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State/Territory Name: Minnesota

State Plan Amendment (SPA) #: MN-20-0015

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, Maryland 21244-1850

Children and Adults Health Programs Group

December 18, 2023

Julie Marquardt
Acting Medicaid Director
State of Minnesota, Department of Human Services
540 Cedar Street
St. Paul, MN 55167-0983

Dear Director Marquardt,

Your title XXI Children's Health Insurance Program (CHIP) State Plan Amendment (SPA) MN-20-0015, received on June 23, 2020, with additional information received on November 15, 2023, has been approved. This SPA has an effective date of October 24, 2019, except as otherwise noted below.

Through this SPA, Minnesota has demonstrated compliance with the SUPPORT Act at section 2103(c)(5) of the Social Security Act (SSA), which requires child health and pregnancy related assistance to include coverage of services necessary to prevent, diagnose, and treat a broad range of behavioral health symptoms and disorders. Minnesota currently provides partial hospitalization only to individuals with a mental health diagnosis or with a co-occurring mental health and substance use disorder (SUD) diagnosis. Currently, individuals with a SUD diagnosis can access levels of care similar to a partial hospitalization benefit, but it is not a state plan benefit.

As part of this SPA, effective January 1, 2025, Minnesota will provide increased access to partial hospitalization by making this service available to individuals diagnosed with only a SUD diagnosis. This modification is part of legislation passed in Minnesota to adopt provisions to comply with the American Society of Addiction Medicine (ASAM) criteria in SUD treatment services and programs. Minnesota will notify CMS if there are any changes to this effective date.

Additionally, Section 2103(c)(5)(B) of the Act requires that these behavioral health services be delivered in a culturally and linguistically appropriate manner. Minnesota demonstrated compliance by providing the necessary assurances and benefit descriptions that the state covers a range of behavioral health services in a culturally and linguistically appropriate manner.

Your Project Officer is Chanelle Parkar. She is available to answer your questions concerning this amendment and other CHIP-related matters. Her contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, MD 21244-1850
Telephone: (667) 290-8798
E-mail: chanelle.parkar@cms.hhs.gov

If you have additional questions, please contact Meg Barry, Director, Division of State Coverage Programs, at (410) 786-1536. We look forward to continuing to work with you and your staff.

Sincerely,
/Signed by Sarah deLone/

Sarah deLone
Director

TEMPLATE FOR CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT
CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: MINNESOTA
(Name of State/Territory)

As a condition for receipt of Federal funds under Title XXI of the Social Security Act, (42 CFR, 457.40(b))_____ (Signature of Deputy Medicaid Director, Date Signed)

submits the following Child Health Plan for the Children's Health Insurance Program and hereby agrees to administer the program in accordance with the provisions of the approved Child Health Plan, the requirements of Title XXI and XIX of the Act (as appropriate) and all applicable Federal regulations and other official issuances of the Department.

The following State officials are responsible for program administration and financial oversight (42 CFR 457.40(c)):

Name: Matt Anderson — Position/Title: Assistant Commissioner, Health Care Administration, &Medicaid Director

Name: Julie Marquardt — Position/Title: Director, Purchasing & Service Delivery

Name: Sarah Orange — Position/Title: Health Care Budget & Finance Director

Disclosure Statement This information is being collected to pursuant to 42 U.S.C. 1397aa, which requires states to submit a State Child Health Plan in order to receive federal funding. This mandatory information collection will be used to demonstrate compliance with all requirements of title XXI of the Act and implementing regulations at 42 CFR part 457. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 0938-1148 (CMS-10398 #34). Public burden for all of the collection of information requirements under this control number is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-2605, Baltimore, Maryland 21244-1850.

Introduction: Section 4901 of the Balanced Budget Act of 1997 (BBA), public law 1005-33 amended the Social Security Act (the Act) by adding a new title XXI, the Children's Health Insurance Program (CHIP). In February 2009, the Children's Health Insurance Program Reauthorization Act (CHIPRA) renewed the program. The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, further modified the program. The HEALTHY KIDS Act and The Bipartisan Budget Act of 2018 together resulted in an extension of funding for CHIP through federal fiscal year 2027.

This template outlines the information that must be included in the state plans and the State plan amendments (SPAs). It reflects the regulatory requirements at 42 CFR Part 457 as well as the previously approved SPA templates that accompanied guidance issued to States through State Health Official (SHO) letters. Where applicable, we indicate the SHO number and the date it was issued for your reference. The CHIP SPA template includes the following changes:

- Combined the instruction document with the CHIP SPA template to have a single document. Any modifications to previous instructions are for clarification only and do not reflect new policy guidance.
- Incorporated the previously issued guidance and templates (see the Key following the template for information on the newly added templates), including:
- Prenatal care and associated health care services (SHO #02-004, issued November 12, 2002)
- Coverage of pregnant women (CHIPRA #2, SHO # 09-006, issued May 11, 2009)
- Tribal consultation requirements (ARRA #2, CHIPRA #3, issued May 28, 2009)
- Dental and supplemental dental benefits (CHIPRA # 7, SHO # #09-012, issued October 7, 2009)
- Premium assistance (CHIPRA # 13, SHO # 10-002, issued February 2, 2010)
- Express lane eligibility (CHIPRA # 14, SHO # 10-003, issued February 4, 2010)
- Lawfully Residing requirements (CHIPRA # 17, SHO # 10-006, issued July 1, 2010)
- Moved sections 2.2 and 2.3 into section 5 to eliminate redundancies between sections 2 and 5.
- Removed crowd-out language that had been added by the August 17 letter that later was repealed.
- Added new provisions related to delivery methods, including managed care, to section 3 (81 FR 27498, issued May 6, 2016)

States are not required to resubmit existing State plans using this current updated template. However, States must use this updated template when submitting a new State Plan Amendment.

Federal Requirements for Submission and Review of a Proposed SPA. (42 CFR Part 457 Subpart A) In order to be eligible for payment under this statute, each State must submit a Title XXI plan for approval by the Secretary that details how the State intends to use the funds and fulfill other requirements under the law and regulations at 42 CFR Part 457. A SPA is approved in 90 days unless the Secretary notifies the State in writing that the plan is disapproved or that specified additional information is needed. Unlike Medicaid SPAs, there is only one 90 day review period, or clock for CHIP

SPAs, that may be stopped by a request for additional information and restarted after a complete response is received. More information on the SPA review process is found at 42 CFR 457 Subpart A.

When submitting a State plan amendment, states should redline the changes that are being made to the existing State plan and provide a "clean" copy including changes that are being made to the existing state plan.

The template includes the following sections:

1. **General Description and Purpose of the Children's Health Insurance Plans and the Requirements**- This section should describe how the State has designed their program. It also is the place in the template that a State updates to insert a short description and the proposed effective date of the SPA, and the proposed implementation date(s) if different from the effective date. (Section 2101); (42 CFR, 457.70)
2. **General Background and Description of State Approach to Child Health Coverage and Coordination**- This section should provide general information related to the special characteristics of each state's program. The information should include the extent and manner to which children in the State currently have creditable health coverage, current State efforts to provide or obtain creditable health coverage for uninsured children and how the plan is designed to be coordinated with current health insurance, public health efforts, or other enrollment initiatives. This information provides a health insurance baseline in terms of the status of the children in a given State and the State programs currently in place. (Section 2103); (42 CFR 457.410(A))
3. **Methods of Delivery and Utilization Controls**- This section requires the State to specify its proposed method of delivery. If the State proposes to use managed care, the State must describe and attest to certain requirements of a managed care delivery system, including contracting standards; enrollee enrollment processes; enrollee notification and grievance processes; and plans for enrolling providers, among others. (Section 2103); (42 CFR Part 457. Subpart L)
4. **Eligibility Standards and Methodology-** The plan must include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. This section includes a list of potential eligibility standards the State can check off and provide a short description of how those standards will be applied. All eligibility standards must be consistent with the provisions of Title XXI and may not discriminate on the basis of diagnosis. In addition, if the standards vary within the state, the State should describe how they will be applied and under what circumstances they will be applied. In addition, this section provides information on income eligibility for Medicaid expansion programs (which are exempt from Section 4 of the State plan template) if applicable. (Section 2102(b)); (42 CFR 457.305 and 457.320)
5. **Outreach-** This section is designed for the State to fully explain its outreach activities. Outreach is defined in law as outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs. The purpose is to inform these families of the availability of, and to assist them in enrolling their children in, such a program. (Section 2102(c)(1)); (42 CFR 457.90)

6. **Coverage Requirements for Children's Health Insurance**- Regarding the required scope of health insurance coverage in a State plan, the child health assistance provided must consist of any of the four types of coverage outlined in Section 2103(a) (specifically, benchmark coverage; benchmark-equivalent coverage; existing comprehensive state-based coverage; and/or Secretaryapproved coverage). In this section States identify the scope of coverage and benefits offered under the plan including the categories under which that coverage is offered. The amount, scope, and duration of each offered service should be fully explained, as well as any corresponding limitations or exclusions. (Section 2103); (42 CFR 457.410(A))
7. **Quality and Appropriateness of Care**- This section includes a description of the methods (including monitoring) to be used to assure the quality and appropriateness of care and to assure access to covered services. A variety of methods are available for State's use in monitoring and evaluating the quality and appropriateness of care in its child health assistance program. The section lists some of the methods which states may consider using. In addition to methods, there are a variety of tools available for State adaptation and use with this program. The section lists some of these tools. States also have the option to choose who will conduct these activities. As an alternative to using staff of the State agency administering the program, states have the option to contract out with other organizations for this quality of care function. (Section 2107); (42 CFR 457.495)
8. **Cost Sharing and Payment-** This section addresses the requirement of a State child health plan to include a description of its proposed cost sharing for enrollees. Cost sharing is the amount (if any) of premiums, deductibles, coinsurance and other cost sharing imposed. The cost-sharing requirements provide protection for lower income children, ban cost sharing for preventive services, address the limitations on premiums and cost-sharing and address the treatment of preexisting medical conditions. (Section 2103(e)); (42 CFR 457, Subpart E)
9. **Strategic Objectives and Performance Goals and Plan Administration**- The section addresses the strategic objectives, the performance goals, and the performance measures the State has established for providing child health assistance to targeted low income children under the plan for maximizing health benefits coverage for other low income children and children generally in the state. (Section 2107); (42 CFR 457.710)
10. **Annual Reports and Evaluations**- Section 2108(a) requires the State to assess the operation of the Children's Health Insurance Program plan and submit to the Secretary an annual report which includes the progress made in reducing the number of uninsured low income children. The report is due by January 1, following the end of the Federal fiscal year and should cover that Federal Fiscal Year. In this section, states are asked to assure that they will comply with these requirements, indicated by checking the box. (Section 2108); (42 CFR 457.750)
11. **Program Integrity**- In this section, the State assures that services are provided in an effective and efficient manner through free and open competition or through basing rates on other public and private rates that are actuarially sound. (Sections 2101(a) and 2107(e); (42 CFR 457, subpart I)
12. **Applicant and Enrollee Protections**- This section addresses the review process for eligibility and enrollment matters, health services matters (i.e., grievances), and for states that use premium assistance a description of how it will assure that applicants and enrollees are given the opportunity at initial enrollment and at each redetermination of eligibility to obtain health

benefits coverage other than through that group health plan. (Section 2101(a)); (42 CFR 457.1120)

Program Options. As mentioned above, the law allows States to expand coverage for children through a separate child health insurance program, through a Medicaid expansion program, or through a combination of these programs. These options are described further below:

- **Option to Create a Separate Program-** States may elect to establish a separate child health program that are in compliance with title XXI and applicable rules. These states must establish enrollment systems that are coordinated with Medicaid and other sources of health coverage for children and also must screen children during the application process to determine if they are eligible for Medicaid and, if they are, enroll these children promptly in Medicaid.
- **Option to Expand Medicaid-** States may elect to expand coverage through Medicaid. This option for states would be available for children who do not qualify for Medicaid under State rules in effect as of March 31, 1997. Under this option, current Medicaid rules would apply.

Medicaid Expansion- CHIP SPA Requirements

In order to expedite the SPA process, states choosing to expand coverage only through an expansion of Medicaid eligibility would be required to complete sections:

- 1 (General Description)
- 2 (General Background)

They will also be required to complete the appropriate program sections, including:

- 4 (Eligibility Standards and Methodology)
- 5 (Outreach)
- 9 (Strategic Objectives and Performance Goals and Plan Administration including the budget)
- 10 (Annual Reports and Evaluations).

Medicaid Expansion- Medicaid SPA Requirements

States expanding through Medicaid-only will also be required to submit a Medicaid State plan amendment to modify their Title XIX State plans. These states may complete the first check-off and indicate that the description of the requirements for these sections are incorporated by reference through their State Medicaid plans for sections:

- 3 (Methods of Delivery and Utilization Controls)
- 4 (Eligibility Standards and Methodology)
- 6 (Coverage Requirements for Children's Health Insurance)
- 7 (Quality and Appropriateness of Care)
- 8 (Cost Sharing and Payment)
- 11 (Program Integrity)
- 12 (Applicant and Enrollee Protections)

- **Combination of Options-** CHIP allows states to elect to use a combination of the Medicaid program and a separate child health program to increase health coverage for children. For example, a State may cover optional targeted-low income children in families with incomes

of up to 133 percent of poverty through Medicaid and a targeted group of children above that level through a separate child health program. For the children the State chooses to cover under an expansion of Medicaid, the description provided under "Option to Expand Medicaid" would apply. Similarly, for children the State chooses to cover under a separate program, the provisions outlined above in "Option to Create a Separate Program" would apply. States wishing to use a combination of approaches will be required to complete the Title XXI State plan and the necessary State plan amendment under Title XIX.

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 457 et seq., the state shall place a check mark to affirm that it will be in compliance no later than the applicable compliance date.

Proposed State plan amendments should be submitted electronically and one signed hard copy to the Centers for Medicare & Medicaid Services at the following address: Name of Project Officer

Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, Maryland 21244
Attn: Children and Adults Health Programs Group
Center for Medicaid and CHIP Services
Mail Stop - S2-01-16

Section 1. General Description and Purpose of the Children's Health Insurance Plans and the Requirements

Guidance: The effective date as specified below is defined as the date on which the State begins to incur costs to implement its State plan or amendment. (42 CFR 457.65) The implementation date is defined as the date the State begins to provide services; or, the date on which the State puts into practice the new policy described in the State plan or amendment. For example, in a State that has increased eligibility, this is the date on which the State begins to provide coverage to enrollees (and not the date the State begins outreach or accepting applications).

1.4. Provide the effective (date costs begin to be incurred) and implementation (date services begin to be provided) dates for this SPA (42 CFR 457.65). A SPA may only have one effective date, but provisions within the SPA may have different implementation dates that must be after the effective date.

Original Plan
Effective Date: 9/30/1998

Implementation Date: 9/30/1998

SPA 20-0015 Purpose of SPA: Comply with requirements in the Support Act Proposed effective date: 10/24/2019

Effective January 1, 2025, all individuals with only a substance use disorder diagnosis will also be eligible to receive partial hospitalization services, as modified by the fourth edition of the ASAM standards..

Proposed implementation date: 10/24/2019

1.4- TC **Tribal Consultation** (Section 2107(e)(1)(C)) Describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.
On 5/12/2020, tribal chairs, tribal health directors, Urban Indian Health Centers, and Indian Health Service directors were given notice and 30-day comment period for this CHIP state plan amendment.

Section 2. General Background and Description of Approach to Children's Health Insurance Coverage and Coordination

Guidance: Section 2.2 allows states to request to use the funds available under the 10 percent limit on administrative expenditures in order to fund services not otherwise allowable. The health services initiatives must meet the requirements of 42 CFR 457.10.

2.2. **Health Services Initiatives-** Describe if the State will use the health services initiative option as allowed at 42 CFR 457.10. If so, describe what services or programs the State is proposing to cover with administrative funds, including the cost of each program, and how it is currently funded (if applicable), also update the budget accordingly. (Section 2105(a)(1)(D)(ii)); (42 CFR 457.10)

Special Health Initiative:
Minnesota will use additional CHIP funds, up to 10 percent of federal CHIP expenditures (after administrative costs for the CHIP populations), for other child health assistance as authorized under §2105(a)(2) of the Act. Such assistance will be costs for postpartum months of undocumented noncitizen mothers of unborn children that are paid on a fee-for-service basis. [*Approved under SPA number 090004*)

2.3-TC **Tribal Consultation Requirements**- (Sections 1902(a)(73) and 2107(e)(1)(C)); (ARRA #2, CHIPRA #3, issued May 28, 2009) Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(1)(C) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Describe the process the State uses to seek advice on a regular, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Include information about the frequency, inclusiveness and process for seeking such advice.

This process is the same as described in the Medicaid State Plan.

Tribal Consultation Requirements [as described in the Medicaid State Plan, section 1.4 of the preprint]

In compliance with §1902(a)(73) and 2107(e)(1)(C) of the Social Security Act, the state agency meets on a quarterly basis with tribal health directors of federally recognized tribes, Indian Health Service (IHS)representatives, and urban Indian healthcare providers to seek advice on matters related to Medicaid and CHIP programs, including consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prepared for submission to CMS.

Ongoing consultation: Since 1999, the state has met on a quarterly basis with tribal health directors, Indian Health Service representatives, and urban Indian healthcare providers. The quarterly meetings provide a forum for the state to solicit input from the providers on any issues of interest to them, including proposed changes to state health care programs, updates on state and federal law and regulation changes and funding opportunities. State agency policy staff attend the meetings to provide information, respond to questions, and accept comments from the providers.

Consultation regarding state plan amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects:
The state agency has designated a staff person in the Medicaid Director's office to act as a liaison to the Indian health care providers regarding consultation. The liaison sends written notification to Tribal Chairs, Tribal Health Directors, and Tribal Social Services Directors, the Indian Health Service Area Office Director, and the Director of the Minneapolis Indian Health Board clinic at least 30 days prior to the anticipated submission of all waiver requests, waiver renewals, or waiver amendments. When a 3O day notice is not possible, the longest practicable notice timeframe will be utilized. The liaison provides written notice to Indian health care programs 30 days in advance of the anticipated submission of all proposed state plan amendments likely to have a direct effect on Indians, Indian health programs, or urban Indian organizations. Changes that are likely to have a direct effect on Indians, Indian health programs, or urban Indian organizations are those that would impact eligibility determinations, reduce payment rates, change payment methodologies, reduce covered services, or change provider qualification requirements.

When a deadline for submission of a state plan amendment is outside the control of the agency, or in severely time-limited situations, the agency expedites the process and may provide, at a minimum, 10 days advance written notice of the change. Notices include a brief description of the proposal, its likely impact on Indian people or Indian health care providers, and a process and timeline for comment. At the request of an Indian health care provider, the liaison will send more information about any proposal.
The liaison arranges for appropriate state agency policy staff to meet with Indian health care providers to receive their input and to answer questions. This consultation may take place as pan of a Quarterly Tribal Health Directors meeting or via a separate meeting, conference call, or other mechanism, as appropriate. The liaison forwards all comments

received from Indian health care providers to appropriate state policy staff for their response.

When an Indian health care provider has requested changes to a proposed state plan amendment or waiver request, renewal, or amendment, the state agency liaison reports back on whether the change is included in the submission, or why it is not included. The state agency liaison informs the Indian health care providers when the State's waiver or state plan changes are approved or disapproved by CMS, and would include CMS' rational for disapproval.

For each state plan or waiver change, the state agency liaison maintains a record of the notification process; the consultation process, including written correspondence from Indian health care providers and notes of meetings or other discussions with them, and the outcome of the process.

Section 6. Coverage Requirements for Children's Health Insurance

6.2-BH Behavioral Health Coverage Section 2103(c)(5) requires that states provide coverage to prevent, diagnose, and treat a broad range of mental health and substance use disorders in a culturally and linguistically appropriate manner for all CHIP enrollees, including pregnant women and unborn children.

Guidance: Please attach a copy of the state's periodicity schedule. For pregnancy-related coverage, please describe the recommendations being followed for those services.

6.2.1- BH Periodicity Schedule The state has adopted the following periodicity schedule for behavioral health screenings and assessments. Please specify any differences between any covered CHIP populations:

State- ☒ developed schedule - DHS C & TC Schedule of Age-Related Screenings
The schedule mirrors that of the AAP Bright Futures. There is no periodicity schedule for 21 and older.

☐ American Academy of Pediatrics/ Bright Futures

☐ Other Nationally recognized periodicity schedule (please specify:) Other

☐ (please describe:)

For mothers of unborn children, the schedule applies to individuals under age 21. [CHIP expansion infants are covered by Medicaid State Plan benefits]

6.2.22. ☒ EPSDT consistent with requirements of sections 1905(r) and 1902(a)(43) of the Act

6.2.22.1 ☒ The state assures that any limitations applied to the amount, duration, and scope of benefits described in Sections 6.2 and 6.3- BH of the CHIP state plan can be exceeded as medically necessary.

6.3- BH Covered Benefits. Please check off the behavioral health services that are provided to the state's CHIP populations, and provide a description of the amount, duration, and scope of each benefit. For each benefit, please also indicate whether the benefit is available for mental health and/or substance use disorders. If there are differences in benefits based on the population or type of condition being treated, please specify those differences.

If EPSDT is provided, as described at Section 6.2.22 and 6.2.22.1, the state should only check off the applicable benefits. It does not have to provide additional information regarding the amount, duration, and scope of each covered behavioral health benefit. MN provides EPSDT at 6.2.22 and 6.2.22.1, in accordance with the benefits in its Medicaid State Plan, Attachment 3.1-A (attached). The benefits checked below apply to the mothers of unborn children who are either under age 21 or age 21 and older. Descriptions of services apply to enrollees age 21 and older under the Medicaid benefit set.

Unless otherwise stated, services are provided as medically necessary services and as approved in a treatment service plan for either mental health or substance use disorders.

Guidance: Please include a description of the services provided in addition to the behavioral health screenings and assessments described in the assurance below at 6.3.1.1-BH.

6.3.1- BH ☒ Behavioral health screenings and assessments. (Section 2103(c)(6)(A)) Applicable to enrollees under age 21 under EPSDT, and age 21 and older. See Minnesota Chapter 245I.10; and for SUD, see Minnesota Chapter 245G.05.

6.3.1.1- BH ☒ The state assures that all developmental and behavioral health recommendations outlined in the AAP Bright Futures periodicity schedule and United States Public Preventive Services Task Force (USPSTF) recommendations graded as A and B are covered as a part of the CHIP benefit package, as appropriate for the covered populations.

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools in primary care practice, providing education, training, and technical resources, and covering the costs of administering or purchasing the tools.

6.3.1.2- BH ☒ The state assures that it will implement a strategy to facilitate the use of age-appropriate validated behavioral health screening tools in primary care settings. Please describe how the state will facilitate the use of validated screening tools.

Managed Care Organization (MCO) contracts requires the use of age-appropriate child screenings for behavioral health in primary care clinics. See the attached model contract sections for descriptions of adult and child mental health assessments. Age-related requirements for adults and children are found in state law, as noted above.

6.1.30 (1) The MCO will require behavioral health Providers performing diagnostic assessments to screen all adolescent Enrollees upon initial access of behavioral health services for the presence of co-occurring mental illness and substance use disorder using screening tools on the IDDT web page: https://mn.gov/dhs/partners-and-providers/policies-procedures/childrens-mentalhealth/

6.3.2- BH ☒ Outpatient services (Sections 2110(a)(11) and 2110(a)(19))
Applicable to enrollees under age 21 with EPSDT, and age 21 and older

Guidance: Psychosocial treatment includes services such as psychotherapy, group therapy, family therapy and other types of counseling services.

6.3.2.1- BH ☒ Psychosocial treatment; applicable to enrollees under age 21 with EPSDT, and age 21 and older
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Treatment methods include individual therapy, family or group therapy, and other types of specialized treatment services, and including counseling related to adjustment to physical disabilities or chronic illness.

6.3.2.2- BH ☒ Tobacco cessation; applicable to enrollees under age 21 with EPSDT, and age 21 and older
Provided for: ☒ Substance Use Disorder

Includes education and assistance for smoking cessation as part of prenatal education. In addition to counseling, services include medications like, the patch, gum, lozenges, nicotine inhaler or nasal spray, Bupropion, or Chantix. The state covers all FDA-approved medications.

Guidance: In order to provide a benefit package consistent with section 2103(c)(5) of the Act, MAT benefits are required for the treatment of opioid use disorders. However, if the state provides MAT for other SUD conditions, please include a description of those benefits below at section 6.3.2.3- BH.

6.3.2.3- BH ☒ Medication Assisted Treatment; applicable to enrollees under age 21 with EPSDT, and age 21 and older
Provided for: ☒ Substance Use Disorder

6.3.2.3.1- BH ☒ Opioid Use Disorder

This service uses medication as a therapeutic support in conjunction with individual and group therapy. This includes but is not limited to methadone, naltrexone, and buprenorphine. The state covers all FDA-approved medications.

6.3.2.3.2- BH ☒ Alcohol Use Disorder

See 6.3.2.3.1

6.3.2.3.3- BH ☐ Other

6.3.2.4- BH ☒ Peer Support; applicable to enrollees under age 21 with EPSDT, and age 21 and older
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Recovery peers provide mentoring, education, advocacy and nonclinical recovery support to the recipient.

6.3.2.5- BH ☒ Caregiver Support; applicable to enrollees under age 21 with EPSDT
Provided for: ☒ Mental Health ☐ Substance Use Disorder

See attachment on EPSDT for full description of Children's Therapeutic Services and Supports

6.3.2.6- BH ☐ Respite Care
Provided for: ☐ Mental Health ☐ Substance Use Disorder

6.3.2.7- BH ☒ Intensive in-home services; applicable to enrollees under age 21 with EPSDT, and age 21 and older
Provided for: ☒ Mental Health ☐ Substance Use Disorder

See 6.3.9 for description.

6.3.2.8- BH ☒ Intensive outpatient; applicable to enrollees under age 21 with EPSDT, and age 21 and older; those with dual diagnoses may have access to such services.

Provided for: ☒ Mental Health ☒ Substance Use Disorder

See 6.3.9 for description for age 21 and older Mental Health intensive services.

See p. 17rr of EPSDT attachment for intensive outpatient services for under 21.

SUD providers are allowed to bill up to 30 hours per week of individual and group therapy which meets the ASAM definition for both intensive outpatient (requiring between 9 to 19 hours/week).

6.3.2.9- BH ☒ Psychosocial rehabilitation; applicable to enrollees under age 21 with EPSDT

Provided for: ☒ Mental Health x☐ Substance Use Disorder

See pp. 17d – 17f of EPSDT attachment for full description.

Components of children's Therapeutic Services and Supports

A. Psychotherapy: patient and/or family; family, and group
B. Individual family or groups skills training designed to facilitate the acquisition of psychosocial skills medically necessary to rehabilitate the child
C. Crisis assistance
D. Mental health behavioral aide

A & B may be combined in a day treatment program provided by multidisciplinary staff under the supervision of a mental health professional, at an outpatient hospital, community mental health center, or county contracted day treatment provider.

Guidance: If the state considers day treatment and partial hospitalization to be the same benefit, please indicate that in the benefit description. If there are differences between these benefits, such as the staffing or intensity of the setting, please specify those in the description of the benefit's amount, duration, and scope.

6.3.3- BH ☒ Day Treatment; applicable to enrollees under age 21 with EPSDT, and age 21 and older

Provided for: ☒ Mental Health ☐ Substance Use Disorder

The state does not consider day treatment and partial hospitalization services to be the same benefit. Day treatment for mental health is authorized for 3 hours/day, up to 15 hours/week. Prior authorization is required. Adult day treatment includes at least one

hour of group psychotherapy and must include group time focused on rehabilitative interventions or other therapeutic services that are provided by a multidisciplinary staff.

Day treatment is not offered for SUD, although a person with a dual diagnosis may be admitted to a mental health day treatment program.

6.3.3.1- BH ☒ Partial Hospitalization
Provided for: ☒ Mental Health X☐ Substance Use Disorder *effective January 1, 2025*

Partial hospitalization (as authorized under title XVIII/Medicare) for mental health covers up to 30 hours/week. The first 21 days are covered without prior authorization, and additional days following that require prior authorization. Prior authorization is needed for any days if fewer than 5 hours/day are provided for a person 18 and older; or fewer than 4 hours/day for a person under age 19. A person with a dual diagnosis may be admitted to a partial hospitalization program.

Under the existing Minnesota Model of Care, the state provides outpatient behavioral health services in a manner that allows individuals with a substance use disorder to access levels of care similar to a partial hospitalization benefit. Individuals may receive up to 30 hours per week of intensive outpatient care, which exceeds the ASAM criteria for partial hospitalization of 20 hours/week. If an individual exceeds 30 hours of care, a prior authorization would be required. The state does not impose a cap on the number of treatments provided and individuals may receive referrals through treatment coordination if additional services are necessary.

Effective January 1, 2025, all individuals with only a substance use disorder diagnosis will be eligible to receive partial hospitalization services, as modified by the ASAM standards fourth edition.

6.3.4- BH ☒ Inpatient services, including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Sections 2110(a)(10) and 2110(a)(18)); Applicable to enrollees under age 21 with EPSDT, and age 21 and older
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Inpatient hospital services include psychiatric care in an acute care hospital for individuals under age 21, or 21 and older, including extended stays. For individuals under age 21, inpatient services include care in a Medicare-certified psychiatric hospital.

Guidance: If applicable, please clarify any differences within the residential treatment benefit (e.g. intensity of services, provider types, or settings in which the residential treatment services are provided).

6.3.4.1- BH ☒ Residential Treatment; applicable to enrollees under age 21 with EPSDT, and age 21 and older

Provided for: ☒ Mental Health ☒ Substance Use Disorder

Residential treatment limitations are established by the individual treatment plan. Residential treatment for children under age 21 includes psychiatric residential treatment programs (PRTF) as authorized in Medicaid. See 6.3.9 for description of residential treatment requirements for adults.

Residential SUD treatment offers 3 treatment levels: High intensity (30 hours /week); medium intensity (15 hours/week); low intensity (5 hours/week).

6.3.4.2- BH ☒ Detoxification. Covered as Withdrawal Management; applicable to enrollees under age 21 with EPSDT (age 18+ only), and age 21 and older

Provided for: ☒ Substance Use Disorder

Withdrawal management services on a 24-hour basis are covered, when meeting clinical monitoring requirements by medical professionals.

Clinically managed withdrawal management is an organized service that meets the ASAM level III.2.D level of care criteria by providing 24-hour structure, support, supervision, and observation for individuals who are intoxicated or experiencing withdrawal symptoms.

A medically monitored program meets the ASAM level III.7.D level of care criteria by providing 24-hour medically supervised evaluation and withdrawal management.

[Other detoxification services have separate licenses, and are county-funded.]

Guidance: Crisis intervention and stabilization could include services such as mobile crisis, or short term residential or other facility based services in order to avoid inpatient hospitalization.

6.3.5- BH ☒ Emergency services; applicable to enrollees under age 21 with EPSDT, and age 21 and older

Provided for: ☒ Mental Health ☒ Substance Use Disorder

Also known as crisis intervention. See below.

6.3.5.1- BH ☒ Crisis Intervention and Stabilization; applicable to enrollees under age 21 with EPSDT, and age 21 and older

Provided for: ☒ Mental Health ☒ Substance Use Disorder

For mental health, services include assessment, intervention and stabilization.
For SUD, services include placement in detox or in a withdrawal management program.

6.3.6- BH ☐ Continuing care services
Provided for: ☐ Mental Health ☐ Substance Use Disorder

6.3.7- BH ☒ Care Coordination; applicable to enrollees under age 21 with EPSDT, and age 21 and older

Provided for: ☒ Mental Health ☒ Substance Use Disorder

Minnesota currently covers the following care coordination services as defined in its Medicaid benefit set: Behavioral Health Home services; Health Homes (Minnesota's patient centered medical home); SUD treatment coordination.

Treatment coordinators synchronize health services with identified patient needs, to facilitate the aims of the care plan. Activities include treatment follow-up, on-going needs assessments, life skills advocacy, education, service referral, and documentation.

If any recipient receiving a care coordination service has identified SUD as an area of concern, or has a SUD diagnosis, the care coordinator is expected to provide referral support to ensure that the person is connected with appropriate screening, diagnostic services, treatment services, and step-down services.

6.3.7.1- BH ☒ Intensive wraparound; applicable to enrollees under age 21 with EPSDT, and age 21 and older
Provided for: ☒ Mental Health ☐ Substance Use Disorder

See 6.3.9 for description of services applicable to adult-age individuals

6.3.7.2- BH ☒ Care transition services; applicable to enrollees under age 21 with EPSDT, and age 21 and older
Provided for: ☒ Mental Health ☒ Substance Use Disorder

Care coordination services include transition services, that is, changing or adding services providers or moving to a different level of care.

6.3.8- BH ☒ Case Management; applicable to enrollees under age 21 with EPSDT, and age 21 and older
Provided for: ☒ Mental Health ☐ Substance Use Disorder

Targeted case management, as defined in Medicaid, for children and adults with serious mental health needs.

Four types of targeted case management services are covered: child welfare; vulnerable adult/adult with developmental disability, adult and children's mental health, and relocation coordination service. If any recipient receiving a targeted case management service has SUD identified as an area of concern, or has a SUD diagnosis, the case manager is expected to provide referral support to ensure that the person is connected with appropriate screening, diagnostic services, treatment services, and step-down services.

6.3.9- BH ☒ Other; applicable to enrollees age 21 and older Provided for: ☒ Mental Health ☐ Substance Use Disorder

Adult Rehabilitative Mental Health Services (ARMHS): The services are provided on a one-to-one basis or in a group in a recipient's home, a relative's home, school, place of employment, or other community setting, by a team of professionals. The services include a functional assessment, a treatment plan, assistance with basic living and social skills, community intervention to help retain stability and avoid decompensation, and certified peer specialist support.

Intensive Outpatient Dialectical Behavior Therapy Services: Must be approved by a mental health professional. A recipient appropriate for dialectical behavior therapy must have mental health needs that cannot be met with other available community-based services or that must be provided concurrently with other community based services and:

1. have a diagnosis of borderline personality disorder; or
2. have multiple mental health diagnoses and is exhibiting behaviors characterized by impulsivity, intentional self-harm behavior and is at significant risk of death, significant morbidity, disability and/or severe dysfunction across multiple domains.

Assertive Community Treatment Services (ACT): Services must be recommended by a mental health professional. Recipients must be over age 18. Individuals age 16 or 17 may receive ACT services upon approval by the Department.

Intensive Rehabilitation Treatment Services (IRTS): The services must be recommended by a mental health professional defined in item 6.d.A. after a diagnostic assessment and a functional assessment. They are provided pursuant to an individual treatment plan, and may include individualized or group services. These services are provided to a recipient age 18 and older meeting the same eligibility requirements for ACT services, but the recipient also requires the level of care and supervision provided in a residential setting. These services are designed to develop and enhance psychiatric

stability, personal and emotional adjustment, self-sufficiency, and skills to live in a more independent setting.

6.4- BH Assessment Tools

6.4.1- BH Please specify or describe all of the tool(s) required by the state and/or each managed care entity:

☐ ASAM Criteria (American Society Addiction Medicine)
☐ Mental Health ☐ Substance Use Disorders

☐ InterQual
☐ Mental Health ☐ Substance Use Disorders

☐ MCG Care Guidelines
☐ Mental Health ☐ Substance Use Disorders

☒ ~~System)~~ CALOCUS/LOCUS (Adult) (~~Child and Adolescent Level of Care Utilization~~
☐ Mental Health ☐ Substance Use Disorders

☐ CASII (Child and Adolescent Service Intensity Instrument)
☐ Mental Health ☐ Substance Use Disorders

☐ CANS (Child and Adolescent Needs and Strengths)
☐ Mental Health ☐ Substance Use Disorders

☒ State-specific criteria (e.g. state law or policies) (please describe)
☒ Mental Health ☒ Substance Use Disorders

The managed care enrollee has a choice of using a Comprehensive Assessment or the state-based assessment tool established by state rule (known as a Rule 25 assessment). Mental health screenings, known as the GAIN SS, are included in each of these tools. The Rule 25 Assessment will be phased out by July of 2022.

When the Rule 25 assessment is used to determine appropriate treatment, an admitted client must still be given the comprehensive assessment to formulate a treatment plan.

State-specific criteria for adult and child mental health assessments are established in rule: Minn. Rule 9505.0372. Four types of diagnostic assessments are covered, when conducted in accordance with the requirements in the rule. Coverage of assessments

includes neuropsychological testing, and psychological testing. The state relies on the professionals to select assessment tools that meet the standards in the rule.

As of 2/15/2022, diagnostic assessments for SUD service needs are governed by Minn. Stat 245G.05.

☐ Plan-specific criteria (please describe)
☐ Mental Health ☐ Substance Use Disorders

☒ Other WHO Disability Assessment Schedule
☒ Mental Health ☐ Substance Use Disorders

☐ No specific criteria or tools are required
☐ Mental Health ☐ Substance Use Disorders

Guidance: Examples of facilitation efforts include requiring managed care organizations and their networks to use such tools to determine possible treatments or plans of care, providing education, training, and technical resources, and covering the costs of administering or purchasing the assessment tools.

6.4.2- BH ☒ Please describe the state's strategy to facilitate the use of validated assessment tools for the treatment of behavioral health conditions.

In addition to diagnostic assessments for adults, a functional assessment using the WHO Disability Assessment Schedule 2.0, or the Level of Care Utilization System (LOCUS) assessment is required for treatment planning with regard to Intensive Rehabilitation Treatment Services (IRTS), and Adult Rehabilitative Mental Health Services (ARMHS).

Criteria that must be met in any diagnostic mental health assessment for adults or children are established by rule (see 6.4.1 and attached requirements in Minn. Rule 9505.0372). The state relies on the professionals to select assessment tools that meet the standards in the rule. In addition, the MN C & TC screening schedule provides a list of acceptable screening tools for providers, as well as recommending certain ones.

Effective 9/15/2022, diagnostic assessments for SUD service needs are governed by Minn. Stat. 245G.05, as provided by amendments to the Medicaid State Plan under MN-22-0024.

6.2.5- BH Covered Benefits. The State assures the following related to the provision of behavioral health benefits in CHIP:

☒ All behavioral health benefits are provided in a culturally and linguistically appropriate manner consistent with the requirements of section 2103(c)(6), regardless of delivery system.

☒ The state will provide all behavioral health benefits consistent with 42 CFR 457.495 to ensure there are procedures in place to access covered services as well as appropriate and timely treatment and monitoring of children with chronic, complex or serious conditions.

Section 9. Strategic Objectives and Performance Goals and Plan Administration

Guidance: Section 9.9 can include discussion of community-based providers and consumer representatives in the design and implementation of the plan and the method for ensuring ongoing public involvement. Issues to address include a listing of public meetings or announcements made to the public concerning the development of the children's health insurance program or public forums used to discuss changes to the State plan.

9.9. Describe the process used by the State to accomplish involvement of the public in the design and implementation of the plan and the method for ensuring ongoing public involvement. (Section 2107(c)) (42CFR 457.120(a) and (b))

Notice was given to the public on May 20, 2020 by e-mail to those requesting notification, with a 30-day comment period, and access to the proposed SPA on the DHS website.

9.9.2. For an amendment relating to eligibility or benefits (including cost sharing and enrollment procedures), describe how and when prior public notice was provided as required in 42 CFR 457.65(b) through (d).

Notice was sent to tribal governments, health directors, Urban Indian Centers, and Indian Health Service facilities on May 20, 2020 with a 30-day comment period. No comments or questions were received.