DEPARTMENT OF HUMAN SERVICES

Frequently Asked Questions (FAQ)

"The ASAM Criteria, 4th Edition"

Q: When will the changes in "The ASAM Criteria, 4th Edition" be implemented?

A: "The ASAM Criteria, 4th Edition" was released in November 2023. DHS is in the process of determining the best way to integrate the 4th edition changes into the SUD continuum. DHS will share its ideas with stakeholders and incorporate feedback into the development of legislative proposals. Adoption and implementation of any changes will be subject to state legislative and federal state plan approvals and timelines will be based on those approvals.

Q: Is it true that under "The ASAM Criteria, 4th Edition" there will not be partial hospitalization but Intensive Outpatient Programs (IOP)?

"The ASAM Criteria, 4th Edition" has changed the name of the partial hospitalization level of care to high intensity outpatient. The 4th Edition still has an intensive outpatient level of care. Adoption and implementation of any 4th Edition criteria will be subject to state legislative and federal state plan approvals and timelines will be based on those approvals.

Q: What risk rating descriptions should be used? State of Minnesota found in statue or "The ASAM Criteria, 3rd Edition"?

A: Minnesota Statutes 245B.04, Subd. 4 – Assessment criteria and risk descriptions – has been added to statute and is based on "The ASAM Criteria, 3rd Edition". The MN 245G Comprehensive Assessment Reference Guide incorporates current Minnesota Statute requirements and ASAM's free and publicly available Criteria Assessment Interview Guide, both of which are based on "The ASAM Criteria, 3rd Edition." Providers should continue to use "The ASAM Criteria, 3rd Edition" dimensions and risk ratings until further notice.

1115 SUD System Reform Demonstration

Is the concept of complexity codes no longer part of 1115?

Providers certified by BHD as meeting the requirements of the 1115 SUD System Reform demonstration have attested to providing treatment services that are aligned with the "The ASAM Criteria, 3rd Edition" standards. Providers that have attested to meeting the ASAM standards are

eligible for enhanced payments for certain services delivered to Medical Assistance (MA) recipients. Providers that have met the statutory requirements of the complexity add-ons defined in 254B are still eligible for payment for those services. Please see the billing section on the SUD Services page of the Minnesota Health Care Program (MHCP) Provider Manual for more information.

If we get rid of the 1115 rate enhancements, will there be less incentive to make sure clients get and keep Medical Assistance (MA)?

The current state plan amendment that seeks to adopt ASAM levels of care 3.1 low intensity and 3.5 high intensity identifies the current 1115 Demonstration Base Rate identified in the BHF Service Rate Grid with Dollar Amounts (DHS-7612). Since all programs licensed by the Department of Human Services as residential treatment programs according to section 245G.21 will be required to deliver services based on the same standards, there is no justification for maintaining two different residential rates. There will continue to be a rate enhancement applied to specific outpatient services until outpatient ASAM levels of care become effective in state law.

It will be important for behavioral health programs and providers, counties, DHS and social service agencies to provide individuals with education relating to decisions about what healthcare coverage best meets their needs. The Behavioral Health Fund only covers certain services and would limit a person's access to the full array of care they might otherwise receive if they were on MA.

Levels of care

Q: When the daily skilled service goes into effect in 2024, can you clarify that there is not a time requirement for that skilled service? What is the minimum amount of time to provide to have a skilled service?

A: Technically, any amount of a skilled treatment services could count. However, if an individual is receiving ASAM 3.5 residential level of care, even if they were to receive as little as 15 minutes of a skilled treatment service, the individual would not be alone for the remainder of 23 hours and 45 minutes. Other interactions and interventions that support the high intensity residential level of care need should be occurring and documented. As a reminder, this is an "ASAM Criteria, 3rd Edition" requirement and MN intends to move to "The ASAM Criteria, 4th Edition" where ASAM identifies the number of weekly clinical hours required in each level of care.

Q: When will we be able to see the new rates or are they already available? Are the rates for residential high and low intensity the same?

The current state plan amendment that seeks to adopt ASAM levels of care 3.1 low intensity and 3.5 high intensity identifies the current 1115 Demonstration Base Rate identified in the BHF Service Rate Grid with Dollar Amounts (DHS-7612). The most recent build out of rates as the result of the rates study can be found in the presentation from Burns and Associates from Sept. 21, 2023, or the

Minnesota Health Care Programs Fee for Service Outpatient Services Rates Study webpage. Any rate changes would require state legislative and federal state plan approval.

Q: Is the rates model that eliminates the medical enhancement different than the current rates being paid within the waiver?

A: Yes. The most recent build out of rates that incorporate the medical enhancement can be found in the presentation from Burns and Associates from Sept. 21, 2023.

Q: Will the IOP per diem make it so we can't bill care coordination or peer recovery support services?

A: DHS is still exploring all available options for the rate methodology for outpatient treatment services and will continue to share information as it becomes available. The hourly requirements identified for ASAM levels of care do not include care coordination or peer recovery support services. Those services may be provided beyond the defined hours for ASAM levels of care.

Comprehensive Assessment

Q: Is the mental health diagnostic assessment (DA) part of the comprehensive assessment?

A: No, not all elements of the mental health DA are required within a comprehensive assessment. Starting Jan. 1, 2024, the comprehensive assessment must include some of the same elements as a DA. Specifically, all the items listed in 245I.10 Subdivision 6 paragraphs (b) and (c) must be included in a comprehensive assessment along with all the items in 245G.05, subdivision 3. A complete list of all required items is on page five of this document: Substance Use Disorder Treatment Programs: 2023 Legislative changes and program implementation. These changes were made to allow clients who receive a DA access to substance use disorder treatment without having to also complete a comprehensive assessment as the DA will now include all elements of a comprehensive assessment.

Q: If an assessment is done prior to admission, is an update still needed within 5 days of admission?

A: If the client received a comprehensive assessment prior to service initiation that authorized the treatment service, you may use that comprehensive assessment, but an alcohol and drug counselor must document a review of the comprehensive assessment and document any updated information as clinically necessary to ensure it contains all required comprehensive assessment items and that the information is current and accurate.

Q: What about someone coming in with no comp assessment with direct access? The comp is usually due the first day. Is this still due within the first day or do we have the 5 days for residential?

A: During the 2023 session there was a legislative change (MS 254B.05, subd 5 (i)) that allows for payment of services from service initiation within a licensed substance use disorder treatment program prior to the completion of a comprehensive assessment when the comprehensive assessment is

completed within the required timelines. For a residential program, a comprehensive assessment must be completed within five calendar days from the day of service initiation (day of admission). For residential programs, the day the client is admitted to the program is always the day of service initiation. The number of days to complete the comprehensive assessment excludes the day of service initiation. (245G.05 Subdivision 1).

Q: What prevents the state from creating a standardized form that meets all the criteria they are requiring in an assessment, like the old Rule 25? The current system of each provider creating their own Comprehensive Assessment is inefficient and not very effective as it makes it much harder and more difficult to read all the different formats that have been created.

A: DHS moved forward with changing requirements for the comprehensive assessment to reduce paperwork, align many requirements with the Uniform Service Standards in chapter 245I and to make the components less prescriptive and rely more heavily on the licensed professional's clinical expertise. A comprehensive assessment reference guide has been developed and is available on the Direct Access webpage. Additional guidance will be provided as we move towards including "The ASAM Criteria, 4th Edition" into law.

Service Initiation

Q: Is day one counted as the day of admission for residential programs?

A: MS 245G.01 Subd 10a defines service initiation as "Day of service initiation" meaning the day the license holder begins the provision of a treatment service identified in section 245G.07. For **residential programs**, room, board and supervision are included in the list of treatment services in 245G.07. Therefore, the day the client is admitted to a residential program is always the day of service initiation.

Starting Jan. 1, 2024, MN 245G.05 Subd. 1 states: For a **residential program**, a comprehensive assessment must be completed within five calendar days from the day of service initiation (day of admission).

For a **nonresidential (outpatient)** program, the comprehensive assessment must be completed by the end of the fifth day on which a treatment service is provided.

For all programs, the number of days to complete the comprehensive assessment excludes the day of service initiation. An explanation of how to count nonresidential days is on page four of this document: Substance Use Disorder Treatment Programs: 2023 Legislative changes and program implementation.

Residential Level of Care

Q: Please define "skilled treatment services."

A: This is a term used in the "ASAM Criteria 3rd Edition." MS 254B.01 Subdivision 10: "Skilled treatment services" includes the treatment services described in section 245G.07 (Treatment Service), subdivisions 1, paragraph (a), clauses (1) to (4), and 2, clauses (1) to (6). Skilled treatment services must be provided by qualified professionals as identified in section 245G.07, subdivision 3.

Q: Does low intensity residential need "daily treatment services"?

A: Low intensity, ASAM 3.1, does not require daily treatment services. High intensity, ASAM 3.5, requires daily skilled treatment services seven days a week. Requirements for ASAM levels of care can be found in MS 254B.19.

Q: Do 3.1 low intensity services need to be staffed 24/7?

A: All residential levels of care need to be staffed 24/7.

Q: Do we need to provide skilled services on holidays?

A: Yes. Programs must have 24-hour staffing coverage and provide, at a minimum, daily skilled treatment services seven days a week according to each client's specific treatment schedule, as directed by the individual treatment plan.

Q: Will the group requirement for high intensity treatment be changing from 30 hours per week to seven days of skilled treatment services in January 2024?

A: This change will be effective on Jan. 1, 2024, or upon federal approval, whichever is later. Programs billing 3.5 are required to continue providing 30 hours of treatment a week until DHS receives approval of the state plan amendment.

Peer Recovery Services

Q: Can a peer recovery provide a skills-based group?

A: Peer Recovery services are not considered a skilled treatment service. Skilled treatment service is defined in the new legislative language. Peer-led groups are not a reimbursable service.

MS 254B.05 (g) states: For the purpose of reimbursement under this section, substance use disorder treatment services provided in a group setting without a group participant maximum or maximum client to staff ratio under chapter 245G shall not exceed a client to staff ratio of 48 to one. At least one of the attending staff must meet the qualifications as established under this chapter for the type of treatment service provided. A recovery peer may not be included as part of the staff ratio.

Q: For supervision of peers, is it now required that the supervisor is an LADC, or can they also be supervised by CPRS-R?

A: Recovery peers must be supervised by an alcohol and drug counselor as defined in 245G.11, subd 5. (245I.04, subd.19)