Chat Questions, February 2024

Q: The September 2023 communications did not list billing modifiers, however, there was verbal communication about a possible co-occurring bump. There was no mention of a medical complexity bump, which prompts the question is there one? In looking to understand medical complexity/components of service, does 2.5 (Clinically Managed) reimburse the same as 2.7 (Medically Managed)? If yes, what is the billing structure? What is the proposed rate?

The most up to date information on proposed rates can be found on the Minnesota Health Care Programs Fee for Service Outpatient Services Rates Study webpage and last year's Thursday Connections with SUD at DHS FAQ document.

Q: Did we get the codes for the digital copy? I do not work in the main campus of our center and wonder how that will be sent out.

Information on how to receive codes that grant access to digital versions of the "ASAM Criteria, 4th Edition" can be found in the Behavioral Health e-Memo, issued Jan. 12, 2024.

Q: Is there an updated org chart for staff in BHD with contact info?

DHS is in the process of updating an org chart that will be made available to the public. More information will be shared when the org chart is posted.

Q: With the new DAANES, how are you collecting information about identified problem drug at admission etc.?

The DAANES is still collecting the drug use at admission within the DAANES admission record. The service initiation data entry prior to admission is only collecting minimal information. This will lessen the burden of duplicate data entry and to allow providers who do not admit clients for formal treatment to be able to bill for services like comprehensive assessments, treatment coordination and peer support.

Q: One other billing question- I'm interpreting the "1115 Base Rate" is the current state rate. Does the "Final Rate" represent estimated reimbursement upon 1115 enrollment/approval, i.e., CA reimbursement estimated to be $234.06 when the base rate is $162.24?

The comprehensive assessment is not eligible for the rate enhancements identified in Minnesota Statutes, Section 256B.0759, subd. 4.

Q: (For OERAC) Is there any recognition that clients use more than one drug and the need to treat the whole person not just opiates?

Thank you for your important question. The Opioid Epidemic Response Advisory Council (OERAC) recognizes that substance use disorders often involve multiple substances and that a comprehensive, whole-person approach to treatment is essential. This aligns with OERAC's core value that substances can't be siloed and a multi-substance, integrative approach is necessary across sectors to create a healthier Minnesota.

OERAC is committed to supporting evidence-based practices that adhere to the American Society of Addiction Medicine (ASAM) continuum of care for opioid use disorder (OUD) and any co-occurring substance use disorder or mental health (SUD/MH) conditions. This means that OERAC prioritizes funding for programs and strategies that treat the whole person, addressing not only opioid use but also other substance use disorders and mental health conditions that may co-occur with OUD.

Furthermore, OERAC recognizes the importance of expanding access to comprehensive treatment services, including medication-assisted treatment (MAT), which is considered the "gold standard" in care for OUD. OERAC also supports initiatives that address social determinants of health, such as housing and transportation, which can significantly impact an individual's ability to access and engage in treatment and recovery services.

In summary, OERAC is dedicated to promoting a holistic, person-centered approach to addressing the opioid epidemic, acknowledging that individuals often struggle with multiple substances and require comprehensive support for co-occurring conditions. OERAC will continue to prioritize funding for evidence-based practices that treat the whole person and improve access to integrated care.

Q: Is someone hired for Alicia's role?

Thank you for your question and for thinking of Alicia! We're thrilled about Alicia's well-deserved promotion. She has been an invaluable member of our team, and her dedication to managing grants has been exemplary. While we are actively working on filling her previous position, Alicia has been incredibly gracious in ensuring a smooth transition for the grants she managed. She has warmly handed off most of her grants to other capable grant managers within our team and she continues to tend to a few remaining grants until we find the perfect candidate to take over her former role. We appreciate Alicia's commitment to the success of these grants and her willingness to go above and beyond during this transition period. Rest assured, we are committed to finding a suitable replacement who will continue the excellent work Alicia has done. Thank you for your interest and support!

Q: For the 1115 provider assurance statement, is there just one needing to be submitted or do providers need to submit a separate assurance statement for all locations once approved for the demonstration?

Q: Just curious. Do you have a typical turnaround time for when providers enroll/apply to when approved if everything is submitted correctly?

Turnaround time is variable. DHS acknowledges receipt of enrollment materials and informs programs what place in line they are for review. DHS strives to review materials in a timely manner, and depending on the number of applications under review, approvals are typically sent in one to four weeks.