DEPARTMENT OF HUMAN SERVICES

Thursday Connections with SUD at DHS

Questions & Answers from July 16, 2026 Meeting

Compiled from the meeting chat log, presentation slides, and meeting transcript.
Please note that some of the repetitive questions from the session have been combined into same/similar questions to help keep the questions and responses more concise.

Table of Contents

Meeting Logistics & General Questions

Q: When will the slide deck be available to everyone for review later? / When and where can we view the slide show again?

A: Once updated, the slide deck will be posted to the Thursday Connections with SUD at DHS webpage.

Q: It would be great to have more notice than the week-of if a session is going to be an extended (two-hour) session.

A: DHS will try to know by the very beginning of August whether the next session needs to run two hours and will let attendees know as soon as possible. The August 20th session is currently planned as one hour.

Q: Is there still a plan for licensing fees to go up in 2027 for SUD providers?

A: Questions about licensing fees can be directed to DHS licensing at dhs.mhcdlicensing@state.mn.us.

Q: Is this meeting being recorded, and will attendees be able to watch a recording afterward?

A: Yes, meetings are recorded, but only for internal notetaking purposes — to help us ensure the FAQ document and follow-up responses are accurate. Recordings are not routinely posted or distributed. If a recording is requested, it can be made available, but please note it may take considerable time to prepare the video for public release. The PowerPoint slides and Q&A document will continue to be posted to the Thursday Connections website after each meeting as the primary resources for attendees.

Behavioral Health Fund (BHF) Eligibility Transition

BHF Process, Portal & Timelines

Q: Did anyone mention when we can expect the BHF portal to be up and running?

A: The BHF online submission portal is live and has been in active use since the July 1, 2026, transition, with over 2,000 submissions as of mid-August. As of August 13, 2026, the portal requires a document attachment to submit and offers an optional applicant email field for confirmation. Applications can also still be submitted by U.S. Mail. The online application tool is expected to be live in the next 60 days.

Q: Is there a phone number to contact for BHF follow-up questions (e.g., on applications sent in that have not been processed)?

A: At this time, there is no phone number for the BHF eligibility team, but we will consider this in the coming months. Please review the DHS webpage Need help paying for substance use disorder treatment? or send questions to DHS.BHF@state.mn.us. Be sure to encrypt the message if you include any Protected Health Information and include ROI if you are not listed as secondary contact on the application. Please wait at least seven business days after a portal submission (14 business days for mailed applications) before emailing to check status.

Q: Now that DHS is processing BHF applications, are any tribes still doing their own BHF applications?

A: There are no Tribes currently processing their own BHF eligibility determinations.

Q: How far behind are approval/denial notifications currently running?

A: At the time of this Thursday connections, spans were being entered in MMIS within 5 business days, with the day application was received being day "0". Spans for approved applications (with no technology issues) are viewable by those with MN-Its access by the sixthbusiness day after submission. Notifications are lagging due to the significant number of submissions and manual nature of the process (until our platform is fully developed for BHF purposes). As of August 17, notices are being sent out around business day seven.

Q: What does "covers 100% of treatment cost" mean if a third-party payer has a deductible but covers all costs after that is met?

A: For applicants with active BHF spans: after the third-party payor has paid, the remaining amount (including co-pays and deductibles) can be submitted to DHS for reimbursement by the Behavioral Health Fund. Please reach out to the MHCP Provider Resource Center for questions about how to request reimbursement for individuals with third party payors and BHF eligibility.

Q: We submitted a BHF application on July 1 and have not heard back on eligibility. Is this delay expected, and does the five-day review window mean the eligibility span itself opens once approved, or just that DHS has issued a decision (with the span opening separately after)?

A: Eligibility spans can be dated in past or future and are not dependent on when the application determination occurred. Page 12 of the application asks for the preferred BHF span start date. If this is blank, DHS is defaulting to the date the application was signed. Applicants can contact BHF eligibility team to request a change in span start date. Send an email to dhs.bhf@state.mn.us with subject line "CHANGE REQUEST: BHF span date". Notices are sent to the applicant (if either an email or mailing address was provided on the application), the Tribe/county of financial responsibility and any secondary contact listed on the application. All applications received in July have been processed with notices sent to the parties named above. If you have questions about the status of an application that was submitted greater than 10 days ago, please email dhs.bhf@state.mn.us .

Q: Can someone without a Social Security number still receive BHF?

A: Yes.

Q: Once the online BHF application is available, will the option to upload documents remain available for clients who still submit a paper application?

A: Once the online tool is available, applicants will continue to be able to submit a PDF electronically using the portal or submit a paper document by mail.

Q: Would BHF eligibility be possible if a client has a PMAP, is recommended for further services and the PMAP denies those services?

A: Applicants with active Medical Assistance are not eligible for the Behavioral Health Fund.

Q: If a client's eligibility status is showing incorrectly in MNITS (for example, changed from straight MA to IM-only) and the county has not corrected it, what should we do?

A: Any concerns with Medical Assistance status should be directed to the county.

Incarcerated Individuals & BHF

Q: How will incarcerated individuals be notified about their BHF eligibility, especially if they don't have a mailing address or email?

A: They would be notified through the methods of contact they provide (email or mailing address indicated on the application) for DHS to send BHF eligibility information, plus any third-party contact they include and the county or tribal nation of financial responsibility will also be notified. If an applicant does not have a mailing address or access to an email address, a third-party contact is then necessary to provide the notice.

Q: If an incarcerated individual and their spouse live separately, does the spouse's income count toward BHF eligibility?

- **A:** See the household income calculator for guidance.
    - **Adults:** Count the combined income of all members of your household (yourself, your spouse, your minor-aged children and your spouse's minor-aged children living in the same home/dwelling)
    - **Minors:** Count the combined income of your household members, excluding your own income (count income of your parents and minor-aged siblings living in the same home/dwelling)
    - **Minors Giving Effective Consent:** Count only your own income.

Q: We were told that incarcerated individuals' MA would remain active even after they qualify for BHF, and that their PMAP would become inactive instead. Is that correct?

A: BHF eligibility criteria states that an applicant cannot be actively enrolled on Medical Assistance (MA). During incarceration, eligibility for MA is suspended, which allows an applicant to be eligible for BHF. Counties (and tribal nations) process MA changes, such as suspension during incarceration, but the process varies by entity. MA must be suspended (inactive) for BHF to cover services as primary payment source during the incarceration period.

Q: If an incarcerated client's MA has not yet been cancelled in the system even though it's expected to be, should we report that they currently have MA? Should an incarcerated client who has MA/PMAP still submit a BHF application, or is there a different process?

A: Yes, they should still submit a BHF application. DHS can approve an applicant with active MA if the individual reports being incarcerated during the dates requested for BHF span. The county or tribal nation will be notified and provided with the application listing living arrangement (LA) as a correctional setting, allowing that entity to make appropriate changes. The provider may verify in MN-ITS that LA has been updated and MA suspended before submitting claims for BHF reimbursement or contact the county or tribe to inquire about this process.

Q: Would an incarcerated person extradited to Minnesota from another state, who reports plans to make Minnesota their home, qualify for BHF?

A: BHF eligibility criteria require applicants be residents of Minnesota, as defined by MHCP. Please review MHCP's definition of State Residency by clicking here: 1.4 MHCP State Residency.

Living Arrangement (LA) Updates

Q: Is there a comprehensive list of county contacts for living arrangement (LA) changes, especially for incarcerated individuals?

A: DHS shared this contact list as a starting point, noting it was originally compiled for BHF contacts and may not be fully current: DHS-5685A-ENG contact list. DHS is still working on ensuring we have the best contact for every county.

Q: If a BHF request is only to update a living arrangement (LA) for someone who already has an open eligibility span (for example, due to incarceration), who initiates that update, DHS or the provider, and is a new BHF request needed at all?

A: Applications for BHF eligibility should only be made if the applicant is seeking eligibility for new BHF span. Please direct all other requests for changes in Living Arrangement (LA) changes to the tribal nation or county of financial responsibility (CFR). DHS does not process requests for changes in LA status.

Q: Is DHS contacting the county directly when a living arrangement change is needed along with a BHF application?

A: DHS provides BHF applications containing LA and TPL update information to the tribal nation or county of financial responsibility (CFR) as part of our notification of eligibility determination.

Audits, Verification & Funds Recovery

Q: If a client is homeless and is selected for a BHF audit, how do they prove they are homeless?

A: There is no need to prove homelessness. Audit requests only require income documentation (or signed statement that there is no income) and list of household members.

Q: If someone is audited for BHF and denied after funds have already been used, is the "funds recovery" process used to recoup funds from the client or from the agency?

A: Under current policy, the approved BHF eligibility span is not impacted by the audit status or outcome. However, the applicant will not be eligible for any future BHF eligibility spans if they fail to respond to the audit request or are found to have provided false information. After the audit form 2780D and applicable documentation is submitted, and if approved, the individual is then eligible to apply for additional BHF eligibility spans.

Q: Where are BHF audit notifications sent for clients who are unhoused or incarcerated, and how will a provider know if a client selected for audit did not submit the required verification?

A: Audit requests are sent as part of BHF eligibility notifications to tribe or county of financial responsibility and contact methods listed in the BHF application for applicants and secondary contacts. Applicants are asked to provide an email and/or mailing address for themselves and an optional secondary contact. For individuals who are unhoused or incarcerated, including a secondary contact is key to ensuring they are notified of determination. These applicants could also consider voluntarily completing and submitting the Audit Documentation Request (form 27080D) as part of their initial BHF application submission. If the applicant is audited and the form is sufficient, then additional follow up would not be required.

If an applicant does not receive the audit request, it will not affect the current BHF span. Upon submitting another BHF eligibility application request, they will be notified of the need to complete the audit before the new application can be reviewed.

SUD Treatment Services & Outpatient Procedure Code Changes (August 1, 2026)

Treatment Services

Q: Most of our clientele have relationship problems. Why has relationship counseling been repealed? What replaces it at DHS?

A: Relationship counseling may fall under the general counseling treatment service type. An individual counseling session can potentially include a client and the client's family member or significant other, if the client wants that and it is within the provider's scope of practice.

Q: Is a guest speaker considered psychoeducation or counseling?

A: It depends on the type of service being provided. Guest speakers may present information as part of a treatment service provided by an alcohol and drug counselor. A program's treatment services description must identify which groups can include a guest speaker (which identifies the service type) and what topics may be presented, per Minnesota Statutes 245G.07, subd. 3a. Although the statute does not specify the types of treatment services which may include a guest speaker, presentation of information is consistent with the description of psychoeducation effective August 1, 2026. Please contact the SUD Policy and Reform team at sud.direct.access.dhs@state.mn.us and the DHS Licensing team at dhs.mhcdlicensing@state.mn.us to discuss the possibility of using a guest speaker for a treatment service besides psychoeducation.

Q: Can you define "individual psychoeducation" and how is it used?

A: Individual psychoeducation is education delivered one-on-one rather than in a group. It may be used, for example, if a client needs education specific to a substance that isn't commonly encountered. It may also be more appropriate depending on a client's stage of change: psychoeducation can be more effective for clients in a pre-contemplative stage, while counseling may be more appropriate for clients in a preparation or action stage.

Q: Do we have to offer both group counseling and group psychoeducation as part of programming or can we offer just group counseling? If a program is required to offer both counseling and psychoeducation, is it required that every client engage in both? Is there a specific amount or ratio of psychoeducation versus counseling required?

A: Both counseling and psychoeducation are required treatment service types. Per 245G.07, a licensed program must offer these services to each client unless clinically inappropriate and the justifying clinical rationale is documented. The specific amount of each service type provided to a client and whether the service is provided individually or in a group setting must be based on client needs. Each ASAM level of care requires a combined amount of “psychosocial services” (counseling and psychoeducation), as indicated in 254B.19, subdivision 1.

Q: So, a program would not be "dinged" if a client never received a standalone, billable psychoeducation service, as long as the program's policy manual states that Group Counseling may include brief education/resources with the intent to process, interact, etc.? This same program has their psychoeducation service identified as a separate service with the intent to provide education only.

A: It would not be consistent with the description of counseling in section 245G.07 to say counseling includes education. Counseling and psychoeducation are different services. Psychoeducation is required to be provided to a client unless clinically inappropriate and the justifying clinical rationale documented. The treatment program must document in the individual treatment plan the plan to provide the specific services.

Q: [Comment] Reimbursement rates are already low, and requiring psychoeducation as a separate service further reduces reimbursement. Treating it as a separate service also doesn't allow room for exploration (i.e., counseling) when psychoeducation brings up thoughts or feelings a client needs to process.

A: Counseling and education have different therapeutic intents and presentations and address different client needs. Although they have been billed together until now, they have been separate in Minnesota statutes, including in the treatment services descriptions in 245G.07. The rate for each type of service was determined based on qualifications required to provide the service and complexity of the service.

Q: Could you provide psychoeducation while clients are eating their lunch (at home)?

A: Potentially, in an individual setting, if the client is comfortable having food while receiving education. For group education, it is unclear how a treatment service could be provided while the entire group is eating lunch together. 245G.07, subdivision 1, (d) states that a treatment service provided in a group setting must be provided in a

cohesive manner and setting that allows every client receiving the service to interact and receive the same service at the same time.

Q: We do an orientation session where we go through all the program requirements and discuss some of the other things required by DHS, like HIV/AID and ISP. Would this be categorized as psychoeducation or counseling?

A: It depends on which type of service was provided and if the staff person doing orientation is qualified to provide counseling and psychoeducation. The person providing the service needs to review the description of the treatment services in section 245G.07 and compare those to what is done during the orientation session to determine which type of treatment service, if any, is provided.

Q: What are some of the topics for counseling group?

A: The description of counseling is in section 245G.07, subdivision 1a, (1). **Q: How is "behavioral health practitioner" defined?**

A: The behavioral health practitioner qualifications are in 245G.11, subdivision 12.

Q: Can Behavioral Health Practitioner (BHP) services be provided virtually, like treatment coordination, or must they be provided in-person?

A: Recovery support must be provided face-to-face, which can include telehealth if the requirements in 245G.07, subdivision 4, (c). Please see the MHCP Provider Manual for requirements when billing telehealth services.

Q: Could a Behavioral Health Practitioner run a multi-week recovery support group (for example, a 10-week group) if all attending clients have recovery support services in their treatment plan and similar levels of need?

A: Recovery support is an optional treatment service that may be provided either individually or in a group setting if a client has a need for the service to restore daily living ability affected by substance use or develop skills and routines for successful community integration and stability. The way the service is provided, including the amount and frequency of the service, will depend on the individual need of the client. Once the skill or functioning has been restored, the service is no longer medically necessary.

Q: We will not have a recovery support person hired. How can we implement some of the living skills, employment, resume writing, sober fun, etc. into our groups?

A: Recovery support can be provided within an SUD treatment program by someone who meets or exceeds the behavioral health qualifications as long as it is consistent with the program's policies, the person's job description, orientation and scope of practice. Recovery support must be identified and billed as recovery support even when provided by someone who exceeds the behavioral health practitioner qualifications. In addition, it is possible for education to be provided on these topics during a psychoeducation group by someone qualified to provide psychoeducation. Please note that a sober fun activity is not a recovery support treatment service.

Q: Is being inflexible about scheduling patient centered? For example, if a counseling group was scheduled every Monday from 9 to 10 a.m., and psychoeducation from 10 – 11 a.m., if a client in the counseling group needed additional time, does the counselor transition despite the patient need? Both groups are the same people, in the same room, with the same counselor.

A: A treatment services schedule can and should be flexible if needed based on the needs of the client group. For example, a program can do a different treatment service than what is scheduled or extend one scheduled treatment service and shorten the next scheduled treatment service. If just one client has a need for the schedule change, the program could also provide an individual service to that client in place of the scheduled group service, such as having the client attend individual counseling following a group counseling service rather than attending group psychoeducation.

Although the schedule can be flexible, the type of service for each group needs to be consistent with the policy. For example, if your treatment services policy says that "Group Recovery" is scheduled from 9 - 10 a.m. and that it is counseling, the program can't do Group Recovery and say it is psychoeducation that day. You could switch and do a different group that is psychoeducation, though.

Q: Within the treatment services description and policy, there are many services that our programs provide that may fall under psychoeducation or counseling depending on client milieu (sometimes both types with in the same group). To clarify, these services need to fall under the category psychoeducation or counseling - not both?

A: Correct. Counseling and education have different therapeutic intents and presentations and address different client needs. Chapter 245G already requires programs to differentiate between treatment service types in policies, documentation and treatment plans. Although a provider may choose which type of service to provide based on the client milieu, the client milieu does not determine what the treatment service type is. Although counseling and education have been billed together until now, they have been separated in Minnesota statutes, including in the treatment services descriptions in 245G.07 and the LADC core functions in 148F.01, subdivision 10. See the Information on 2026 Changes (PDF) on the SUD Reform website for additional information on the difference between counseling and psychoeducation.

Q: Is there a checklist summarizing the new treatment service and billing changes, and if so, how can providers access it?

A: Information on the treatment services changes and outpatient procedure codes and rates effective for services provided on and after August 1, 2026 can be found in the Information on 2026 Changes (PDF) and the MHCP Provider Manual.

Combining Services and Documentation

Q: When a group combines elements of both psychoeducation and counseling (for example, a brief overview of a topic followed by exploring clients' personal experiences with it), how should it be classified? If we do one group that encompasses both psychoeducation and counseling, would we indicate in the note how many minutes of each and bill the corresponding units? For example, 1 hour group consisting of 15 minutes of psychoeducation and 45 minutes of counseling would be one unit of psychoeducation and 3 units of group counseling? Would it need to be documented in each note, one note for psychoeducation and one note for group counseling?

A: When planning a treatment service, the intent must be to provide one of the treatment service types in 245G.07, provided according to the client's treatment plan. The plan for a single treatment service cannot be a combination of treatment service types. The documentation of a treatment service must identify the type of service it was, and the service must be billed using the corresponding procedure code.

It is possible to provide a psychoeducation group service directly followed by a counseling group service, without a break in between, but they are still two separate treatment services, and the documentation and billing requirements must be met for both services. If the two services are documented on the same form, the documentation must clearly distinguish between what was the counseling service and what was the psychoeducation service, including the amount and client response to that specific service.

The number of units to bill for a treatment service type is based on the total combined minutes of that treatment services type/procedure code that were provided to the client that day. Please see the MHCP Provider Manual for information on Billable Units and Time Requirements

Q: Can the 15-minute unit be the point of separation between services? For example, 15 minutes of education and two hours 45 minutes of therapy in the same session? How does that work if one of the services is psychoeducation and the other is group counseling?

A: There is not a minimum amount of treatment service that must be provided. It is possible to provide 15 minutes of psychoeducation followed by two hours 45 minutes of counseling. However, these are separate treatment services, and they must be billed separately, and the documentation requirements in 245G.06, subdivision 2a must be met for each of the services.

Q: Do we need to split up billing and notes for individual sessions as well, if this type of switch (counseling/psychoeducation, or change in facilitator) occurs?

A: Yes. Individual counseling and individual psychoeducation are different treatment services, and they would each need to meet the documentation requirements in 245G.06, subdivision 2a. In addition, there will be different procedure codes for the different treatment service types effective August 1, 2026.

Q: [Comment] This seems to contradict an earlier statement about switching the type of a group for a change in facilitators.

A: Each treatment service must be documented by the staff person who provided the service, so different facilitators need to document separately. However, billing is combined for each treatment service type (based on procedure code) for the day, even when provided by different facilitators.

Effective Date & MCO/Commercial Billing

Q: Can DHS share the CCBHC communication that was sent out the day of the meeting regarding when these changes will go into effect for us? Not everyone who needed it appears to have received it.

A: DHS sent communication for CCBHCs via email from the general CCBHC team mailbox to CCBHC contacts on file. If you did not receive that or if you have CCBHC specific questions, please email mn_dhs_ccbhc@state.mn.us.

Q: If the statute says, "upon federal approval," how can you move forward without that and will services provided be paid? It was said that this would all begin July 1, or upon federal approval and we all prepared for this for July 1, and then it changed to August 1, because of Federal approval. How do we know that this will not be delayed again?

A: DHS implemented the treatment services changes and new outpatient procedure codes for MA and fee-for-service effective August 1, 2026, for services provided on and after that date. It is expected that federal approval of the state plan amendment will be retroactive to August 1, 2026.

Q: It was said that only new codes [can be used] starting August 1, yet it was also stated that MCOs may not be ready and we would need to check with them. But if they're NOT ready then essentially, we DO need to hold billing to those MCOs.

A: The new procedure codes are effective when billing for MA and fee-for-service for services provided on and after August 1, 2026. Implementation of the new procedure codes by each MCO will be up to the MCO. Please contact the MCO directly for more information on how to bill.

Q: If the commercial insurances and MCO's do not adopt these new codes on August 1, do the billers need to bill MA the new codes and other insurance the old codes? Will state insurance plans accept H2035 after August 1, 2026, if the primary commercial plan requires us to use that code?

A: Providers that are enrolled with MHCP are required to use the new procedure codes to bill MA and fee-for-service for services provided on and after August 1, 2026. Please contact each MCO and commercial insurance provider directly for more information on their procedures.

Q: How would we bill a service with MA as secondary if commercial wants H2035? How can we send the claim to both insurances if they require different codes and units? How does that work with COB if the insurance needs a denial for the same codes before they will be paid? I would assume this is like most billing guidelines where they have to match the primary EOB so they will have to honor the primary payor codes if they are secondary.

A: Please refer to the subsection “Billing Different Procedure Codes to MHCP” in the Medicare & Other Insurance section of the MHCP Provider Manual. You can change the code after billing commercial insurance, but you will need to document the reason for the code change in the members record when billing to secondary. Providers that are enrolled with MHCP are required to use the new procedure codes to bill MA and fee-for-service for services provided on and after August 1, 2026.

Q: Are PMAPS all set with the new codes for August 1? Will MHCP adjudicate claims submitted with the new outpatient SUD codes and 15-minute units on August 1 if CMS approval has not yet been granted? If they are not accepting the new codes, are we still supposed to bill the old codes until they accept them?

A: It will depend. It is best to talk with each MCO as their billing processes and direction may be different.

Q: If DHS is rolling out these code changes but MCOs have their own compliance windows and aren't all switching over at the same time, doesn't that create a lot of billing chaos for facilities in the meantime? Are we expected to just track each MCO's go-live date separately, or is there guidance coming on how to handle claims during that gap?

A: Please contact each MCO directly for more information on the MCO’s implementation date and procedures.

Q: How are we supposed to bill commercial after August 1st?

A: Commercial insurance plans determine their own billing procedures. Providers need to confirm procedures with the commercial insurance.

Q: We were told we'd receive a document that providers could give to their EHRs to help update systems for the new billing process. Was this posted somewhere?

A: See Accounting for breaks in SUD treatment documentation and billing (PDF).

Billing Procedure Codes, Modifiers, & Limits

Q: If not all clients in a group are co-occurring, can we still bill the U8 modifier for all group members, or is there a new substance use disorder code for these clients?

A: The U8 modifier code is included with the procedure code for all of the new outpatient SUD services. If a program is approved for the co-occurring enhanced rate, modifier code HH is added to the SUD procedure code for the type of treatment service provided, in addition to the U8 modifier code.

Generally, a program that is approved for the co-occurring enhanced rate can apply the enhanced rate to all individuals within the program when billing, if the requirements in 254B.0507, subdivision 6 are met, because the program is considered co-occurring, not each individual client.

Q: Licensing told us in our last audit that if we provide co-occurring services and bill all clients in the group at the enhanced rate, we need a Diagnostic Assessment (DA) on file for every client in the group to qualify for that enhanced rate. Is this still true?

A: The requirements for the co-occurring enhanced rate in 254B.0507, subdivision 6 include that clients scoring positive on a standardized mental health screen receive a mental health diagnostic assessment within ten days of admission, excluding weekends and holidays. A program cannot receive the enhanced rate for a client if the requirements are not met. Please email dhs.mhcdlicensing@state.mn.us if you have additional questions.

Q: Does the culturally specific modifier apply to all groups including the ones that are not culturally specific if they are in the same program?

A: A program that is approved for the culturally specific enhanced rate described in 254B.0507, subdivision 3, can bill the enhanced rate for clients in the program, according to their program policies and how they were approved. The enhanced rates generally apply to the program overall, not specific groups or specific clients. However, some programs are only approved for the culturally specific rate enhancement for a culturally specific "subprogram". Please review your MHCP attestation forms and email bhd.enhancements.dhs@state.mn.us if you have additional questions.

Q: If an individual attends group, individual session and treatment coordination would that exceed the limit for four modifiers?

A: No, the modifier limit is four per procedure code, and each treatment service type has a different procedure code.

Q: How does billing work if one of the services provided is psychoeducation and the other is group counseling?

A: Counseling and individual psychoeducation are separate treatment services and outpatient services provided on or after August 1, 2026, must be billed separately using the new procedure codes. The Billable Units and Time Requirements section of the MHCP Provider Manual indicates that the actual number of minutes of each treatment service type/procedure code must be combined to get the total billable unit for the day.

Q: If one individual leaves a group 15 minutes earlier than the rest, does that individual need to be billed for fewer minutes?

A: Yes. The number of units to be billed for each treatment service is based on the actual number of minutes the client attended the service. Please see the MHCP Provider Manual for more information.

Q: If psychoeducation is 53 minutes (rounds to four units), do we need to subtract the additional 7 minutes from other services provided that day?

A: If you "claim" the time by rounding up to a billing unit, that same block of time cannot also be claimed for another service, meaning another service could not be started in the remaining 7 minutes that were claimed. Please see the MHCP Provider Manual for more information.

Also, please note that if more than one session of the same treatment type is provided on the same day, the unit to be billed is not determined for each session. Rather, the daily unit for that procedure code is only determined after adding all the minutes for all sessions of that treatment service type provided to the client that day.

Q: Is there a limit to the number of units that can be billed per day/per week? Currently it is six units per day and 30 units per week — have those limits changed or stayed the same?

A: The six-hour-per-day and 30-hour-per- week limit for outpatient SUD treatment is still in effect and will apply to any combination of psychosocial services starting August 1, 2026. The recovery support limit is 16 units per day per individual, regardless of whether the recovery support is provided individually or in a group or a combination of both. Updated limits will be reflected in the MHCP Provider Manual.

Q: Does "one code per client per day" billing mean we can't charge for a second period if we see a client for 30 minutes, break for lunch, and then meet again for another 30 minutes afterward?

A: Multiple treatment service sessions may be provided to a client in a day, but each procedure code can only be billed once for the day of service. Providers must combine the number of minutes for all sessions of the same treatment service type/procedure code to get the unit to bill for the day. Please see the MHCP Provider Manual for more information.

Q: Under federal billing requirements, can two clients be billed within the same hour (30 minutes each)?

A: Effective for services provided on or after August 1, 2026, all outpatient services procedure codes are 15-minute units, so a counselor is able to provide two 30-minute treatment services within one hour and bill for both. Please see the MHCP Provider Manual for more information on billing units and duplicative claim submissions.

Q: [Comment] Could part of the billing confusion be related to how federal regulations state one billing unit per hour?

A: It is not clear which federal regulations are being referenced. Minnesota's Medicaid state plan has been amended to reflect that outpatient SUD billing is done in 15-minute units.

Q: Can Peer Recovery Support Services be billed in the same day as a residential program that may be billing for that client already?

A: If the residential SUD program can provide peer recovery as part of its programming, then no, that service would already be covered in the residential per diem rate.

Recovery Residence Certification

Q: If we are a board & lodging facility but have an ongoing contract with our county, do we still need to be a certified Level 2 recovery residence?

A: Along with being eligible for the Housing Support Program (HSP) through DHS, certification also offers additional visibility through HB101 and the upcoming DHS online registry, as well as having access to the Recovery Residence portal that is currently in development. Certification is voluntary but DHS's housing support team is hearing that counties are considering whether they will continue to extend/re-approve local housing support agreements, or whether that will eventually shift to DHS agreements which do require certification to be approved. If you currently have a housing support agreement through the county, that is a conversation to have with your county financial representative.

Q: Once we are up and running with Certified Recovery Residence (CRR) status, can we add additional properties?

A: Certification is tied to each location and cannot be transferred. If you are interested in adding additional properties, each location would need to go through the certification process separately.

Q: We have not yet received access to setting up NetStudy 2.0. Is there something more we need to do? Our applications were sent prior to July 1, 2026 and have left multiple messages with no response.

A: First call the Minnesota Department of Human Services Background Study Division at 651-431-6620, or email dhs.netstudy2@state.mn.us. If you do not receive a response from either of those resources, please submit an email to the Recovery Supports mailbox at recovery_supports_bha.dhs@state.mn.us and someone will follow up on DHS's end.

Q: Is recovery_supports_bha.dhs@state.mn.us the correct email address to reach out to?

A: For questions regarding certification, please use recovery_supports_bha.dhs@state.mn.us. For questions regarding the Housing Support Program, please use dhs.dhs.grh@state.mn.us

Q: [Comment] If DHS uses the DHS-7122 Professional Statement of Need form for recovery residences, hope it is simplified, similar to the Section 5 process for the residential-to-GRH transition — so clients already on MA or BHF don't have to go through full re-qualification, and so it can be signed by anyone at a 245G program.

A: DHS has brought this comment/suggestion back to the housing support team for consideration.

New Tobacco Legislation Changes

Q: Who can do tobacco/nicotine screening or diagnostic assessments?

A: This refers to screening/diagnosing tobacco use disorder as being within a mental health professional's scope, per Minnesota Statutes 245I.10, paragraph D (which applies to Standard Diagnostic Assessments completed by mental health providers). Tobacco/nicotine use is also now an explicit part of Comprehensive Assessments for SUD services.

Q: When you say, "mental health staff," do you mean to include SUD providers or not?

A: This specific reference was to 245I.10, paragraph D, which applies to mental health providers/Diagnostic Assessments specifically. Separately, Comprehensive Assessment (SUD) requirements under 245I.10, subd. 6, paragraph B (clauses 9 and 11) also now require documenting the client's tobacco/nicotine use and treatment history, regardless of assessor type.

Q: In a co-occurring program, if tobacco information is captured in the Comprehensive Assessment, does it still have to be captured separately in the Diagnostic Assessment if both are performed within the same program?

A: Yes, each assessment must meet the criteria in statute for each assessment service.

Q: When are you hoping to have the tobacco educational handout completed?

A: DHS hopes to have the final handout available to providers around November 2026. The plan is to move it into final editing in September 2026, so providers have it in hand well ahead of the January 1, 2027, effective date rather than scrambling at the last minute.

Q: Do you know when DHS will release their legislative changes implementation guides?

A: A guide is expected to go out this fall, tentatively around September 2026.

Key Contacts & Resources

Topic	Contact
General Thursday Connections updates / past Q&A	Thursday Connections with SUD at DHS webpage
SUD treatment services / billing implementation questions	sud.direct.access.dhs@state.mn.us
Behavioral Health Fund (BHF) eligibility questions	dhs.bhf@state.mn.us
Recovery Residence certification questions	recovery_supports_bha.dhs@state.mn.us
Recovery Residence workgroup meeting info	beckys@theimprovegroup.com
NetStudy 2.0 background study access issues	651-431-6620 or dhs.netstudy2@state.mn.us

Tobacco & nicotine policy / educational handout feedback	nicotinepolicy.dhs@state.mn.us
HB101 / statewide housing registry	hb101.places.dhs@state.mn.us
CCBHC policy questions	mn_dhs_ccbhc@state.mn.us