DEPARTMENT OF HUMAN SERVICES

Legislative Report

Rate Recommendations for Non-Tribal Opioid Treatment Programs

Behavioral Health Division

Health Care Administration

May 3, 2022

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Contents

I. Executive summary

Medication for opioid use disorder (MOUD), also known as medication-assisted treatment (MAT), is an evidence-based treatment for individuals diagnosed with opiate use disorder (OUD). Minnesota Health Care Programs (MHCP) cover medically necessary MAT. Medication-assisted treatment can be provided by licensed opioid treatment programs (OTPs) and also within primary care clinics. Bundled rate methodologies for MAT are common. Many of the MAT delivery models that are most frequently cited as "innovative" use bundled rate methodologies, and the new Medicare Part B benefit for OTPs is structured through a weekly bundled rate.

Currently, non-tribal OTPs are reimbursed under a bundled rate method established by the Department of Human Services (DHS) for services provided to MHCP enrollees. MAT services provided within primary care clinics are not reimbursed under a bundled method. Tribal providers can also provide MAT, however, tribal providers are reimbursed under a unique payment method authorized in federal law, so this report is limited to the payment method that applies to non-tribal OTPs.

Although bundled rates can offer simplicity for providers, there are concerns about reimbursing OTPs through a bundled rate. The bundled rate may disincentivize OTPs from meaningfully engaging patients in non-medication treatment because the bundled rate may not support that treatment in a sustainable way. OTPs often cite a lack of patient interest in the non-medication components that OTPs offer. Lack of clear protocols to bridge the gap between "offering" and "providing" appropriate non-medication services is not conducive to comprehensive care.

Additionally, internal and external stakeholders have questioned whether the Department of Human Services (DHS) has the authority to reimburse non-tribal OTPs per diem payments for take-home doses of medication that patients self-administer on days in which they receive no other services.[1] The current payment method used by DHS to reimburse non-tribal OTPs is a bundled daily rate. Under the current policy, an OTP bills each day the patient is participating in their program, even on days when the patient is not seen by the OTP.

In the report issued in October 2019 which reviewed payments made to tribal MAT providers[2], the Office of the Legislative Auditor (OLA) concluded that DHS did not have the authority to allow reimbursement under Minnesota Health Care Programs (MHCP) to OTPs for take-home doses that patients self-administer. The OLA claimed that this policy conflicts with the general payment requirement in Minnesota Rule, part 9505.0210 that health services must be "personally furnished by a provider except as specifically authorized in parts 9505.0170 to 9505.0475" to be eligible for Medicaid reimbursement. Moreover, the Center for Medicare and Medicaid Services (CMS) requires providers participating in state Medicaid programs to keep records to support their claims for payment of services they render on a given date. Providers billing on days a patient only self-administered medication cannot verify or document that a service was rendered on that day.

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[1] The same question, but for tribal MAT programs, was the subject of a high-profile Office of the Legislative Auditor report. DHS determined that tribal MAT programs may not be reimbursed for take-home doses that patients self-administer because our Medicaid state plan has a face-to-face requirement for the tribal encounter rate.

[2] https://www.auditor.leg.state.mn.us/sreview/dhsover.pdf

This report explains the current non-tribal OTP rate structure and proposes a revised OTP rate structure that aligns the payment for the drug component of MAT with the Medicare program and unbundles the non-drug components. The proposed rate method results in an investment to support the full array of services an OTP is required to provide, promotes transparency and accountability, and addresses concerns related to risks associated with billing for days the patient only self-administers their medication. In addition, the report includes recommendations to support OTPs, followed by draft legislation.

II. Legislation

This report is mandated by the Laws of Minnesota 2021, First Special Session, Chapter 7, Article 11, Section 32:

DIRECTION TO THE COMMISSIONER; RATE RECOMMENDATIONS FOR OPIOID TREATMENT PROGRAMS.

The commissioner of human services shall evaluate the rate structure for opioid treatment programs licensed under Minnesota Statutes, section 245G.22, and report recommendations, including a revised rate structure and proposed draft legislation, to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance by December 1, 2021.

III. Introduction & background

Report purpose

This report is submitted to the Minnesota Legislature pursuant to Laws of Minnesota 2021, First Special Session, Chapter 7, Article 11, Section 32. This law addresses the current non-tribal OTP rate structure and requires report recommendations, including a revised rate structure and proposed draft legislation.

There are two ways people in Minnesota can receive treatment for opioid use disorder (OUD) that include medication as a component to assist in management of the condition: through office-based opioid treatment (OBOT) or through an opioid treatment program (OTP).

OBOT programs are generally regulated at a federal level with respect to prescribing of medications to treat opioid use disorder and the state licensing boards regulate the prescribing providers. In the OBOT model, prescribing of medications to treat OUD occur in the primary care setting, and drugs are dispensed by licensed pharmacies and self-administered by the patient. Substance use disorder counseling and other services are typically rendered by providers in other locations. Under the state's public health care programs, each of these providers is paid separately when services are provided to an enrollee, providing visibility into which services an enrollee is receiving on a given date of service. In addition, the state is able to collect federal rebates on the drugs dispensed, helping to reduce the cost of these medications.

There are 15 OTPs licensed by DHS, with the exception of the Minneapolis Veterans Affairs Medical Center OTP, which is federally regulated and not licensed by DHS. The OTPs prescribe and administer medications and offer counseling and other SUD treatment services. This report focuses on the services provided by OTPs and the payment method used for reimbursement under MHCP fee-for-service.

Overview of Medication-Assisted Treatment (MAT) in Opioid Treatment Programs (OTPs)

Opioid treatment programs (OTPs) deliver medication-assisted treatment (MAT) to treat opioid use disorder (OUD). Several types of medication can be used to treat OUD, but methadone is only available through an OTP. Although reliance on medication alone is not uncommon, a combination of psychosocial treatment and medication generally is recommended for the treatment of OUD.[3] The National Academies of Sciences, Engineering, and Medicine recently concluded that the evidence about the efficacy of different behavioral interventions used to complement MAT is limited and the evidence that is available is mixed.[4] Concurrent counseling or behavioral therapy designed to address patients' needs and risks is certainly beneficial in addressing a broader range of problems that medication alone cannot, including referral and treatment of mental health conditions that frequently co-occur in individuals with OUD.

Current reimbursement for opioid treatment programs

Reimbursement for MAT delivered through OTPs is under a single daily bundled rate to the OTP. The OTP bills using two codes that distinguish between treatment with methadone and treatment with all other types of MAT medications (buprenorphine, naltrexone, or suboxone, the last of which is a combination of buprenorphine and naloxone).

The four current code/modifier combinations for the OTP per diem billing include the cost of medication and all treatment services. Treatment services include group therapy, individual therapy, a comprehensive assessment, treatment coordination, and peer recovery support. At a minimum, to bill for any of the code/modifier combinations that do not include nine or more hours of clinical services, only the medication is required to be rendered. OTPs must also follow other requirements such as frequency of assessments and other services. The billing codes MHCP uses for OTPs are described in more detail in *Appendix A. Summary of OTP daily bundled payment reimbursement through MHCP.*

There is one hospital-based residential OTP in Minnesota, which bills differently from the rest of the outpatient OTPs. Specifically, this residential OTP bills the SUD residential daily bundle with a special modifier for the appropriate MAT daily bundle, but cannot bill the MAT plus clinical services daily bundle because the non-medication components are already contemplated in the SUD residential daily bundle.

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[3] SAMHSA. *Medicaid Coverage of Medication-Assisted Treatment for Alcohol and Opioid Use Disorders and of Medication for the Reversal of Opioid Overdose.* HHS Publication No. SMA-18-5093. Rockville, MD: SAMHSA, 2018.

[4] National Academies of Sciences, Engineering, and Medicine 2019. *Medications for Opioid Use Disorder Save Lives.* Washington, DC: The National Academies Press. https://doi.org/10.17226/25310.

IV. Proposed OTP Rate Structure

DHS Medication-Asssisted Treatment (MAT) work group

The DHS Medication-Assisted Treatment (MAT) work group convened in the summer of 2020 with representation from the Community Supports Administration, Health Care Administration, and Office of Inspector General to work together on the following objectives:

- Review the current MAT continuum in Minnesota, including the non-medication components of the model.
- Recommend strategies to improve access and quality of opioid use disorder treatment provided in the state.
- Identify a rate structure and payment method for OTPs that addresses the concerns identified in the Office of the Legislative Auditor's report.

See *Appendix B: Medication-assisted treatment work group members* for list of DHS staff involved in the work group.

The work group identified the components of MAT treatment within the two MAT treatment models and the regulatory requirements that apply to each model. Likewise, the work group discussed the patient experience of the two models. The work group concluded that both models have strengths and weaknesses.

For example, in the OBOT model, the non-medication clinical components are often delivered by providers that are not associated with the prescribing provider. This creates a potential gap in coordination of care and can result in patients not receiving counseling or other services that may be beneficial to them. The OTPs are required to offer counseling, which should promote the integration of services and lead to increased access and engagement with counseling and other services.

Conversely, the OBOT model may reduce stigma and promote improved management of co-occurring physical and behavioral conditions. The OBOT model provides services in a primary care setting, with providers who are likely managing other chronic conditions and medications. Services are provided in a medical clinic that provides a wide array of services and, therefore, no one would know the reason a patient is receiving care.

An OTP provides services for treatment of OUD and unless the OTP is part of and located within a larger integrated care system, it is unlikely the OTP is managing other chronic physical conditions and it is easily known that individuals entering the OTP facility are likely doing so because they are receiving treatment for OUD.

Ultimately, the work group concluded that regardless of the treatment model an enrollee determines is best suited for them, state public health care program policies and rates should promote high quality of care and equitable outcomes, promote access to necessary services, promote integration of care, and reduce stigma for enrollees seeking medically necessary and appropriate care to manage OUD. With those principles in mind, the work group began a review of what services were being provided by OTPs as well as other payment methods to inform changes to the OTP payment method.

DHS collaborated with the University of Minnesota Humphrey School of Public Affairs to develop preliminary tools and protocols to assess the non-medication interventions of OTP programs. The preliminary tools were developed by graduate students and tested on a small number of patient records with one provider. Although

further analysis and refinement of the tools and approach is warranted, it provides a means by which to conduct post-payment review of provider records to obtain some qualitative information about what services were provided, completeness of documentation and progress toward treatment goals, and quality of assessments and treatment planning, including periodic review and adjustment. Such reviews provide opportunities to work with providers on best practices, and ways to improve patient engagement and quality of care.

The group also discussed use of the Project ECHO (Extension for Community Healthcare Outcomes) approach to offer a case-based learning approach to promote best practices within OTPs to improve patient adherence and outcomes. Project ECHO hubs exist for OBOT providers that manage patients with OUD to obtain support from addiction medicine teams; another hub addresses peer recovery support services for OUD and other substance use disorders. The OBOT-related Project ECHO was evaluated by the Minnesota Department of Management and Budget, which found significant improvements in access to MAT and patient engagement compared to providers not participating in ECHO. Conceivably, a Project ECHO designed for OTPs could also generate improvements in patient care.[5]

The work group also reviewed Medicare's payment model, which is based on a weekly rate, but has separate components within the bundled rate to account for the differing costs of the medications. The group examined the bundle of services included in the weekly billing and the drug costs incorporated in the rate. Likewise, the work group reviewed the current MHCP fee-for-service rates and payment methods applicable to the OBOT model for each of the component services provided by OTPs. The Medicare model offers a separate bundle, but would still require validation of counseling hours and other clinical services. Medicare began covering OTP services only recently, so the payment method is relatively new. In order to evaluate the engagement of MHCP enrollees receiving treatment from an OTP in counseling and other services, the work group concluded that unbundling the payments would provide transparency, align payments with intensity of services, and promote the full array of services consistent with MAT evidence-based treatment that are required to be offered by an OTP.

The proposal breaks apart the current OTP daily bundle and separates the drug component from the rest of the OTP services. The proposed payment method includes a weekly drug bundle and non-medication components of MAT (e.g., substance use counseling, individual and group therapy, and toxicology testing) that are billed and paid under the same provisions as if provided separately under the OBOT method. The drug bundle payment rate is based on Medicare's weekly drug cost (*See Appendix C: Medicare billing for MAT*). Naltrexone is administered by an injection delivered monthly, so providers would be instructed to only bill for the drug in the week the injection is received by the patient.

Non-medication treatment services

Comprehensive assessments, individual and group counseling, treatment coordination, peer recovery support, evaluation and management (including medication management by the prescriber), and toxicology services make up the non-medication services that may be provided by an OTP. The proposed payment rates for non-medication treatment services are the fee-for-service rates for each service, including any rate adjustments that

[5] AR Solmeyer, AT Berger, SL Bart, et al. *Evaluation of ECHO Programs in Minnesota Impact of Project ECHO on Opioid Use Disorder Treatment*. St. Paul, MN: Minnesota Department of Management and Budget, 2021.

may apply to individual and group therapy services. Non-medication services will be billed per unit of service as defined by the billing code. This will align the billing and payment of these services delivered by OTPs with those delivered in OBOT settings. Toxicology testing that is provided by outside laboratories must be billed by the outside laboratory in accordance with federal requirements, whether MAT services are provided by an OTP or through the OBOT model.

V. Stakeholder engagement

Feedback session on DHS OTP rate recommendations

On January 20, 2022, DHS convened an OTP stakeholder session with providers and advocacy organizations in the substance use disorder community to gather feedback on the proposed OTP rate structure. The following statements were shared by stakeholders. DHS will continue to work with stakeholders to implement the recommendations.

- The current workforce shortage continues to be a concern, causing reduction in census for OTPs.
- Concerns were expressed that the proposed model would incent providers to provide services not medically indicated.
- The group agreed on the urgent need of reviewing the sustainability of non-medication services under current rates. DHS is conducting a rate study for behavioral health rates that will cover all the services under SUD treatment.
- The revised rate methodology does not reflect all the services provided by the OTPs and would result in a 40-50% reduction.
- DHS should host additional discussion with providers.

VI. Report recommendations

Proposed rate structure:

In the proposed drug bundle modeling Medicare's weekly billing, the following would be included in the rate:

- Drug cost
- Drug administration and observation
- Drug packaging and preparation
- Nursing staff time

In addition, the following services would be paid out separately as Medicaid reimbursable services:

- Individual therapy (substance use counseling would be covered under individual therapy)
- Group therapy (substance use counseling would be covered under group therapy)
- Peer recovery services
- Treatment coordination
- Evaluation and management, including medication management
- Toxicology testing

See *Appendix D: Methadone & buprenorphine current per diem vs. proposed rate structure* for an estimate of the differences in payment between the current per diem rate and the proposed rate method using methadone and buprenorphine, respectively. The scenario used for treatment services is based on state[6] and federal[7] requirements for treatment and take-home doses during the first year of treatment. Whether methadone or buprenorphine is used, the proposed payment method would result in additional investment in the first three months of treatment, when interaction with the patient is more frequent and engagement in non-medication components of treatment is likely at a higher intensity.

Provide support to opioid treatment programs and evaluate and identify strategies to facilitate access to quality non-medication components of OTPs:

Opioid treatment programs (OTPs) in Minnesota would benefit from implementation of a Project ECHO for OTPs. A change in the payment method should be accompanied by support for OTPs in promoting patient engagement in counseling and other non-medication services and ensure prescribing and take home dosing are safe and effective. ECHO can provide OTPs a meaningful approach to address quality concerns and make full use of the reimbursement opportunities provided by the recommended billing approach. An ECHO hub, comprised of a multidisciplinary team from a high-performing OTP, would reach out to the state's other OTPs to provide a supportive, mutual learning environment.

DHS should also work with OTP providers to develop an action plan to further develop and utilize the tool developed in collaboration with graduate students from the Humphrey Institute and generate a report on process and outcomes associated with non-medication components. Based on this analysis, DHS can develop specific plans to provide ongoing technical assistance and evaluation of these services to ensure optimum utilization of MAT in addressing substance use disorder in Minnesota.

VII. Draft Legislation

Minnesota Statutes 2021, section 254B.05, subdivision 5, is amended to read:

Subd. 5.**Rate requirements.**

(a) The commissioner shall establish rates for substance use disorder services and service enhancements funded under this chapter.

(b) Eligible substance use disorder treatment services include:

(1) outpatient treatment services that are licensed according to sections 245G.01 to 245G.17, or applicable tribal license;

(2) comprehensive assessments provided according to sections 245.4863, paragraph (a), and 245G.05;

[6] Minnesota Statutes, section 245G.22

[7] Code of Federal Regulations, title 42, section 8.12

(3) care coordination services provided according to section 245G.07, subdivision 1, paragraph (a), clause (5);

(4) peer recovery support services provided according to section 245G.07, subdivision 2, clause (8);

(5) on July 1, 2019, or upon federal approval, whichever is later, withdrawal management services provided according to chapter 245F;

(6) [delete]~~medication-assisted therapy services that are~~[end delete] [add]substance use disorder treatment with medication for opioid use disorders provided in an opioid treatment program [end add]licensed according to sections 245G.01 to 245G.17 and 245G.22, or applicable tribal license;

[delete]~~(7) medication-assisted therapy plus enhanced treatment services that meet the requirements of clause (6) and provide nine hours of clinical services each week;~~[end delete]

(8) high, medium, and low intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license which provide, respectively, 30, 15, and five hours of clinical services each week;

(9) hospital-based treatment services that are licensed according to sections 245G.01 to 245G.17 or applicable tribal license and licensed as a hospital under sections 144.50 to 144.56;

(10) adolescent treatment programs that are licensed as outpatient treatment programs according to sections 245G.01 to 245G.18 or as residential treatment programs according to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or applicable tribal license;

(11) high-intensity residential treatment services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable tribal license, which provide 30 hours of clinical services each week provided by a state-operated vendor or to clients who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community; and

(12) room and board facilities that meet the requirements of subdivision 1a.

(c) The commissioner shall establish higher rates for programs that meet the requirements of paragraph (b) and one of the following additional requirements:

(1) programs that serve parents with their children if the program:

(i) provides on-site child care during the hours of treatment activity that:

(A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter 9503; or

(B) meets the licensure exclusion criteria of section 245A.03, subdivision 2, paragraph (a), clause (6), and meets the requirements under section 245G.19, subdivision 4; or

(ii) arranges for off-site child care during hours of treatment activity at a facility that is licensed under chapter 245A as:

(A) a child care center under Minnesota Rules, chapter 9503; or

(B) a family child care home under Minnesota Rules, chapter 9502;

(2) culturally specific or culturally responsive programs as defined in section 254B.01, subdivision 4a;

(3) disability responsive programs as defined in section 254B.01, subdivision 4b;

(4) programs that offer medical services delivered by appropriately credentialed health care staff in an amount equal to two hours per client per week if the medical needs of the client and the nature and provision of any medical services provided are documented in the client file; or

(5) programs that offer services to individuals with co-occurring mental health and chemical dependency problems if:

(i) the program meets the co-occurring requirements in section 245G.20;

(ii) 25 percent of the counseling staff are licensed mental health professionals, as defined in section 245.462, subdivision 18, clauses (1) to (6), or are students or licensing candidates under the supervision of a licensed alcohol and drug counselor supervisor and licensed mental health professional, except that no more than 50 percent of the mental health staff may be students or licensing candidates with time documented to be directly related to provisions of co-occurring services;

(iii) clients scoring positive on a standardized mental health screen receive a mental health diagnostic assessment within ten days of admission;

(iv) the program has standards for multidisciplinary case review that include a monthly review for each client that, at a minimum, includes a licensed mental health professional and licensed alcohol and drug counselor, and their involvement in the review is documented;

(v) family education is offered that addresses mental health and substance abuse disorders and the interaction between the two; and

(vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder training annually.

(d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program that provides arrangements for off-site child care must maintain current documentation at the chemical dependency facility of the child care provider's current licensure to provide child care services. Programs that provide child care according to paragraph (c), clause (1), must be deemed in compliance with the licensing requirements in section 245G.19.

(e) Adolescent residential programs that meet the requirements of Minnesota Rules, parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements in paragraph (c), clause (4), items (i) to (iv).

(f) Subject to federal approval, substance use disorder services that are otherwise covered as direct face-to-face services may be provided via telehealth as defined in section 256B.0625, subdivision 3b. The use of telehealth to deliver services must be medically appropriate to the condition and needs of the person being served. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to direct face-to-face services.

(g) For the purpose of reimbursement under this section, substance use disorder treatment services provided in a group setting without a group participant maximum or maximum client to staff ratio under chapter 245G shall not exceed a client to staff ratio of 48 to one. At least one of the attending staff must meet the qualifications as established under this chapter for the type of treatment service provided. A recovery peer may not be included as part of the staff ratio.

(h) Payment for outpatient substance use disorder services that are licensed according to sections 245G.01 to 245G.17 is limited to six hours per day or 30 hours per week unless prior authorization of a greater number of hours is obtained from the commissioner.

Sec. x. Minnesota Statutes 2021, section 245G.22, subdivision 15, is amended to read:

Subd. 15. **Nonmedication treatment services; documentation.**

[delete]~~(a) The program must offer at least 50 consecutive minutes of individual or group therapy treatment services as defined in section 245G.07, subdivision 1, paragraph (a), clause (1), per week, for the first ten weeks following the day of service initiation, and at least 50 consecutive minutes per month thereafter. As clinically appropriate, the program may offer these services cumulatively and not consecutively in increments of no less than 15 minutes over the required time period, and for a total of 60 minutes of treatment services over the time period, and must document the reason for providing services cumulatively in the client's record. The program may offer additional levels of service when deemed clinically necessary.~~[end delete]

[add](a) The program must meet the requirements in 245G.07, subdivision 1, paragraph (a) and must document each occurrence of when the client was offered an individual or group counseling service. If the individual or group counseling service was offered but not provided to the client, the license holder must document the reason the service was not provided. If the service is provided, the license holder must ensure that the staff member who provides the treatment service documents in the client record the date, type, and amount of the treatment service and the client's response to the treatment service within seven days of providing the treatment service.[end add]

(b) Notwithstanding the requirements of comprehensive assessments in section 245G.05, the assessment must be completed within 21 days from the day of service initiation.

(c) Notwithstanding the requirements of individual treatment plans set forth in section 245G.06:

(1) treatment plan contents for a maintenance client are not required to include goals the client must reach to complete treatment and have services terminated;

(2) treatment plans for a client in a taper or detox status must include goals the client must reach to complete treatment and have services terminated; and

(3) for the ten weeks following the day of service initiation for all new admissions, readmissions, and transfers, a weekly treatment plan review must be documented once the treatment plan is completed. Subsequently, the counselor must document treatment plan reviews in the six dimensions at least once monthly or, when clinical need warrants, more frequently.

[add]Sec. X. **DIRECTION TO THE COMMISSIONER.**

The commissioner must revise the payment methodology for medication-assisted therapy services under 254B.05, subdivision 5, paragraph (b), clause (6). Payment is only allowed if the provider renders the service or services billed on that date of service or in the case of drugs and drug-related services, within a week as defined by the commissioner. The revised payment methodology must include a weekly bundled rate that includes the costs of: drugs; drug administration and observation; drug packaging and preparation; and nursing time. The bundled

weekly rate must be based on the Medicare rate. The commissioner must seek all necessary waivers, state plan amendments, and federal authorities required to implement the revised payment methodology.

EFFECTIVE DATE. This section is effective January 1, 2023 or upon federal approval, whichever is later.[end add]

VII. Appendices

Appendix A: Summary of OTP daily bundled payment reimbursement through MHCP

The four current code/modifier combinations for the OTP per diem billing include the cost of medication and all treatment services. Modifiers are used to describe the intensity of weekly clinical services and the SUD rate enhancements available to OTPs.[8]

HCPCS Code	Service Description	Base Rate	Co-occurring (rate enhancement)	Special population (rate enhancement)	Medical services (rate enhancement)
H0020	MAT, methadone; daily bundle.	$13.39	+$1.20	+$0.81	+$3.21
H0047 with modifier U9	MAT, all other; daily bundle.	$22.66	+$2.04	+$1.36	+$5.44
H0020 with modifier UA	MAT, methadone; daily bundle if OTP provides a minimum 9 hours clinical services per week.	$48.42	+$4.35	+$2.91	+$11.63
H0047 with modifier UB	MAT, all other; daily bundle if OTP provides a minimum 9 hours clinical services per week.	$57.69	+$5.19	+$3.46	+$13.85

[8] There are three types of SUD rate enhancements available to OTPs under section 254B.05, subdivision 5, paragraph (c): (1) Co-occurring services (HH) address both the client's identified SUD and mental health issues, including standardized mental health screening and appropriate mental health diagnostic assessment, monthly multi-disciplinary case review, and family education addressing both disorders and the interaction between the two; (2) Special population services (U4) are specifically designed to address the unique needs of individuals who share a common language, racial, ethnic, or social background. The rate is based on the additional cost of program material translation, amending curriculum to address cultural perspectives, and staff training; and (3) Medical services (U5) include health care, nursing, dietary and emergency physician services that are documented as provided to clients. The rate is based on additional costs for medical staff.

Appendix B: Medication-assisted treatment work group members

List of DHS staff involved in the work group

[LEAD] Julie Marquardt*: Health Care Administration*- Purchasing & Service Delivery Deputy Assistant Commissioner & Assistant Medicaid Director

[LEAD] Neerja Singh: *Community Supports Administration*- Behavioral Health Clinical Director

Regina Acevedo: *Community Supports Administration*- Behavioral Health Researcher

Molly Binger: *Community and Care Integration Reform Division*- Reform Policy Analyst

Nathan Chomilo: *Health Care Administration*- Medicaid Medical Director

Nathaniel Dyess: *Behavioral Health Division*- Former 1115 Waiver Lead

Ellie Garrett: *Health Care Administration*- Population Health Innovation Manager

Paula Halverson: *Office of Inspector General*- Licensing Mental Health & Substance Use Disorder Manager

Tara Holt: *Behavioral Health Division*- Policy Specialist

Chad Hope: *Health Care Administration*- Purchasing and Service Delivery Deputy Director

Dominique Jones: *Behavioral Health Division*- Treatment Manager

Carol LaBine: *Health Care Administration*- Benefits Policy Manager

Richard Moldenhauer: *Behavioral Health Division*- State Opioid Treatment Authority

Fritz Ohnsorg: *Health Care Administration*- Policy Specialist

Kristi Strang: *Office of Inspector General*- Licensing Substance Use Disorder Unit Supervisor

Linda Monchamp: *Health Care Administration*- Tribal Relations

Donald Moore: *Behavioral Health Division*- American Indian Team Supervisor

Appendix C: Medicare billing for MAT[9]

The Medicare payment rates are included in the table below. The "Drug Cost" column is the weekly payment rate proposed to be paid for each drug administered or take-home supply.

HCPCS	Service Description	Drug Cost	Non-Drug Cost	Total Cost
G2067	MAT, **methadone**; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed.	$37.38	$178.29	$215.67
G2068	MAT, **buprenorphine (oral);** weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed.	$78.79	$178.29	$257.08
G2069	MAT, **buprenorphine (injectable)**; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed.	$1,695.09	$184.96	$1,880.05
G2070	MAT, **buprenorphine (implant insertion);** weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed.	$4,950.00	$422.26	$5,372.26
G2071	MAT, **buprenorphine (implant removal)**; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed.	$0	$422.40	$422.40
G2072	MAT, **buprenorphine (implant insertion and removal)**; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed.	$4,950.00	$649.10	$5,599.10

[9] Medicare Learning Network- Opioid Treatment Programs (OTPs) Medicare Billing & Payment Booklet

HCPCS	Service Description	Drug Cost	Non-Drug Cost	Total Cost
G2073	MAT, **naltrexone**; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing if performed.	$1,264.26	$184.96	$1,449.22
G2074	MAT, **weekly bundle not including the drug**, including substance use counseling, individual and group therapy, and toxicology testing if performed.	$0	$167.42	$167.42
G2078	**Take-home supply of methadone; up to 7 additional day supply**; list separately in addition to code for primary procedure.	$37.38	$0	$37.38
G2079	**Take-home supply of buprenorphine (oral); up to 7 additional day supply**; list separately in addition to code for primary procedure.	$78.79	$0	$78.79
G2215	**Take-home supply of nasal naloxone**; **2-pack of 4mg per 0.1 mL nasal spray;** list separately in addition to code for primary procedure.	$89.47	$2.58	$92.05
G2216	**Take-home supply of injectable naloxone**; list separately in addition to code for primary procedure.	Contractor-priced	$2.53	Contractor-priced
G1028	**Take-home supply of nasal naloxone; 2-pack of 8mg per 0.1 mL nasal spray**; list separately in addition to code for primary procedure.	$125.00	$2.58	$127.58

Appendix D: Methadone & buprenorphine current per diem vs. proposed rate structure

The two tables in the following pages provide an estimate of the differences in payment between the current per diem rate paid to OTPs and the proposed rate method using methadone and buprenorphine, respectively.

Methadone (oral)- Baseline per 245G.22 & 42 CFR 8.12

Period	Current Per Diem	Drug Bundle & Other Costs Paid Out Separately
First 3 months- 1 unsupervised dose per week	$13.39 (methadone per diem less than 9 hours counseling a week) x 90 days = **$1,205.10**	1 E/M (new patient 1 hour)= $159.38 1 comprehensive assessment= $162.24 1 hour of group therapy= $35.03 $37.39 (drug bundle) x 13 weeks = $486.07 $72.11 (1 hour of individual therapy) x 10 weeks= $721.10 $46.84 (1 hour of treatment coordination) x 10 weeks= $468.40 $60.08 (1 hour of peer recovery support) x 10 weeks= $600.80 Week 11-13 (1 hour of individual therapy)= $72.11 Week 11-13 (1 hour of treatment coordination)= $46.84 Week 11-13 (1 hour of peer recovery support)= $60.08 **Total $2,812.05**
After 3 months to 6 months- 2 unsupervised doses per week	$13.39 (methadone per diem less than 9 hours counseling a week) x 90 days = **$1,205.10**	$37.39 (drug bundle) x 13 weeks= $486.07 Week 14-18 (1 hour of individual therapy)= $72.11 Week 14-18 (1 hour of treatment coordination)= $46.84 Week 14-18 (1 hour of peer recovery support)= $60.08 Week 19-22 (1 hour of individual therapy)= $72.11 Week 19-22 (1 hour of treatment coordination)= $46.84 Week 19-22 (1 hour of peer recovery support)= $60.08 Week 23-26 (1 hour of individual therapy)= $72.11 Week 23-26 (1 hour of treatment coordination)= $46.84 Week 23-26 (1 hour of peer recovery support)= $60.08 **Total $1,023.16**
After 6 months to 9 months- 3 unsupervised doses per week	$13.39 (methadone per diem less than 9 hours counseling a week) x 90 days = **$1,205.10**	$37.39 (drug bundle) x 13 weeks= $486.07 Week 27-31 (1 hour of individual therapy)= $72.11 Week 27-31 (1 hour of treatment coordination)= $46.84 Week 27-31 (1 hour of peer recovery support)= $60.08 Week 32-35 (1 hour of individual therapy)= $72.11 Week 32-35 (1 hour of treatment coordination)= $46.84 Week 32-35 (1 hour of peer recovery support)= $60.08 Week 36-39 (1 hour of individual therapy)= $72.11 Week 36-39 (1 hour of treatment coordination)= $46.84 Week 36-39 (1 hour of peer recovery support)= $60.08 **Total $1,023.16**
After 6 months to 9 months- 3 unsupervised doses per week	$13.39 (methadone per diem less than 9 hours counseling a week) x 90 days = **$1,205.10**	$37.39 (drug bundle) x 13 weeks= $486.07 Week 40-44 (1 hour of individual therapy)= $72.11 Week 40-44 (1 hour of treatment coordination)= $46.84 Week 40-44 (1 hour of peer recovery support)= $60.08 Week 45-48 (1 hour of individual therapy)= $72.11 Week 45-48 (1 hour of treatment coordination)= $46.84 Week 45-48 (1 hour of peer recovery support)= $60.08 Week 49-52 (1 hour of individual therapy)= $72.11 Week 49-52 (1 hour of treatment coordination)= $46.84 Week 49-52 (1 hour of peer recovery support)= $60.08 **Total $1,023.16**

Buprenorphine (oral)- Baseline per 245G.22 & 42 CFR 8.12

Period	Current Per Diem	Drug Bundle & Other Costs Paid Out Separately
First 3 months- 1 unsupervised dose per week	$22.66 (buprenorphine per diem less than 9 hours counseling a week) x 90 days = **$2,039.40**	1 E/M (new patient 1 hour)= $159.38 1 comprehensive assessment= $162.24 1 hour of group therapy= $35.03 $78.79 (drug bundle) x 13 weeks= $1,024.27 $72.11 (1 hour of individual therapy) x 10 weeks= $721.10 $46.84 (1 hour of treatment coordination) x 10 weeks= $468.40 $60.08 (1 hour of peer recovery support) x 10 weeks= $600.80 Week 11-13 (1 hour of individual therapy)= $72.11 Week 11-13 (1 hour of treatment coordination)= $46.84 Week 11-13 (1 hour of peer recovery support)= $60.08 **Total $3,350.25**
After 3 months to 6 months- 2 unsupervised doses per week	$22.66 (buprenorphine per diem less than 9 hours counseling a week) x 90 days = **$2,039.40**	$78.79 (drug bundle) x 13 weeks= $1,024.27 Week 14-18 (1 hour of individual therapy)= $72.11 Week 14-18 (1 hour of treatment coordination)= $46.84 Week 14-18 (1 hour of peer recovery support)= $60.08 Week 19-22 (1 hour of individual therapy)= $72.11 Week 19-22 (1 hour of treatment coordination)= $46.84 Week 19-22 (1 hour of peer recovery support)= $60.08 Week 23-26 (1 hour of individual therapy)= $72.11 Week 23-26 (1 hour of treatment coordination)= $46.84 Week 23-26 (1 hour of peer recovery support)= $60.08 **Total $1,561.36**
After 6 months to 9 months- 3 unsupervised doses per week	$22.66 (buprenorphine per diem less than 9 hours counseling a week) x 90 days = **$2,039.40**	$78.79 (drug bundle) x 13 weeks= $1,024.27 Week 27-31 (1 hour of individual therapy)= $72.11 Week 27-31 (1 hour of treatment coordination)= $46.84 Week 27-31 (1 hour of peer recovery support)= $60.08 Week 32-35 (1 hour of individual therapy)= $72.11 Week 32-35 (1 hour of treatment coordination)= $46.84 Week 32-35 (1 hour of peer recovery support)= $60.08 Week 36-39 (1 hour of individual therapy)= $72.11 Week 36-39 (1 hour of treatment coordination)= $46.84 Week 36-39 (1 hour of peer recovery support)= $60.08 **Total $1,561.36**
After 6 months to 9 months- 3 unsupervised doses per week	$22.66 (buprenorphine per diem less than 9 hours counseling a week) x 90 days = **$2,039.40**	$78.79 (drug bundle) x 13 weeks= $1,024.27 Week 40-44 (1 hour of individual therapy)= $72.11 Week 40-44 (1 hour of treatment coordination)= $46.84 Week 40-44 (1 hour of peer recovery support)= $60.08 Week 45-48 (1 hour of individual therapy)= $72.11 Week 45-48 (1 hour of treatment coordination)= $46.84 Week 45-48 (1 hour of peer recovery support)= $60.08 Week 49-52 (1 hour of individual therapy)= $72.11 Week 49-52 (1 hour of treatment coordination)= $46.84 Week 49-52 (1 hour of peer recovery support)= $60.08 **Total $1,561.36**