Thursday Connections Q&A November 2025

Billing and Treatment Services:

Q: What is the current Low intensity 15 hr. minimum rate?

A: ASAM 3.1 Low intensity Residential (Minimum 15 hrs. per wk., also known as “medium intensity”) is $171.11 per day

Q: What impact on available services and billing does DHS expect from rate for 15+hours being substantially less than rate for 5+hours?

A: This is part of moving away from the "Medium Intensity" which is not part of ASAM. We are hoping with the rate changes to ASAM 3.5 and ASAM 3.1 (Low - 5 hours) that we will have a better continuum for those needing low intensity services.

Q: Please repeat the revised 3.5 and 3.1 rates

A: ASAM 3.5 = $294.67 per day (Daily skilled treatment service); ASAM 3.1 (minimum 5 hours per week) = $216.90 per day

Q: When room and board is removed as a category for residential, how does this affect total billable revenue per client day served?

A: Room and board will still be billable, it just won’t be listed as a “treatment service” in 245G.07 (because it is a component of residential treatment, not actually a treatment service)

Q: Am I understanding correctly that Co-occurring will no longer be an add on service that we can provide and bill for starting 7/1/2026?

A: Co-occurring will still be an option as an enhanced rate in for programs meeting the requirements identified in Minnesota Statutes 254B.0507, subdivision 6. All programs are expected to be ”co-occurring capable” and address co-occurring issues as needed within the treatment services provided as identified in Minnesota Statutes 245G.20.

Q: Will supportive services by behavioral health practitioners qualify as a skilled service that contributes to required programming hours?

A: No, recovery support services by behavioral health practitioners will not count toward the required treatment hours for the ASAM levels of care. As a reminder, behavioral health practitioners cannot provide services until July 1, 2026, or upon federal approval (whichever is later). At that time, pending federal approval, the required treatment hours for ASAM levels of care will be based on “psychosocial services“ as defined in Minnesota Statutes 245G.07, subd 1a, which does not include recovery support services.

Q: Will residentials need to have the U8 modifier as well?

A: There will not be any changes to residential billing procedures.

Q: For the new non-residential rates, will DHS propose new rates, based off modeled rates in the study? I was anticipating the hourly rate would be divided by 4 to determine the new 15-minute rate. It would be a great step to move towards the modeled rates for individual, group, PRS, and assessments.

A: Because there is currently one rate for all "individual treatment" and one rate for all "group treatment", and each of those will be split into three separate services (counseling, psychoeducation, and recovery support services), the rates for the 15-minute units won't all be a direct translation (meaning, the rate for 1 hour divided by 4). The rates are being determined based on the type of service and the level of qualifications to provide that service. No rate changes for peer recovery or comprehensive assessments have been proposed at this time.

Q: On the nonresidential service type change, I understand the need for billing in 15 min increments. However, it will be really hard to differentiate between education and therapy, since most groups are a combination of the 2. Hopefully we aren't required to do multiple group notes for the same group when you go back and forth between education and therapy? Too much to keep track of.

A: Providers will need to examine the descriptions of the treatment service types in 245G.07 and identify how to differentiate between the two services. Counseling and psychoeducation will have different billing codes and different rates, so they cannot be provided simultaneously / billed together. In addition, although there is currently only one billing option for "group treatment", there are current requirements in 245G for programs to differentiate between types of treatment services, including counseling and education, in their policies, procedures, and documentation:

- 245G.12, (10): [policy manual must include] a description of treatment services that: (i) includes the amount and type of services provided; (ii) identifies which services meet the definition of group counseling under section 245G.01, subdivision 13a;
- 245G.10, subd. 4: Group counseling shall not exceed 16 clients.
- 245G.06: Subd. 2a. 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 each treatment service provided to a client and the client's response to each treatment service within seven days of providing the treatment service.
- Keep in mind that "group" can be the format of the service but is not the type of treatment service. The types are counseling, education, treatment coordination, peer recovery, etc.
- If one staff person provides more than one type of treatment to a client in a day, that staff person can document the services together in a single note; however, the documentation must distinguish between the different types of services provided and document each one with the amount and the client response to that service.

If you have additional questions about differentiating between counseling and psychoeducation, please contact either DHS Licensing at dhs.mhcdlicensing@staste.mn.us or the BHA SUD Policy team at SUD.Direct.Access.DHS@state.mn.us

Q: Is it fair to say that 'medium' intensity can be billed as 'low' intensity, as the 5+ hours per week requirement has been met?

A: ASAM 3.1 programs that provide at least 15 hours of skilled treatment services per week may choose to bill using the value/procedure codes associated with either a minimum of 5 hours per week or a minimum of 15 hours per week. Only claims submitted with codes for low intensity (at least five hours per week) will receive the new rate of $216.90 per day.

C: For determining the new non-residential rates, please include stakeholders while developing rates, before they get posted for public comment.

ASAM:

Q: Do we have a guesstimate of when ASAM 4 will make it into legislation?

A: Very much dependent on legislation however, aiming for the 2027 session

Q: Regarding the 1115 SUD waiver extension (e-memo #25-21), it's another one-month extension through the end of November. Are there concerns being raised by CMS? Was this short-term extension due to the federal shutdown? What happens if CMS doesn't approve this 1115 extension??

A: We have another temporary extension through 3/31/26 (e-Memo #25-32). CMS has been looking closely at all states' budget neutrality, including Minnesota. We remain in close communication with CMS and this latest extension was lengthened to provide ample time for them to gather any further information. Our Federal Relations team is not worried that CMS will not grant approval. If the waiver is not extended, there would be a period of at least 18 months to operationally end the waiver. Additionally, if the waiver is not extended, Minnesota would no longer have the IMD (Institute for Mental Disease) exclusion waived, which would result in decreased Federal Financial Participation covering SUD IMD stays.

1115 Re-entry:

Q: Is this already active?

A: No, Minnesota submitted our application in 1/25, it is pending CMS review.

Q: Does the 1115 waiver apply to jails and prisons?

A: When the implementation and reinvestment plans are approved by CMS, the waiver will apply to the demonstration sites as they are able to meet CMS readiness requirements. Current legislation allows the demonstration to include 3 Department of Corrections (DOC) Sites, one of which must be MCF-Shakopee and 4 county jail and 1 tribal jail (being determined by the request for proposal process).

Q: What is the relationship between the 3 entities and the 5 jails?

A: There is no relationship currently between the 3 DOC sites and 5 county/tribal jails as that decision is still in process.

Q: Does this apply to adolescents?

A: The 1115 Reentry Waiver excludes adolescents as they are covered under the Consolidated Appropriations Act (CAA) of 2023. The CAA requires states to provide specific Medicaid-financed services to eligible incarcerated youth within the period immediately surrounding their release.

Q: Are the jails within the 3 districts?

A: The location of jails for participation in the waiver demonstration has not yet been determined.

PMAP and Other Insurance Billing:

Q: Will also need details if they are to be sent on UB04 or CMS1500

A: CMS-1500 are for Professional claims used for outpatient services and office type visits, UB04 are Institutional claims used for inpatient and hospital settings.

Q: Will Medica PMAP still be able to require a per diem rate for IOP that has been incredibly unfair to providers after 7/1/2026?

A: Possibly, the MCOs do have the ability to determine if additional benefits and/or alternative services are cost effective and medical necessary to meet the needs of their members.

Q: There has been a huge increase in COB issues with MN MA and MCOs both providing inconsistent information. DHS just tells us to call the MCO and deal with them and MCO says that there is nothing we can do. I have not been able to get in touch with anyone for years at the DHS MCO department, does this department still exist?

A: If this is concerning members who are covered under MinnesotaCare and MA for a short time during a change in circumstances, there is some direction on that in the provider manual here: Billing Policy Overview.

Q: Medica just sent out on 11/19/2025 that starting 1/1/2026 that in accordance with Minnesota law is Medica receives claims for services provided to a member, but we did not receive a prior authorization request prior to services being rendered that Medica will request medical records or the claim will be denied. This will cause issues with direct access clients as we cannot request prior authorizations until we have a completed assessment done which we have 5 days after the intake day to complete. This will increase the administrative burden for both MCOs and providers as we will have to provide documentation twice and will expect delays on claim payments for all direct access clients. Medica is the only one who I have seen say this so far. Are they misinterpreting MN law or is this something we should be expecting from all providers where PA is needed? I am not sure how this law will improve client care since if services require PA (which we need to send medical records for) and we do not get one the claims will deny anyways which makes this law seem a little senseless and only increases administrative burden for providers and MCOs.

A: MCOs have the discretion to determine which services require prior authorization or referrals, unless otherwise mandated by statute or contract, and providers should follow the processes indicated. If you are able to provide a copy of the notice or a link to SUD.Direct.Access.DHS@state.mn.us that would helpful for our awareness.

Q: Does State contract with PMAPs allow the PMAP contract with providers to set different times for rate changes than BHF timing?

A: Provider contracts often include set rates for specific services, which are negotiated directly between the provider and the MCO. MCOs are not required to automatically update these contracts when DHS changes rates. For example, UCare had a process that allows providers to submit DHS rate changes for review, after which they typically updated the contract rates accordingly. Other MCOs, however, may require providers to initiate a contract amendment to reflect new rates. In cases where a service is reimbursed at the “going rate,” MCOs align their reimbursement with DHS’s published rates. MCOs are only required to match our fee for service rates if mandated by directed payment language in statute/contract.

Additional Information:

Q: It looks as though the web page was not updated for Oct. Does it take a while for the information session to be uploaded on the website?

A: The PowerPoint presentation from the Oct. 16 Thursday Connections is posted. The goal is to post information within one month, however, there are sometimes delays.

RSVP links for Community of Practice

SUD Community of Practice webpage link

MN Sober Home Scan Survey