July chat questions & answers

General

Q: Are the slides available after the meeting?

A: Slides are published on the Thursday Connections with SUD at DHS webpage after the meeting.

Q: Is there a place we can find a recording of today's meeting to share with the rest of our team that could not attend?

A: This meeting is not recorded. You can find the slides and the Q&A on our website.

Billing

Q: I saw the changes that require billing the sum of time for the entire day. Meaning 45 mins one group and 35 mins for another group would total 1 hour 20 mins. You shared about the round up rule, but this change is important. Will you please clarify this for the group?

A: Additional billing guidance can be found on the MHCP Substance Use Disorder Provider Manual page.

Q: The way the provider manual is written is not very clear, especially the unit and measurement chart - I don't understand what this is for.

A. The Unit and Measurement chart was added to the provider manual SUD page to clarify when to round up or round down to a billing unit. The chart lists the minimum and maximum number of minutes of service which must be provided for each number of units to be billed. For example, the first row is for 1 unit and shows that if the unit is a 15-minute code, 1 unit is billed when 8 to 22 minutes of service are provided, and if the unit is a 60-minute code, 1 unit is billed when 31 to 90 minutes of service are provided. The number of minutes is based on the total combined amount of that type of service provided to the individual that day. Above that chart, the Revenue and Procedure Codes list the types of SUD services and the corresponding billing units and procedure codes for each. You may email sud.direct.access.dhs@state.mn.us if additional clarification is needed on this information.

Q: For the new billable units and time requirements, does that apply to mental health services as well? For example, is the following example true: Client is in SUD group at 10 a.m., gets pulled for a mental health service at 10:40 a.m. Only one of these services could be billed for the 1-hour period

of 10 a.m. to 11 a.m., even though one is SUD and one is MH? Are there exceptions regarding mental health crisis scenarios or any other scenarios? Thanks!

A: Statute 254B.06, subdivision 5, "prohibition of duplicative claim submission" applies to all of the procedure codes which may be billed by SUD service providers, regardless of the type of service provided. So if both a mental health service and a SUD group are billed by a single SUD provider, billing one hour for a session that did not last the entire hour and then starting a different service within the remaining balance of time of that one-hour unit would be considered duplicative and ineligible for payment. Please refer to the MHCP Substance Use Disorder Provider Manual page for the full list of SUD procedure codes and additional information and examples.

Q: How will the 15 min increment changes work for group? For a 3-hour group we do give clients a break. How are we supposed to code that correctly?

A: Please refer to the additional billing guidance found on the MHCP Substance Use Disorder Provider Manual page which includes examples for both 15-minute units and 60-minute units. When the new 15-minute unit codes become effective, the guidance will be the same, but a 60-minute group service will be 4 units instead of 1 unit. Providers must bill based on the total combined number of minutes of the same service code for the same member in the same day. Combined time must only account for direct service with members and does not include time for breaks.

Q: So, the 15-minute increment changes don't go into effect until next year?

A: The legislation to establish six new billing codes for nonresidential substance use disorder corresponding to a 15-minute unit will become effective for services provided on or after July 1, 2026, or upon federal approval, whichever is later. The new billing codes will correspond to individual counseling, group counseling, individual psychoeducation, group psychoeducation, individual recovery support services and group recovery support services.

Q: Are PRS now allowed to bill for group services instead of just individual services?

A: No. Statute 245G.07, subd. 2, (8) now clarifies that peer recovery support services must be provided one-to-one and face-to-face.

Q: These are such important changes, and I feel like they were just glossed over and gone through so quickly. The group will also be billed in 15-minute increments?

A: Yes. Effective July 1, 2026, or upon federal approval, whichever is later, there will be new billing codes for nonresidential substance use disorder, corresponding to individual counseling, group counseling, individual psychoeducation, group psychoeducation, individual recovery support services, and group recovery support services. The unit for all of these will be 15 minutes.

Q: Time Based Billing Codes - 15-minute increments - when does this start?

A: The current time-based billing codes for non-residential are 1-hour units for individual and group treatment and 15-minute units for treatment coordination and peer recovery support. The current billing codes and guidance can be found on the MHCP Substance Use Disorder Provider Manual page. Effective July 1, 2026, or upon federal approval, whichever is later, there will be new 15-minute unit

billing codes for nonresidential substance use disorder, corresponding to individual and group counseling, individual and group psychoeducation, and individual and group recovery support services. The current 15-minute unit codes for non-residential treatment coordination and peer recovery support will remain the same.

Q: So, my math is not great. Client will get only 5-minute break from an hour group to bill for a full unit?

A: Please refer to the additional billing guidance found on the MHCP Substance Use Disorder Provider Manual page.

Q: For SUD group and individual services: Can you clarify when the 15-minutes increments go into effect? Are we limited to 60-minute units until 7/1/2026? Is the process on counting total minutes to determine number of units billable currently in effect?

A: The process on counting total minutes to determine number of units that are billable is currently in effect. Additional billing guidance can be found here. Currently, non-residential treatment coordination and peer recovery support are billed in 15-minute units and non-residential individual and group treatment are billed in 1-hour units. Effective July 1, 2026, or upon federal approval, whichever is later, there will be new 15-minute unit billing codes for nonresidential substance use disorder, corresponding to individual and group counseling, individual and group psychoeducation and individual and group recovery support services. The current 15-minute unit codes for non-residential treatment coordination and peer recovery support will remain the same.

Q: Was it your intention that five-minute breaks not be deducted from treatment billing?

A: Per the HCPCS and CPT guidelines, the total billed time must only account for direct service with members and does not include time for breaks.

Q: When we are charting the groups, for example, they go from 8 a.m. - 12 p.m. but there is a 15-minute break. Do we chart that the group actually went from 8 a.m. - 11:45 a.m.?

A. Each treatment service provided to a client must be accurately documented by the staff member who provided the service, including the amount. If a break occurred during a treatment service, the documentation should reflect that. If a break occurred between two different treatment services, each service must be documented with the amount of service, and the break time isn't relevant.

Q: Comprehensive Assessment now billed in 15 minutes increments?

A. No, there was not a change to the procedure for billing for Comprehensive Assessments, and the unit for those is still "1 session".

Q: It would be helpful to have billing examples with the new 15-min units.

A: Please refer to the additional billing guidance found on the MHCP Substance Use Disorder Provider Manual page, which includes examples for both 15-minute units and 60-minute units. When the new 15-minute unit codes become effective, the guidance will be the same.

Housing

Q: I heard that DHS would be releasing a list of all SUD Board & Lodge approved facilities - this would be very helpful for us workers who are helping clients get into sober housing. Could you please respond and/or send this list to me if indeed it has been created.

A. Link to Free Standing Room and Board Providers. Additionally, we created a new Free-standing Room and Board webpage with information that may be helpful.

Q: To clarify, I have had two "sober homes" state that as of Aug. 1, the residents have to pay the full rent- it sounds like that payments may continue past Aug 1? Many rents are $700 and people with GA only receive $350 a month.

A: Individuals and sober home providers that are approved for Housing Support payments are able to use that funding to subsidize the individual's housing costs.

Q: Are there any plans to address the housing crisis we are facing now until 2027?

A: The SUD unit at DHS is committed to working with the Homelessness, Housing and Support Services Administration (HHSSA) to meet the housing needs for all Minnesotans.

Q: If the Recovery Residence work group recommendations are due Jan. 1, and housing operators can enter into agreements for Housing Support early Jan 2027, when can these operators expect to begin offering services to the client population? The assumption here being that there will be a time period where the work group recommendations are reviewed, and policies created and implemented before actual recovery residence services can begin.

A: The legislative report from the Recovery Residence work group, due Jan. 1, 2027, is separate from the voluntary Recovery Residence certification process. As noted, providers that are licensed by MDH or their local jurisdiction and certified by DHS, can enter into a housing support agreement, effective Jan. 1, 2027.

Q: Will there be a universal criterion established and utilized for the counties to follow in establishing housing support agreements?

A. DHS, rather than counties, will serve as the lead agency for housing support agreements with certified recovery residences. Additional information on housing support procedures can be found in Chapter 256I.

Q: What are the implications of ending new vendor approvals for FSRB and the full termination of the program effective 7/1/2027?

A: The origin for Free Standing Room and Board was to meet a need in rural Minnesota communities that did not have the capacity to serve individuals with a residential treatment level of care need. Since then, the program has outgrown it's original intent, requiring the shift into a more flexible housing model for individuals who are unhoused and needing SUD treatment. All vendors that are

currently approved for FSRB services, can continue to submit claims for BHF until July 1, 2027. Those vendors who were not approved for FSRB services before the June 30, 2025, end date, should work with their local treatment centers and Coordinated Entry Access Points for alternative supports that will meet the individual's support needs.

Q: Any planned changes or expansions to the Housing Support program?

A: Questions regarding the Housing Support program can be directed to dhs.dhs.grh@state.mn.us

Q: What is the status and plans for the Recovery Residence Work Group and implementation timeline?

A: Appointments to the work group will be made by Oct.1, 2025, with the first work group meeting taking place by Jan. 15, 2026.

Q: Resources or strategies to address immediate and near-term housing needs through 2027. What options do sober home/recovery residence vendors have? What are the immediate housing options for non-residential clients outside of Housing Supports or FSRB?

A: Individuals who are unhoused or at risk of being unhoused, should reach out to their local Coordinated Entry Access Point which can be found at HB101 Minnesota - Homeless Services in Minnesota

Q: Recovery residence providers with board and lodge licenses are asking treatment providers to update assessment to reflect risk level 4 in order to be able to justify need for board and lodging daily billable rate- how do you suggest this is handled?

A. A person attending outpatient SUD treatment must meet the eligibility requirement in section 254B.04, subdivision 2a, for room and board services to be reimbursed through the Behavioral Health Fund. Specifically, the person must score at level 4 on assessment dimensions related to readiness to change, relapse, continued use or recovery environment. Clinicians must score dimensions based on clinical judgement and assessment criteria. A person who does not meet criteria for scoring at a level 4 is not eligible for room and board reimbursement.

Q: I heard that DHS would be releasing a list of all SUD Board & Lodge approved facilities - this would be very helpful for us workers who are helping clients get into sober housing.

A. Link to Free Standing Room and Board Providers. As a reminder, a person attending outpatient SUD treatment who does not meet the requirement in section 254B.04, subdivision 2a, is not eligible for room and board services to be reimbursed through the Behavioral Health Fund.

Q: For sober homes that were granted Board and Lodge, they are all waiting on provider enrollment, there is a need to get through that process quickly because of the new laws. Can you provide feedback as to timing on provider enrollment processing?

A: Please contact the Provider Resource Center phone line at 651-431-2700 or 800-366-5411 for questions regarding MHCP enrollment.

Q: Can Board and Lodge homes exclude medical cannabis?

A: Information on board and lodge facilities, including a contact link for the Department of Health, can be found here.

Q: What are the available options for housing for those sober homes that were not granted Board and Lodge? Those that are not able to pay $650.00 for the room?

A: More information on how to obtain a Board and Lodge license, can be found here. More information on additional housing programs can be found here.

Q: Similar to MARCO with RCOs, is MASH being considered for Recovery Residence certification?

A: The legislative report produced by the Recovery Residence work group will include any potential recommendations for the certification process to be delegated to a third-party organization.

Q: No follow up direction from DHS with our FSRB licenses after we were approved. How long does provider enrollment take? How long can we expect payments to take?

A: Please contact the Provider Resource Center phone line at 651-431-2700 or 800-366-5411 for questions regarding MHCP enrollment and payments.

Q: How do we obtain a variance to increase our FSRB beds?

A. Capacity is determined by your board and lodge license and registration. Information on board and lodge facilities, including a contact link for the Department of Health, can be found here.

Q: What is the difference between the "levels" of recovery residences?

A: The levels are outlined in 2025 Special Session Law, Chapter 9, Article 4, Sec. 43.

Q: The posted list FSRB list are all current housing available, correct?

A: The posted list includes agencies that have been approved by DHS to provide Free Standing Room and Board services. For more information on Housing Support programs in your area, you can reach out to your local county or tribal office.

Q: Is the room and board rate increasing for the low and high intensity residential?

A. No.

Q: Can Supportive Housing beds (formerly GRH), be held and/or be kept exclusive to a specific program? It is my understanding that the beds have to be offered to everyone and that the residents don't even have to be in a SUD program. Please clarify.

A: For more information on Housing Support programs in your area, you can reach out to your local county or tribal office.

Q: What is a board and lodging license used for or what can we use it for if we were not approved for free standing board and lodging through DHS? We basically paid for nothing.

A: Information on board and lodge licensing, including a contact link for the Department of Health, can be found here.

Q: A lot of these freestanding beds belong to treatment centers; are they open to everyone, like a GRH bed is?

A: Free Standing Room and Board is a separate service from SUD treatment. With Direct Access, providers should be informing clients of their right to choose where they receive services. Additional information can be found on the FSRB website here.

Q: What solutions are being provided for the CURRENT sober homes that are NO Longer able to invoice if they are not currently approved Board and Lodge. The bed that was invoiced to the treatment center is no longer an option, that client and resident now has to pay FULL amount which creates a new displacement to the client if they cannot afford the amount of the bed.

A: Where available, vendors may be able to enroll as Housing Support providers. More information can be found here or through their county financial office.

Q: To clarify: the new free-standing board and lodging facilities-that were previous sober homes/ with current clients in a IOP 2.1 and lower treatment program do not meet risk level criteria to pay for Board & Lodging services?

A. Approved FSRB facilities that meet the requirements in section 254B.05, subdivision 1 are eligible for room and board services to be reimbursed through the Behavioral Health Fund when the individual resident is attending outpatient SUD treatment and meets the eligibility requirement in section 254B.04, subdivision 2a. Specifically, the person must score at level 4 on assessment dimensions related to readiness to change, relapse, continued use or recovery environment. Clinicians must score dimensions based on clinical judgement and assessment criteria. A person who does not meet criteria for scoring at a level 4 is not eligible for room and board reimbursement.

Q: Who do we contact to update the referral contact information?

A: Please send the updated contact information to angela.dannewitz-johnson@mn.state.us

BHF eligibility

Please note that due to the large number of similar questions, for this section we have developed narrative that addresses all of the questions in one response. If there are any questions not answered by this response, please reach out to sud.direct.access.dhs@state.mn.us.

Q: How does DHS plan to handle the workload when all County eligibility work transfers to DHS?

Q: What is the turnaround time going to look like? That's a hefty load for DHS to take on and currently most counties process within 48 hours.

Q: How will that turnaround look like for jail comps?

Q: How long will DHS take to respond to BHF eligibility determinations?

Q: Why is the eligibility period being cut so drastically? This significantly increases provider workloads and DHS workloads.

Q: For BHF eligibility - what if the application processing for MA takes a long time to process & the 60 days lapses?

Q: I have worked with folks who are on Medicare or a parent's commercial plan yet qualify for the BHF which used to be a year. This allowed them to access treatment services. With this change, will there now be no option for those folks?

Q: Is it just one 60-day period for BHF per year? Wondering about folks who start with BHF, obtain insurance then lose it that same year, then re-seek services.

Q: How will the State notify the County of residents who are approved or not approved for BHF? So much of the work we do here at the county is helping clients with treatment coordination, placement, handholding etc. Since the State will be determining eligibility, we at the counties will not know who is eligible and who needs our services. I'm concerned about all the Minnesota residents who need help once they gain BHF or are not eligible and still need coordination/navigation services.

Q: With the change of no longer sending BHF applications to the counties, where will we send them? Do you anticipate a longer turnaround time?

Q: BHF eligibility is 60 consecutive calendar days - what if a client needs programming for more than 60 days?

Q: So, who is the one who would advocate for the extension of the BHF? The provider providing the services at that time?

Q: Why would we need to apply for an extension for person eligibility for BHF and not for MA. Why wouldn't "extension" be automatic?

Q: A person could be on MA for 6mo then lose it because they are unable to work 20 hours a week?

Q: When is DHS taking over entering BHF?

Q: Will DHS offer staff to help individuals to complete the BHF applications in the community?

Q: How will county of financial responsibility be determined when BHF requests go to DHS rather than counties? Addresses are not always correct at time of application or excluded time services may apply.

Q: I believe it will be very important to have plans in place for the BHF changes because MA verification is also changing. As we have all seen, with even the 12-month eligibility without verification folks were losing their MA. It is changing to every 6 months needing verification. How

many staff will be managing the BHF applications? If an extension is needed who submits for an extension? Will they still be eligible for Tx Coordination through their county of residence?

Q: What about persons who are incarcerated for more than 60 days and attending treatment in jail? The BHF is the only fund available for them.

Q: Once day 1 of services starts, that starts the 60-day clock, regardless of weekends, days not receiving services, correct?

Q: If a client gets 45 days of service with one provider, the client leaves and readmits somewhere else, how would the second provider know they only have 15 days of service eligible?

DHS's Behavioral Health Administration (BHA) will begin reviewing Behavioral Health Fund (BHF) eligibility applications starting July 1, 2026. We recognize the concerns around workload, turnaround times and coordination with counties and providers and are actively working to streamline processes and ensure timely determinations.

All BHF applications will be submitted to one central location managed by BHA. While counties will no longer process applications, we are developing systems to keep them informed of eligibility decisions and payments to support coordination and client navigation. Our goal is to process applications as quickly as possible and align with existing DHS eligibility processes, though specific timelines are still being finalized.

BHF eligibility will generally provide 60 consecutive days of coverage per year, beginning on the date of request. However, extensions will be allowed in certain situations, such as delays in Medical Assistance (MA) processing, incarceration or other special circumstances. Providers, individuals or those supporting clients may request extensions once the process is finalized.

The intent of this change is to ensure individuals transition to more comprehensive health coverage, like MA, whenever possible. If MA processing delays occur or someone loses insurance mid-year, DHS is exploring options for additional eligibility periods or extensions. Individuals on BHF or MA will remain eligible for treatment coordination through their county of residence.

For clients transitioning between providers, the handling of "remaining days" within the 60-day period is still under review and will be clarified during implementation planning. DHS will continue collaborating with county partners, providers, and Tribal nations to address operational details and support smooth implementation.

Rates

Q: No rate increase for outpatient treatment centers?

A. The only outpatient treatment service rate change included in the changes effective January 1, 2026, is an increase for treatment coordination. The rates for the new outpatient billing codes and treatment services to be effective July 1, 2026, or upon federal approval, are not yet determined.

Q: Is the co- occurring rate enhancement being discontinued?

A. No, the co-occurring rate enhancement was not discontinued in this legislative session.

Q: For low intensity residential treatment moment what are the clinical hours requirements as of Jan. 1? Currently there is a 5- and 15-hour level and rate.

A. The requirements for hours per week in residential programs did not change this session. According to section 254B.19, subdivision 1, clause (5), ASAM level of care 3.1 programs must provide at least 5 hours of skilled treatment services per week. Effective January 1, 2026, or upon federal approval, the rate for low-intensity residential services will increase to $216.90 per day. However, the legislation does not include a separate rate change for low-intensity residential programs that provide 15 or more hours of skilled treatment services each week.

Q: Does the annual cost of living increase that will start in 2027 apply to all SUD programs or only residential?

A. The annual payment rate adjustment referenced in statute 254B.05, subd. 6, paragraph (b) (Special Session 2026 Law, Chapter 9, Article 4, Sec. 34) was not intended to be limited to residential SUD services. DHS hopes this will be clarified in the upcoming legislative session, and will provide additional information when available.

Q: Can you share more on the modeled rates and the approved percentages for non-residential services and what we can expect those rates to look like?

A. The modeled rates are identified in the Minnesota Health Care Programs Fee for Service Outpatient Rate Study. The legislation in statute 254B.05, subd. 6, paragraph (a), for rate changes based on the modeled rates, included increasing treatment coordination to the modeled rate effective January 1, 2026, or upon federal approval, but did not include an increase for any other non-residential services rates. There will be new codes and rates for non-residential services effective July 1, 2026, or upon federal approval; however, those rates are not yet determined.

Q: For the auto inflation piece, the rate study did not include an analysis for adolescent residential and non-residential. Does this mean that those rates would be excluded from an auto inflation adjustment? Is there a plan to evaluate the adolescent rates soon?

A. It is not clear at this time which SUD payment rates will be adjusted annually based on statute 254B.05, subd. 6, paragraph (b) (Special Session 2026 Law, Chapter 9, Article 4, Sec. 34). DHS hopes this will be clarified in the upcoming legislative session. In addition, DHS is considering conducting additional rate studies as we examine how Minnesota will align with “ASAM Criteria, 4th Edition.”

Q: For FQHC, will the alcohol and or drug assessment codes like 99408 and 99409 be considered a qualifying visit or still bill with mental health codes?

A. Please reach out to the MHCP Provider Resource Center for this question.

Q: What will the rates be for the new service codes? Or will they be the same as group and individual?

A. The rates for the 6 new billing codes for non-residential treatment services have not yet been determined. Communication will be issued when available.

Q: Is it possible for rates to decrease if inflation trends down?
A. It is not the intent for the State to decrease rates, however this is not currently specified in law. We are looking into this further.

Q: Are rate enhancements eligible for inflation adjustment?
A. Although the legislation only specifically referred to the base rates, it is DHS's understanding that the enhancement rates will also likley increase proportionately. Additional information will be communicated when available.

Staffing and Services

Q: Can BHP facilitate groups?

A. Effective July 1, 2026, or upon federal approval, whichever is later, behavioral health practitioners may provide recovery support services either individually or in a group setting. Qualifications of behavioral health practitioners and the description of recovery support services are included in the Substance Use Disorder Services legislative side-by-side.

Q: For recovery support services, does this qualify as peer support? MN DHS has unique scope of practice and licensing that I would really appreciate some assistance on if there is a good contact for me. Please and thank you.

A. No, recovery support services and peer recovery support services are separate and distinct. They are both included under "Ancillary Services" in the changes to section 245G.07, Subd. 2a, which will be effective July 1, 2026, or upon federal approval, whichever is later:

Subd. 2a. Ancillary treatment service. (a) A license holder may provide ancillary services in addition to the hours of psychosocial treatment services identified in section 254B.19 for the ASAM level of care provided to the client. (b) A license holder may provide the following ancillary treatment services as a part of the client's individual treatment:
(1) recovery support services provided individually or in a group setting, that include:
(i) supporting clients in restoring daily living skills, such as health and health care navigation and self-care to enhance personal well-being;
(ii) providing resources and assistance to help clients restore life skills, including effective parenting, financial management, pro-social behavior, education, employment, and nutrition;
(iii) assisting clients in restoring daily functioning and routines affected by substance use and supporting them in developing skills for successful community integration; and
(iv) helping clients respond to or avoid triggers that threaten their community stability, assisting the

client in identifying potential crises and developing a plan to address them, and providing support to restore the client's stability and functioning; and
(2) peer recovery support services provided according to sections 254B.05, subdivision 5, and 254B.052.

Q: What about the portion it talks about with PRS for the individual recovery plan. Is that for PRS or is that for the "Recovery Support Services"?

A. Individual recovery plans are described in section 254B.052 for peer recovery support services provided by a recovery community organization or county. Effective July 1, 2026, or upon federal approval, recovery support services can be provided in substance use disorder programs when included in the client's individual treatment plan. The description of recovery support services and the qualifications for who can provide these services and are included in the Substance Use Disorder Services side-by-side legislative table found here.

Q: What are the distinguishing qualifications of a Behavioral Health Practitioner in contrast on the one had to a Licensed Professional and on the other hand to a Peer Recovery Support Specialist?

A. The qualifications and scopes of practice for behavioral health practitioners and recovery peers are quite different. The qualifications for behavioral health practitioners, effective July 1, 2026, or upon federal approval, are the same as the current qualifications for mental health practitioner in section 245I.04, subdivision 4. The qualifications for recovery peers are in section 245G.11, subdivision 8, and also in section 245I.04, subdivision 18. The qualifications of a licensed professional depend on the type of license; however, the qualifications for behavioral health practitioners do not include holding a professional license.

Q: Can you provide clarification on whether the services provided by Behavioral Health Practitioner are considered to be "skilled" services in a residential setting and billable in an outpatient setting?

A. Effective July 1, 2026, or upon federal approval, whichever is later, the treatment services requirements for each ASAM level of care in section 254B.19 will change from "skilled treatment services" to "psychosocial treatment services", which includes counseling and education. Recovery support services, which are the services behavioral health practitioners will be able to provide, are not included under psychosocial services and do not count towards the amounts of psychosocial services indicated. In outpatient programs, recovery support services will be able to be provided and billed in addition to the psychosocial services. Residential programs receive a per diem and are not able to bill for services separately. Behavioral health practitioners are not qualified to provide treatment services until July 1, 2026, or upon federal approval, so they cannot provide skilled treatment services currently.

Q: Who can provide a recovery support service?

A. Effective July 1, 2026, or upon federal approval, whichever is later, recovery support services may be provided by a behavioral health practitioner. The description of recovery support services and qualifications of behavioral health practitioners and are included in the Substance Use Disorder Services legislative side-by-side.

Q: It used to be that a qualified professional was prohibited from simultaneously having that role at the same period as acting in a peer recovery support role (even if the roles were with different clients). Is that still the case with the inclusion of behavioral health professionals in this session?

A. The scope of practice and qualifications of recovery peers and behavioral health professionals are quite different and the roles should be considered distinct. Substance use disorder treatment programs that may employee both recovery peers and behavioral health professionals should have policies on dual roles. Peer recovery specialists should consult their certification board and program policies regarding dual roles. The Code of Ethical Conduct for Peer Recovery Specialists from the Minnesota Certification Board includes the following principle: "I will not enter into dual relationships/boundary issues or commitments that conflict with the interests of individuals that I serve. This applies to both in person and electronic/social media interactions or relationships."

Q: Is there some consideration of expanding scope of practice for LADC 's where capable?

A. DHS does not have oversight of the scope of practice of LADCs. This question can be directed to the Board of Behavioral Health and Therapy: bbht.board@state.mn.us

Q: Does treatment coordination require client presence?

A. Treatment coordination does not have to be provided face-to-face with the client.

Q: Is the psychoeducation code supposed to be used for non-psychotherapeutic services? Or would it still be considered psychotherapeutic?

A. Separate billing codes for counseling and psychoeducation will be effective July 1, 2026, or upon federal approval. The psychoeducation code will be used for psychoeducation services described in section 245G.07, subdivision 1a, added by Chapter 9, Article 4, Section 12. The term "psychotherapeutic" is not used in that description. The revised treatment services descriptions can be found in the Substance Use Disorder Services legislative side-by-side. You may also email sud.direct.access.dhs@state.mn.us if additional clarification is needed on this information.

Q: For the 12 hours of co-occurring training to complete the comprehensive assessment, will DHS provide clarification on what training(s) will meet this requirement?

A. To clarify, the new qualifications for who can provide a comprehensive assessment reference 12 hours of training in substance use disorder and treatment, not 12 hours of co-occurring training. The statute language is:
(b) A comprehensive assessment must be administered by:
(1) an alcohol and drug counselor;
(2) a mental health professional who meets the qualifications under section 245I.04, subdivision 2, practices within the scope of their professional licensure, and has at least 12 hours of training in substance use disorder and treatment;
(3) a clinical trainee who meets the qualifications under section 245I.04, subdivision 6, practicing under the supervision of a mental health professional who meets the requirements of clause (2); or

(4) an advanced practice registered nurse as defined in section 148.171, subdivision 3, who practices within the scope of their professional licensure and has at least 12 hours of training in substance use disorder and treatment.

DHS does not have any additional requirements on a specific training that must be done for this. If you have additional questions about a specific training, you can contact either sud.direct.access.dhs@state.mn.us or dhs.mhcdlicensing@state.mn.us .

Q: What is considered training for the changes of who can admin a comp assessment?

A. No additional training is required for alcohol and drug counselors to administer comprehensive assessments. See previous answer regarding qualifications, including training, for others who can provide assessments.

Side-by-side legislative tables

Q: Link for the Side-by-Side table please?

A. The side-by-side legislative tables can be found on the Substance Use Disorder Reform web page under the Legislative section.

Q: Can you make a table by the dates of the changes? In other words, organize the changes by effective date, rather than by statute position?

A. The side-by-side legislative tables have already been posted for this year, but we will keep this suggestion in mind for next year.

Other

Q: In Chapter 38, article 5, the definition of 'patient' here is not consistent with federal confidentiality definition. For what purpose does the definition here apply?

A. The change in Chapter 38, article 5, section 4 applies to the definition of "patient" under section 144.651, which is the Health Care Bill of Rights. The change means that patients, according to that definition, have the rights identified in that section. It also means that 245G license holders must include the rights from that section when complying with the requirements in section 245G.15, subdivision 1.

Anti-Kickback Statute

The Department of Human Services is not able to provide responses to the questions below due to them being hypothetical in nature and organizations should seek legal advice if they have questions.

1) DHS now has the authority to take an action when it is determined the provider has provided a 'kickback' resulting in the misuse of Medicaid funds
2) Because this is now also a crime, DHS must refer any evidence of a crime to the Medicaid Fraud Control Unit for possible criminal investigation and charging
3) Each provider is responsible for understanding whether their current practices meet the definition of a kickback – OIG cannot provide legal advice on this determination.

Additionally, if you want to report any of concerns to OIG, please email oig.investigations@state.mn.us.

Q: Can programs take clients to a community outing and not violate AKS? Some examples include meals, activities in the community, etc.

Q: How will contingency management be handled?

- **Buying lunch for indigent person, not currently a client?**
- **Are there any 'safe harbor' protections?**
- **The anticipated impact of enforcing clear state guidance on anti-kickback regulations?**

Q: There are many questions and changes in the federal per person, per year level of value that exceed the maximum assumed not to be a kick-back. What are the federal standards right now? Are there any specific state standards?

Licensing

Thank you for the questions related to Licensing. The Licensing Division's 2025 Legislative Updates presentation will address many of these questions and is planned to occur near the end of September or early October in a separate meeting from Thursday Connections. Please have your authorized agent be on the look out for more communications. If you have immediate questions, feel free to contact your licensor or email the general email box: dhs.mhcdlicensing@state.mn.us.

Q: Can you speak to the annual license renewal fees and what is meant by "capacity served"?

Q: In addition to the questions MARRCH already sent in, here's a couple more about the changes to licensing fees: For non-residential programs, how would low intensity clients be factored into total capacity? A program could easily have scores of low intense clients that have infrequent billing month over month. The new $20,000 fee for a non-residential program could easily be hit when counting these clients.

Q: When a program wants to increase capacity during the year, do they have to pay for the higher capacity? If a program reduces capacity during the year, will the overpayment for the fee be reimbursed on a pro-rated basis?

Q: $20,000 fee?!

Q: 245A.10 subd 4 The annual license fee increase amount is based on capacity: is the capacity clients per clinic license or total capacity (if multiple clinics) of all clinics combined? ex: 10 OP clinics with 245G license. is it a fee per clinic or total of 10 clinics capacity?

Q: The table listed is for residential and non-residential combined. If a program has both services under the one license, they will need to total the client capacity for the fee tier. The licensed capacity is based on the max number of clients at a point in time, correct? For example, a non-residential program that has two 16-client tracts would have a capacity of 32.

Q: Licensing moratorium—if an agency has a new licensing application in process when a moratorium is declared, is that in-process license still processed, or does it just stop mid-process? If a moratorium is placed, would that just impact any new applications? Concern about provider rights in this process.

Q: Will that then lift moratoriums across the state?