative has created an online data dashboard, and will next focus on a statewide strategic plan. The Department of Public Safety (DPS) collaborated with the MDH to share law enforcement and public health data in order to identify new trends. The Department of Human Services (DHS) is creating a campaign directed to health care providers on how to educate patients about the safe use of opioids. The DHS received a federal grant to raise awareness and bring prescription drug abuse prevention education to schools, communities, parents, prescribers and their patients. Substance use disorder reforms passed in 2017 (as proposed by DHS) mean that individuals will soon be able to go directly to providers to receive an assessment, providers will be reimbursed for services off-site, and three new services—</p>		

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<p>treatment coordination, peer recovery support, and withdrawal management—will be added.</p>		
<p><b>Criterion 5:</b> Facilitate the state’s ability to properly match patients receiving opioid prescriptions with patients in the PDMP</p>	<p>Minnesota’s PMP vendor provides the Minnesota Board of Pharmacy patient matching within the system. There is no interaction with a master patient index. However, The Prescription Monitoring Program (PMP) offers prescribers and dispensers the ability to view controlled substance prescription history for individual patients. As of July 2017, prescribers and pharmacist are required to have a PMP account. The BOP sends out controlled substance insight alerts to prescribers and pharmacies concerning individuals who, based on PMP data, may be doctor shopping.</p>	<p>Any systems integration or data sharing will hinge on legislative approval, as noted previously.</p> <p>While Minnesota currently does not have the statutory authority to create a universal master patient index (MPI) that can be used across all systems, payers, program, and benefits, Minnesota DHS is working to develop a Universal Person Identifier (UPI). Ideally, this UPI could be used across all business departments and programs that would leverage efficiency and coordination for citizens, workers, and systems. The MPI would have well defined rules to identify and</p>	<p>In addition to the creation of a universal MPI, the BOP (in collaboration with other stakeholders) would need to utilize predictive analytics to forecast increased risk of long-term opioid use based on initial prescribing characteristics.</p>

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<p>State law provides DHS with limited authority to access the PMP: (1) for purposes of placing a recipient into the Restricted Recipient Program and monitoring their care; and (2) for purposes of monitoring care of people receiving care from an opioid treatment program</p>	<p>correct data inaccuracies or duplicate records without jeopardizing program efficiencies or historical records for members, while also preserving confidentiality for the member.</p> <p>Specific to healthcare, the ideal MPI could be used across multiple payers and follow a member from plan to plan regardless of who is providing coverage (public programs, private insurance, Medicare, etc.).</p>	
<p><b>Criterion 6:</b> Develop enhanced provider workflow / business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance to address the issues which follow</p>	<p>46 healthcare entities and pharmacies within Minnesota have contracted with Apriss Health to use PMP Gateway Services, a software solution that integrates the PMP into the clinical workflow. Another 10 are awaiting approval.</p>	<p>The BOP will consider the feasibility of conducting a randomized controlled trial to determine the return on investment for statewide integration of access to the PMP report via the electronic health record systems. The study will be conducted beginning in 2020 with estimated completion by 2021.</p>	<p>Responsible: MN Board of Pharmacy, Controlled Substances Reporting Section, Director. Seeking sustainable funding to offer statewide services. Initial funding has been established and will last until 9/30/2021. Progress Monitoring: MN Board of Pharmacy, Controlled Substances Reporting Section, Director.</p> <p>Minnesota DHS will</p>



Milestone Criteria	Current State	Future State	Summary of Actions Needed
			continue to promote integration to access the PMP within the clinical workflow.
<p><b>Criterion 7:</b> Develop enhanced supports for clinician review of the patients’ history of controlled substance prescriptions provided through the PDMP—prior to the issuance of an opioid prescription</p>	<p>In December 2018 Minnesota launched NarxCare, a robust analytics tool and care management platform that helps prescribers and dispensers analyze real-time controlled substance data from PMPs and provides clinical resources for risk assessment and patient support, including interactive graphical representation of the PMP data, with risk scores and morphine milligram equivalents.</p>	<p>Minnesota will continue to work with its PMP vendor to include additional data which would be provided from outside (of the PMP), such as overdose event data, etc.</p> <p>Once the new system is fully implemented, additional analytic capabilities will be explored and implemented, as feasible, in order to enhance provider workflow / business processes, to support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance, and to promptly address the issues related to over-prescription of opioids.</p>	<p>MN Board of Pharmacy, Controlled Substances Reporting Section, Director. Seeking sustainable funding to offer statewide services. Initial funding has been established and will last until 9/30/2021. Progress Monitoring: MN Board of Pharmacy, Controlled Substances Reporting Section, Director.</p> <p>Both fiscal and policy barriers will be addressed in a collaborative manner by BOP and identified stakeholders.</p>
<p><b>Criterion 8:</b> Enhance the master patient index (MPI) or master data management service (MDMS) in support of</p>	<p>There is currently a DHS Unique Person Identifier (UPI) project underway, which is an</p>	<p>While Minnesota currently does not have the statutory authority to create a universal master</p>	<p>In addition to the creation of the UPI by DHS, the BOP (in collaboration with other stakeholders) would</p>

Milestone Criteria	Current State	Future State	Summary of Actions Needed
SUD care delivery.	<p>enterprise wide solution to (1) merge duplicate client records and (2) prevent duplicate records in the future. Gaps have been identified between current and future state requirements and specific, objective and relevant factors identified for each gap. Systems impacted include legacy systems and Minnesota Electronic Technology Systems (METS). One outcome is improved oversight of Program Eligibility which will reduce fraud, waste and abuse.</p> <p>The 2019 Minnesota legislative session passed requirements for the Unique ID project to design and implement a corrective plan to address the issue of Medical Assistance enrollees being assigned more than one personal identification number.</p>	<p>patient index (UPI) that can be used across all systems, payers, program, and benefits, ideally, Minnesota is developing a UPI that will ultimately be used across all business departments and programs, that would leverage efficiency and coordination for citizens, workers, and systems. The MPI would have well defined rules to identify and correct data inaccuracies or duplicate records without jeopardizing program efficiencies or historical records for members, while also preserving confidentiality for the member.</p> <p>Specific to healthcare, the UPI could be used across multiple payers and follow a member from plan to plan regardless of who is providing coverage (public programs, private insurance, Medicare, etc.). This could create a uniform and</p>	<p>need to utilize predictive analytics to forecast increased risk of long-term opioid use based on initial prescribing characteristics.</p> <p>Any systems integration or data sharing will hinge on legislative approval, and fiscal collaboration, as noted previously.</p>

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<p>This must be completed by June 30, 2021. A report to the legislature is due February 15, 2020 detailing the progress and plan to meet the deadline.</p>	<p>comprehensive record of a member’s healthcare and eligibility.</p>	
<p><b>Criterion 9:</b> Leverage the above functionalities / capabilities / supports (in concert with any other state health IT, TA or workflow effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing—and to ensure that Medicaid does not inappropriately pay for opioids</p>	<p>MN has several programs in place to implement effective controls and minimize risk of inappropriate opioid overprescribing. As a result, prescriptions for opioid analgesics in Minnesota declined over the last few years, but the state still seeks to impose penalties against certain physicians who overprescribe them. New opioid prescriptions for residents benefitting from state programs fell 33% since 2016. Opioid dosages exceeding new state guidelines have also declined, falling by more than one-half. There is a new state law under which DHS sends private reports to providers each year regarding personal prescription rates. DHS also manages a</p>	<p>All implemented programs will benefit from increased utilization of and integration with the MN PDMP.</p> <p>In addition, thresholds that will trigger quality improvement (and ultimately termination from the Minnesota Health Care Program enrollment) will be refined on an ongoing basis.</p> <p>The Opioid Prescribing Work Group (OPWG) is an advisory body of experts convened to forward DHS’ <a href="#">Opioid Prescribing Improvement Program (OPIP)</a>. The program plays a crucial role in Minnesota’s response to the crisis of prescription opioid misuse and abuse, namely addressing inappropriate</p>	<p>MN 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.</p>

Milestone Criteria	Current State	Future State	Summary of Actions Needed
	<p>quality improvement program for providers who prescribe beyond community standards. Physicians with high prescribing rates could potentially be removed from such programs as MinnesotaCare and Medical Assistance.</p> <p>The application, Drug and Alcohol Abuse Normative Evaluation System (DAANES) is a web-based application which tracks chemical dependency treatment episodes in Minnesota. Fulfills federally mandated reporting requirements necessary to receive federal funds. Primary functions of DAANES includes: (1) tracking detoxification services (2) tracking chemical dependency treatment services; and (3) tracking and reporting the State's Methadone Treatment Program</p>	<p>prescribing behavior among Minnesota health care providers. The OPWG, stakeholders, and collaborative agencies will work with BOP to develop data collection mechanisms and sharing agreements that will address those providers that exhibit persistently concerning prescribing practices.</p>	

**Acronyms:**

DHS – Department of Human Services

MDH – Minnesota Department of Health

DCT – Direct Care and Treatment

**Part 2: Attestation**

**Statement 1:** Indicate whether the state has sufficient health IT infrastructure/ “ecosystem” at every appropriate level (i.e. state, delivery system, health plan/MCO and individual provider) to achieve the goals of the demonstration

The state has sufficient Health IT infrastructure within state Medicaid and pharmacy systems, contracted managed care organizations, and provider electronic health records. The state has a high level of electronic health record adoption and health information exchange to achieve the goals of the demonstration. There are more than 385 active computer systems within the DHS environment. The applications listed here are considered major because of size, scope, and/or impact.

DHS System	Primary Function(s)
Avatar	Certified health care case management system focused on behavioral health, individuals with intellectual and developmental disabilities, addiction treatment and public health. Avatar provides: care coordination between providers and staff that regularly interact with the individuals that we serve, electronic submission of bills for the services provided and expected reimbursement, electronic submission of mandated measures for CMS, and other items. Functions include an electronic record of mental and physical treatment, a record of medications prescribed, taken and refused, a vital record, health care directives, and assessments for the likelihood of suicide, fall risk, drug usage, and willingness to participate in treatment.
<a href="#">MAARC</a>	The 24/7 state centralized common entry point operated by DHS under <a href="#">Minnesota Statutes 626.557.9</a> . This is for the public and mandated reporters to report suspected maltreatment of a vulnerable adult. Reports are accepted over the phone at 844-880-1574 by the public and online by mandated reporters at <a href="http://mn.gov/dhs/reportadultabuse/">mn.gov/dhs/reportadultabuse/</a> .
<a href="#">MAXIS</a>	<b>Public assistance eligibility and payments</b>
<a href="#">Minnesota Child Support Online (MCSO)</a> <i>(web front-end to PRISM)</i>	Parent and employer access to view case and payment information, track progress, get contact information, check appointments, make payments and view financial status of their case.  Child support participants can update financial statements and Pro Se documents.  <b>Employers can access payment information, report employee terminations, and make payments.</b>

<a href="#">MEC<sup>2</sup></a>	Helps determine client eligibility, pays providers, supports program integrity and tracks child care expenses
<a href="#">METS</a> (Minnesota Eligibility Technology System)	Health care eligibility determination and plan enrollment (Minnesota Health Care Programs as well as assisted and private health coverage)
<a href="#">MMIS</a> (Medicaid Management Information System)	<ul style="list-style-type: none"> <li>• Provider enrollment</li> <li>• Claims processing</li> <li>• Provider payments</li> <li>• Third-party liability programs</li> <li>• Service authorizations</li> </ul> <b>Managed care capitation payments</b>
<a href="#">MnChoices</a>	<b>Assessment and support planning for Minnesotans who need long-term services and supports</b>
<a href="#">MN-ITS</a> (provider “front-end” to MMIS)	<p>Enables MHCP-enrolled providers to:</p> <ul style="list-style-type: none"> <li>• Verify client eligibility</li> <li>• Submit authorization and service agreement requests</li> <li>• Submit claims</li> <li>• Copy, replace or void a previously-submitted claim</li> <li>• Check claim status</li> </ul> <b>Retrieve remittance advices, authorization and service agreement letters and other provider communications</b>
Phoenix	<p>Manages Minnesota Sex Offender Program business operations, including:</p> <ul style="list-style-type: none"> <li>• Housing location of clients</li> <li>• Scheduling of vocational, educational, health appointments, clinical sessions, and therapeutic recreation programming</li> <li>• Client and facility tracking</li> <li>• Staff routing and ticketing</li> </ul> <b>Clinical and health services information</b>
<a href="#">PRISM</a> (parents, employers use MSCO)	<b>Child support collection and enforcement</b>
<a href="#">SMI</a> (Shared Master Index)	<ul style="list-style-type: none"> <li>• Cross-reference of the person identifying numbers in the major DHS systems, MNsure and many county systems.</li> <li>• Provides a reusable person search function to remove duplicate client records across program areas and DHS/county systems.</li> <li>• Unifies information from multiple systems onto a single client/case profile view.</li> </ul> <b>Streamlines the interchange of information among state and county systems.</b>
<a href="#">SSIS</a> (Social Services Information System)	Case management system for county social workers supporting child protection, foster care, adoption, children’s mental health and other child welfare programs. Also supports adult maltreatment reporting, waiver claiming and other adult services.

**Statement 2: Indicate whether the state’s SUD Health IT Plan is “aligned with the state’s broader State Medicaid Health IT Plan (SMHP) and if applicable, the state’s Behavioral Health (BH) Health IT Plan**

*Minnesota received approval from CMS on November 3, 2011 and the most recent SMHP addendum was approved by CMS on February 9, 2017.*

The State’s SUD Health IT Plan and the Behavioral Health IT Plan are aligned with the SMHP.

Although significant progress has been made towards many of the goals originally established in Minnesota’s SMHP, the results of Minnesota’s HIT survey<sup>1</sup> reveal that gaps remain in providers’ ability to consistently exchange clinical information. Minnesota has implemented value-based purchasing strategies, which increase the accountability of providers to engage in well-coordinated, patient-centered health care. Payment reform and expanded integrated care models such as the Integrated Health Partnership initiative, Behavioral Health Homes, Certified Community Behavioral Health Clinics (CCBHC), and others, have brought increased focus on the need to address gaps in providers’ ability to send and receive admission, discharge, and transitions of care information including with providers outside their own clinic systems, on a different EHR platform, and across a full complement of care settings including long-term services and supports and behavioral health.

Over the past several years, Minnesota has been able to advance much of its HIT activity under the State Innovation Model (SIM) grant, and is using lessons from SIM to shape planning and identification of future needs. In continued support for ongoing activities related to established goals, the state has identified some new activity and objectives required to advance the meaningful use of health information technologies and promote electronic health information exchange. Ongoing activities include: DHS continues to maintain the MEIP website with current technical assistance, program information, and links to federal resources; DHS distributes program updates through the MEIP e-List on an as-needed basis; DHS staff provide presentations to professionals and organizations representing EPs and EHS; DHS collaborates with other HITECH programs through the e-Health Advisory Committee and Workgroups and presents at HITECH program educational events; DHS continues to work in cooperation with the State Office of Rural Health and Primary Care to provide updates and information to rural and safety net stakeholders; DHS provides a quarterly update to the e-Health Advisory Committee on program activities.

The Minnesota e-health Roadmap for Behavioral Health, Health, Local Public health, Long-Term and Post-Acute Care, and Social Services documented recommendations and actions that can accelerate adoption and use of e-health in these priority settings is now completed. Planned activities include: (1) Testing of the use of a personal health record that contains both their acute health care and long-term services and supports information for people enrolled in community-based services and supports. (2) Include behavioral health, long-term care, and DHS DCT in onboarding to MN Encounter Alerting Service so that applicable care coordinators from these settings can access timely care transition information about Medicaid enrollees. Implementation is expected to continue to include other provider types who serve Medicaid beneficiaries.

### **Part 3: Advancing Interoperability using Health IT Standards**

**Statement 3: Indicate that the state will include appropriate standards referenced in the ONC Interoperability Standards Advisory (ISA) and 45 CFR 170 Subpart B in subsequent MCO contract amendments or Medicaid funded MCO/Health Care Plan re-procurements**

The Minnesota e-Health Initiative (the Initiative) is a private/public collaboration focused on accelerating the adoption and use of e-health. The Advisory Committee is a 25-member legislatively authorized committee appointed by the Commissioner of Health to lead the Initiative. It represents the spectrum of Minnesota's health community, including providers, payers, public health, researchers, vendors, consumer, and more. The Advisory Committee has the responsibility to

1. Make recommendations to the Commissioner of Health on policies and strategies, and
2. Provide guidance to the community that support its mission to.

These responsibilities support the goals of the Initiative to

- Empower consumers with information to make informed health and medical decisions.
- Inform and connect health care providers by promoting the adoption and use of interoperable EHRs and health information exchange.  
Protect communities and improve public health by advancing efforts to make public health systems interoperable and modernized.
- Modernize the infrastructure through:
  - a) Adoption of standards for health information exchange;
  - b) Policies for strong privacy and security protection of health information;
  - c) Funding and other resources for implementation;
  - d) Training and informatics education; and
  - e) Assessing and monitoring progress on adoption, use and interoperability.

The Initiative will continue to encourage and support efforts to implement e-prescribing of controlled substances (EPCS) to help address the opioid misuse epidemic. They will provide input on e-Health Strategies for Preventing and Responding to Drug Overdose and Substance Misuse, and address ongoing priority topics such as:

- Full implementation of SCRIPT standards
- Promote use of Diagnosis code on prescriptions
- Advance medication management therapy
- How to improve medication reconciliation process.

Additional ancillary and ongoing activities advancing interoperability include:

- Minnesota Electronic Health Records Incentive Program (MEIP), implements and maintains an incentive payment system for Medicaid providers to implement an Electronic Health Record



- The Minnesota Promoting Interoperability Program (MPIP) was created in response to the passage of the HITECH Act as part of the American Recovery and Reinvestment Act of 2009, which mandated the creation of a state-run program to supervise the distribution of incentive funds for meeting the requirements for promoting the interoperability of electronic health records as defined by CMS. Project accomplishments: continued operation of MPIP attestation portal, continued payments processing, collection of meaningful use criteria and clinical quality measures, data analysis and coordination with quality improvement team at DHS.
- Health Information Exchange (HIE) activities, such as a new MMIS Enterprise Service bus (ESB), which once operationalized, will allow greater sharing of data with less work and development needed directly on the mainframe systems. The ESB will integrate across systems and the enterprise and is foundational to any project that needs to access data from another system. Business value includes: provides real time information for DHS agency systems that need MMIS information, reduce need for MMIS staff to answer or provide MMIS data questions by providing well- documented services.

## **Section II – Implementation Administration**

**Please provide the contact information for the state’s point of contact for the SUD Health IT Plan.**

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