DEPARTMENT OF HUMAN SERVICES

Legislative Report

Service Design & Rate Recommendations for Children's Residential Crisis Stabilization Services

Developing a new Medical Assistance benefit for CRCS

Behavioral Health Administration

September 2026

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Minnesota Statutes, Chapter 3.197, requires the disclosure of the cost to prepare this report. The estimated cost of preparing this report is $154,951.00.

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Contents

I. Executive summary

Minnesota's behavioral health system for children is at a breaking point. System partners (e.g., providers, counties, managed care organizations) report an urgent lack of stabilization options for children and youth in acute behavioral health crises. Without developmentally appropriate residential services, emergency departments (EDs), child welfare shelters and juvenile justice settings have, inappropriately, become default holding environments. This situation is costly, traumatic for children and families and unsustainable for the state.

State data from prior reports and system partner input show:

- Pediatric ED visits for behavioral health needs are increasing, including by as much as 30% for some hospitals between 2020 and 2022.[1][2]
- Children frequently board in EDs for days or weeks due to a lack of placements.**Error! Bookmark not defined.**[3]
- Youth of color and children in child welfare face disproportionate barriers to timely mental health care.[4]
- Families in Greater Minnesota often travel long distances or wait weeks for placement due to scarce local resources.**Error! Bookmark not defined.**[5]

II. Legislation

This report is submitted to the Minnesota Legislature pursuant to Minnesota Laws 2024, Chapter 127, Article 61, Section 30.

Sec. 30. MEDICAL ASSISTANCE CHILDREN'S RESIDENTIAL MENTAL HEALTH CRISIS STABILIZATION.

(a) The commissioner of human services must consult with providers, advocates, Tribal Nations, counties, people with lived experience as or with a child in a mental health crisis, and other interested community members to

[1] Dorman et al. (2025). Getting to Yes: Supporting Children with Complex Needs, CASCW, UMN.

[2] Minnesota Department of Health & Wilder Research. (2024). Transfer and Discharge Delays for Behavioral Health Patients at Minnesota Hospitals: Results from the 2023 Health Behavioral Health Data Collection. Retrieved from https://www.health.state.mn.us/data/economics/docs/dischargedelays.pdf

[3] Snow, K.D. et al. (2025). Pediatric Mental Health Boarding: 2017 to 2023. *Pediatrics*, 155(3), e2024068283. https://doi.org/10.1542/peds.2024-068283

[4] Hoffmann, J. A. et al. (2022). Disparities in pediatric mental and behavioral health conditions. Pediatrics, 150(4), e2022058227. https://doi.org/10.1542/peds.2022-058227

[5] Minnesota Department of Health, Rural Health Advisory Committee. (2021). Recommendations on Strengthening Mental Health Care in Rural Minnesota. Retrieved from https://www.lrl.mn.gov/docs/2022/mandated/220510.pdf

develop a covered benefit under medical assistance to provide residential mental health crisis stabilization for children. The benefit must:

(1) consist of evidence-based promising practices, or culturally responsive treatment services for children under the age of 21 experiencing a mental health crisis;

(2) embody an integrative care model that supports individuals experiencing a mental health crisis who may also be experiencing co-occurring conditions;

(3) qualify for federal financial participation; and

(4) include services that support children and families, including but not limited to:

(i) an assessment of the child's immediate needs and factors that led to the mental health crisis;

(ii) individualized care to address immediate needs and restore the child to a precrisis level of functioning;

(iii) 24-hour on-site staff and assistance;

(iv) supportive counseling and clinical services;

(v) skills training and positive support services, as identified in the child's individual crisis stabilization plan;

(vi) referrals to other service providers in the community as needed and to support the child's transition from residential crisis stabilization services;

(vii) development of an individualized and culturally responsive crisis response action plan; and

(viii) assistance to access and store medication.

(b) When developing the new benefit, the commissioner must make recommendations for providers to be reimbursed for room and board.

(c) The commissioner must consult with or contract with rate-setting experts to develop a prospective data-based rate methodology for the children's residential mental health crisis stabilization benefit.

(d) No later than October 1, 2025, the commissioner must submit to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance a report detailing the children's residential mental health crisis stabilization benefit and must include:

(1) eligibility criteria, clinical and service requirements, provider standards, licensing requirements, and reimbursement rates;

(2) the process for community engagement, community input, and crisis models studied in other states;

(3) a deadline for the commissioner to submit a state plan amendment to the Centers for Medicare and Medicaid Services; and

(4) draft legislation with the statutory changes necessary to implement the benefit.

EFFECTIVE DATE.

This section is effective July 1, 2024.

III. Introduction

Minnesota is facing an urgent challenge in meeting the behavioral health needs of children and youth. Emergency departments, child welfare shelters and other inappropriate settings are increasingly being used to house young people in acute crisis due to the lack of timely, developmentally appropriate stabilization options. Families, providers and counties alike have identified this as a pressing gap in the state's behavioral health continuum of care.

The Minnesota Legislature enacted a requirement directing the Department of Human Services (DHS) to develop a new Medicaid-covered benefit for Children's Residential Crisis Stabilization Services (CRCS). This benefit would provide short-term, trauma-informed, culturally responsive residential stabilization for children and youth under age 21 who do not require hospitalization but cannot be safely stabilized in their home or community.

To carry out this requirement, DHS contracted with Public Consulting Group LLC (PCG). As part of this engagement, the vendor worked closely with DHS's Behavioral Health Administration (BHA), providers, counties, managed care organizations and other interested parties to conduct research, analyze peer state models, develop cost-based rate methodologies that reflect staffing needs, operational realities, fiscal sustainability and facilitate broad partner input.

Two key reports were produced under this contract:

- **Service design recommendations report (June 30, 2025):** Defined the proposed CRCS model, including service eligibility, clinical and operational requirements, staffing ratios and licensing standards.
- **Rate recommendations report (August 1, 2025):** Presented detailed cost modeling, peer state comparisons and reimbursement options to ensure CRCS could be implemented sustainably through Medicaid.

This consolidated legislative report integrates the findings of both reports into a single document tailored for policymakers. It brings together the "what" (service design), the "how" (rate methodology) and the "why" (system need and outcomes).

A. Purpose of report

The purpose of this report is to consolidate service design and rate methodology recommendations for a potential CRCS benefit into a single legislative report. Specifically, the report aims to:

- **Explain the need:** Document the current challenges facing Minnesota's behavioral health system for children, including emergency department boarding, workforce shortages and service inequities.
- **Define the service model:** Provide clear recommendations for CRCS design, including eligibility, admission criteria, clinical elements, staffing ratios and licensing standards.

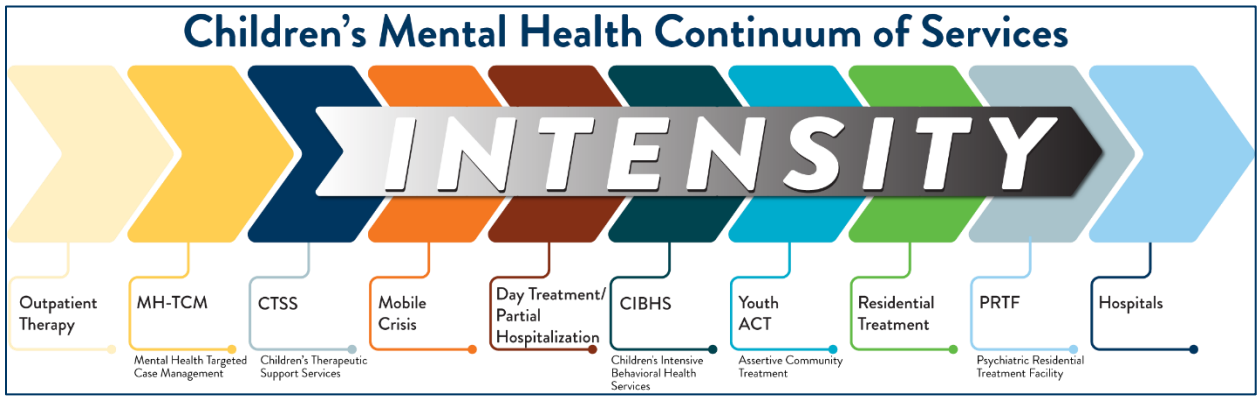
- **Present reimbursement options:** Outline the cost-based methodology used to develop rate recommendations, compare peer state models and present reimbursement structures for legislative consideration.
- **Highlight implementation considerations:** Identify workforce, equity and provider readiness issues that must be addressed to ensure successful rollout.

This report provides a comprehensive roadmap to transform a critical gap into a sustainable solution for Minnesota's children and families by outlining recommendations for the service design and rate methodology needed to cover Children's Residential Crisis Stabilization Services under Medicaid.

IV. Current landscape

Minnesota has invested heavily in building a comprehensive continuum of behavioral health services for children and youth, as illustrated in Figure 1. This continuum spans prevention and early intervention, outpatient treatment, mobile crisis response and inpatient care.[6][7] While many of these services are strong and innovative, persistent gaps in access, capacity and coordination create significant challenges for children, families and providers.

Figure 1. Children's mental health continuum of services



A. Current continuum of services

- **Community-based and outpatient services**: Minnesota offers a robust range of outpatient supports, including individual, family and group therapy; medication management; and Children's Therapeutic Services and Supports. School-linked mental health programs provide early identification and engagement in educational settings. These services are effective for many youth with mild to moderate needs but are insufficient for those in acute crisis.
- **Crisis response services**: Mobile crisis teams operate statewide and can respond to homes, schools and community settings. Programs like Minneapolis' Behavioral Crisis Response team deploy trained mental health professionals through 911 dispatch to avoid unnecessary law enforcement involvement. However, teams vary in capacity by county, and rural regions often struggle with timely response.
- **Structured non-residential programs**: Day treatment, intensive outpatient programs and Children's Intensive Behavioral Health Services provide structured support for youth who can remain at home. These programs are not designed for children who require 24/7 supervision or stabilization.
- **Residential and inpatient programs**: Minnesota licenses children's residential facilities under Minnesota Rules, Chapter 2960, with Psychiatric Residential Treatment Facilities (PRTFs) delivering physician-led care for complex psychiatric needs. Inpatient psychiatric units provide the most intensive care but are

[6] MN's Children's Intensive Mental Health Continuum, Minnesota House of Representatives. Accessed 2025. Roadmap Updated 9 5 23.
[7] Children's Mental Health Programs and Services webpage, Minnesota Department of Human Services website. Accessed 2026.

expensive, highly restrictive and often serve children who could be stabilized in a less intensive/restrictive setting.

B. Gaps in the care continuum

Despite these investments, Minnesota's behavioral health system remains under strain:

- **Emergency department boarding:** Pediatric ED visits for mental health have increased, with some Minnesota hospitals reporting upsurges by as much as 30% from 2020 to 2022.**Error! Bookmark not defined.** Many children are boarding for days or weeks due to a lack of stabilization options.**Error! Bookmark not defined.**[2]
- **Inappropriate placements:** Without alternatives, youth in crisis may be placed in child welfare shelters, juvenile justice settings or foster care beds that are not clinically equipped to address acute behavioral health needs.**Error! Bookmark not defined.Error! Bookmark not defined.**
- **Culturally and linguistically responsive services:** Partner engagement efforts called for strategies to address racial, cultural and linguistic inequities.[8]
- **Rural disparities:** Families in Greater Minnesota face limited access to mobile crisis teams and few or no crisis bed options within their region.[5]
- **Workforce shortages:** Providers report significant difficulty recruiting and retaining licensed mental health professionals, nurses and peer specialists, which contributes to uneven availability of services.**Error! Bookmark not defined.**[9]

C. Where CRCS fits in the care continuum

Children's Residential Crisis Stabilization Services (CRCS) would be designed to bridge the gap in the continuum of care, serving as a vital middle tier between community-based crisis or outpatient services and higher-intensity treatment settings such as inpatient hospitalization or Psychiatric Residential Treatment Facilities (PRTFs). CRCS would provide:

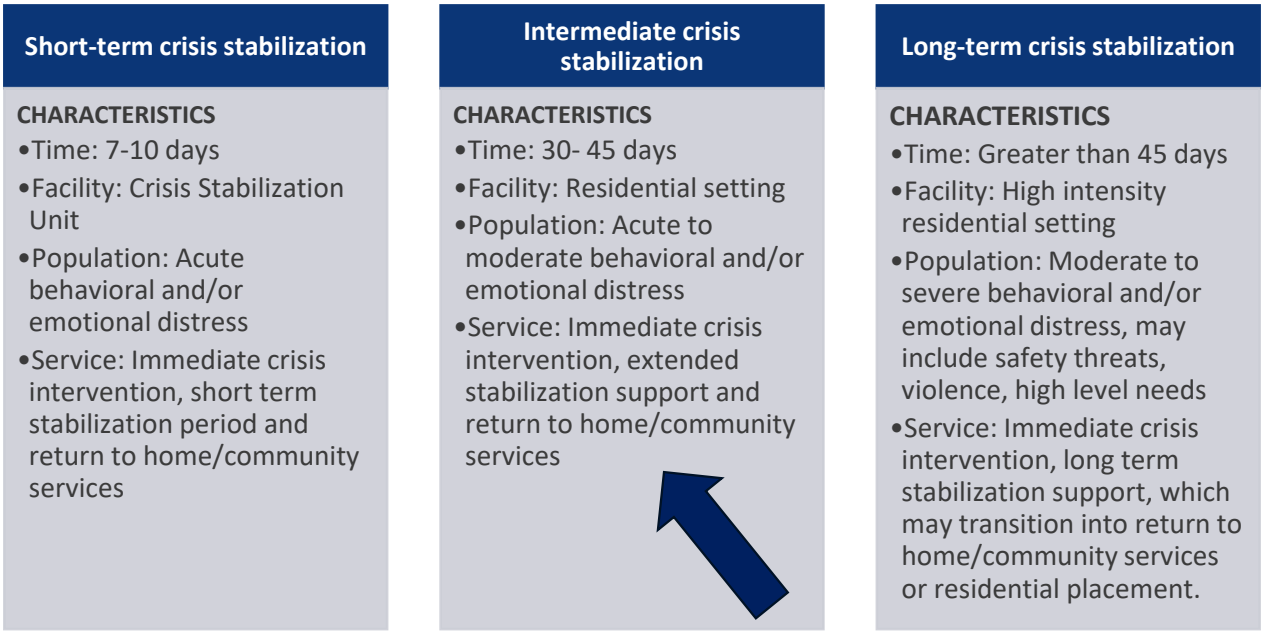
- 24/7 therapeutic support in a trauma-informed, culturally responsive environment
- A short-term length-of-stay (up to 35 days), designed to stabilize the crisis, engage families and support discharge planning
- An alternative to inappropriate placements such as ED boarding, shelters or detention
- A bridge between community-based interventions and hospital-based treatment

[8] Capacity Building Center for States. (2017). Working with children and youth with complex clinical needs: Strategies in the safe reduction of congregate care. Washington, DC: Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services; Remlin, C.W., Cook, M., Erney, R. (2017). Safe havens: Closing the gap between recommended practice and reality for transgender and gender-expansive youth in out-of-home care.

[9] Fritsma, T. (2023). Minnesota social work workforce: Findings from the 2022 MDH workforce survey. Minnesota Board of Social Work.

Figure 2 illustrates the proposed crisis care pathway, denoting where CRCS would fall on the continuum. Youth in acute behavioral health crisis who cannot achieve stabilization safely at home or in outpatient settings, but who do not meet inpatient criteria, can be referred to CRCS. This creates a clear and responsive service pathway that reduces reliance on emergency departments and institutional care while improving outcomes for children and families.

Figure 2. Proposed crisis care pathway



In practice, this pathway ensures youth are:

- First assessed through community-based supports or mobile crisis teams
- Referred to CRCS if they cannot be stabilized at home but do not meet inpatient psychiatric criteria
- Stabilized in a residential setting with therapy, medication management and family engagement for up to 35 days
- Transitioned to outpatient care, school-linked services or other community supports through discharge planning that begins at admission.

In sum, a newly authorized CRCS Medicaid benefit would allow Minnesota to move away from a patchwork of variously funded programs into a reimbursable, standardized and scalable component of Minnesota's children's behavioral health system.

V. Service design recommendations

The Minnesota Department of Human Services (DHS) developed service design recommendations to enhance Children's Residential Crisis Stabilization (CRCS) services. These recommendations are grounded in the legislatively mandated components, which include: assessment of the child's immediate needs and crisis factors; individualized care to restore the child to a pre-crisis level of functioning; 24-hour on-site staff and assistance; supportive counseling and clinical services; skills training and positive support services; referrals to community service providers to support successful transition; development of an individualized, culturally responsive crisis response action plan; and assistance with accessing and storing medication. The recommendations were informed by extensive research, engagement with system partners, and analysis of peer state models.

Although program licensing standards are currently defined under Minnesota Statute §245A.26, these recommendations support the further development of the service and its transformation into a Medical Assistance (MA)-covered benefit. CRCS would provide short-term, developmentally appropriate, trauma-informed stabilization for youth under 21 who are experiencing acute behavioral health crises but do not meet hospitalization criteria.[Error! Bookmark not defined.] Implementation of the enhanced service design recommendations would require legislative updates to Minnesota Statute §245A.26, further consideration of provider standards and licensing requirements, and revisions to Minnesota Rules, Chapter 2960 (governing residential care and treatment licensing) and Minnesota Statute §256B.0624 Subdivision I (governing Medicaid-covered crisis response services).

A. Definition & goals

Definition:

Under the recommended enhanced service design, Children's Residential Crisis Stabilization Services (CRCS) are defined as short-term, 24/7, facility-based services designed to stabilize youth in acute behavioral health crisis. CRCS provides individualized therapeutic interventions, family engagement and discharge planning with the goal of facilitating a safe return to the home or community within 35 days or less.

Goals:

- Stabilize acute behavioral health crises
- Prevent unnecessary hospitalizations or out-of-state placements
- Maintain and strengthen family and community connections
- Provide culturally responsive and trauma-informed care
- Facilitate smooth transitions to ongoing community-based services

B. Eligibility, admission, and service limits

Eligibility:

- Youth under 21 years of age who are experiencing an acute behavioral health crisis
- Youth who are eligible for Minnesota Health Care Programs
- Youth who do not meet criteria for inpatient psychiatric hospitalization but cannot be safely supported at home, in outpatient care or through mobile crisis alone; e.g. youth who does not require a locked unit for safety, but whose symptoms cannot be safely managed by family members
- Youth who completed a crisis assessment, the results of which indicate they are experiencing a behavioral health crisis

Admission & referral pathways:

- Referrals could be submitted by families, county human services agencies, managed care organizations, mobile crisis teams, hospitals, courts or community providers
- Admission decisions should prioritize timeliness and standardized criteria to reduce delays
- Require a completed crisis assessment
- Do not require a completed Diagnostic Assessment
- Do not require DSM-5 or ICD-10 diagnosis
- Do not require Prior Authorization

Service limits:

- Maximum of 35 days per admission with clinical review required for extensions
- Services may be repeated if clinically necessary with DHS monitoring for appropriate utilization

C. Required service & clinical elements

Children's Residential Crisis Stabilization (CRCS) programs must provide the following service and clinical elements, consistent with Minnesota Statutes §245A.26; Minnesota Rules, Chapter 2960; Minnesota Rules, Chapter 3525 and informed by peer state best practices:

- **Crisis assessment:** Within 12 hours of admission, as defined in Minnesota Statute 256B.0624 subd. 6
- **Individualized crisis treatment planning:** Collaborative plan developed with youth and family participation, including addressing cultural and linguistic needs
- **Therapeutic interventions:** Crisis intervention, mental health services as outlined in the crisis treatment plan; skill-building activities; recreational and educational supports, as defined in Minnesota Statute §256B.0624 and Minnesota Statute §256B.0671
- **Medication services:** Medication management and ongoing monitoring
- **Family engagement:** Required involvement in care planning and treatment, unless contraindicated

- **Educational continuity:** Required access to ongoing educational services provided by the school district in which the facility is located, as outlined in Minnesota Rules, Chapter 2960 and Minnesota Rules, Chapter 3525.2325
- **Transition & discharge planning:** Begins at admission, with linkage to outpatient therapy, school supports and case management

It is recommended that these elements be maintained in the enhanced CRCS service design. Also, in response to system partner feedback and peer state best practices, the addition of an **educational continuity** element is recommended, recognizing that residential placements may last up to 35 days and the risk of harm caused by educational disruption. Per Minnesota Rules, Chapter 3525.2325, it is the responsibility of the school district in which the facility is located to provide and finance educational services to all children residing in a residential facility that is located within their district. It is the responsibility of the provider to ensure all clients are able to access the educational services offered.

D. Staffing requirements & ratios

Staffing recommendations under the enhanced CRCS service design are developmentally tiered to promote safety, therapeutic engagement, and age-appropriate support. Ratios are adjusted to reflect the increased supervision and care needs of younger children, as shown in Table 1. Comprehensive age-specific staffing ratios and workforce role expectations are detailed in Appendix A.

Table 1. Staffing ratios for CRCS by age group

Age group	Staff-to-youth ratio	Age-specific staffing needs
Under 6	1:3	Requires close supervision, individualized developmental support and consistent adult presence to ensure safety and emotional regulation.
Ages 6–8	1:4	Benefits from structured routines, therapeutic play and guided social interaction to support emerging independence.
Ages 9–11	1:6	Engages in group-based activities, skill-building and peer interaction with moderate supervision to foster autonomy and resilience.

Age group	Staff-to-youth ratio	Age-specific staffing needs
Ages 12–21	1:8	Requires support for emotional regulation, identity development and life skills. Emphasis is placed on preparing for independence, vocational readiness and successful transitions to adulthood.

Staffing model includes:

- Licensed Mental Health Professionals (LICSW, LPCC, LMFT), including those licensed by Tribal authority as defined in Minnesota Statutes 245I.
- Mental Health Practitioners
- Clinical trainees under supervision
- Registered Nurses (for on-call medication and health needs)
- Direct Support Professionals/Youth Care Workers
- Certified Peer Specialists or Family Peer Specialists

This multidisciplinary model ensures a balanced blend of clinical expertise, peer support, and developmentally appropriate supervision, consistent with provider qualifications outlined in Minnesota Statutes § 245I.04. Implementation of these staffing ratio requirements may require updates to Minnesota Statutes §256B.0624, Subdivision 7, to support MA reimbursement and regulatory alignment.

E. Licensing & facility standards

While MA-funded Crisis Response Services are currently available to both children and adults in Minnesota under Minnesota Statutes §256B.0624, MA-funded residential crisis programs are currently limited to adults. Although Minnesota Statutes §245A.26 defines Children's Residential Facility Crisis Stabilization Services, H.F. 5247 directed DHS to further develop the CRCS program design to support MA-funding approval.

Wherever feasible, service design recommendations were aligned with existing licensing requirements under §245A and Minnesota Rules, Chapter 2960. However, implementation of an MA-funded, enhanced CRCS model would require statutory changes to §245A, §256B and Minnesota Rules, Chapter 2960.

Under the recommended enhanced service design, CRCS facilities must be:

- Licensed under Minnesota Statutes §245A.26 and Minnesota Rules, Chapter 2960
- Eligible for certification under the FFPSA, if Title IV-E funds are used.[10]

[10] Administration for Children and Families (2018). *ACYF-CB-PI-18-09*. Retrieved from https://acf.gov/sites/default/files/documents/cb/pi1809.pdf.

- Limited to 16 beds, to align with the CMS Institute for Mental Disease (IMD) exclusion
- Designed to provide trauma-informed, culturally responsive environments that respect the dignity and developmental needs of children
- Equipped with appropriate space for therapy, education, recreation and family visitation

F. Partner engagement findings

Input from providers, counties, families and other partners emphasized:

- **Timeliness of access:** Families need rapid admission to avoid ED boarding
- **Family engagement:** Parents and caregivers must be central to treatment and discharge planning
- **Cultural responsiveness:** Services must address racial, cultural and linguistic needs, particularly for youth of color who are overrepresented in crisis and child welfare systems
- **Geographic equity:** Rural communities need access to CRCS beds, potentially through regional partnerships
- **Workforce readiness:** Training in trauma-informed care and incentives for staff retention are essential

A summary of partner engagement themes that informed service design is included in Appendix D.

G. Peer state analysis

Review of peer states demonstrates consistent elements but varying structures and rates**Error! Bookmark not defined.**:

- **Maine:** Medicaid benefit providing individualized interventions in secure settings, $539/day average
- **Georgia:** Crisis stabilization units designed to divert from hospitalization. Not exclusive to children
- **New Jersey:** Hospital-embedded acute crisis intervention services, average length of stay ≤30 days
- **North Carolina:** Facility-based crisis service as an alternative to hospitalization, up to $895/day
- **New York:** Residential Crisis services, with distinct rates based on geography and acuity, up to $1056.70/day (downstate) and $940.46/day (upstate)

Implications for Minnesota:

- A per diem rate model is most consistent nationally
- CRCS should be distinct from PRTFs, children's residential facilities (CRF) and shelters, emphasizing short-term stabilization
- Medication management, therapy, family involvement and transition planning are key differentiators of successful models

VI. Rate design recommendations

Children's Residential Crisis Stabilization Services (CRCS) would be a proposed Medical Assistance (MA)-covered benefit, and no historical cost or utilization data currently exists to inform reimbursement rates. To support sustainability and program integrity, the Minnesota Department of Human Services (DHS), in partnership with the vendor, developed a prospective, cost-based rate methodology designed to reflect the staffing and operational realities of CRCS facilities. This legislative report presents the recommended rate methodology framework but does not include reimbursement rate recommendations. Those recommendations are provided separately in the Rate Recommendations Report, which includes tiered-base rate structures and an acuity-based add-on modifier. Ultimately the legislature would need to authorize DHS to seek federal approval for a new benefit and appropriate funding and statutory authority for the reimbursement rates and methodology.

A. Prospective rate methodology

A prospective, cost-based rate methodology was developed to support the proposed MA-coverage of CRCS. The methodology is designed to promote sustainability and equity through a core reimbursement approach that reflects the staffing and operational requirements of CRCS facilities. The methodology is guided by four foundational principles: cost-based design, transparency, alignment with Medicaid policy, and equity across providers.

Key rate model elements include:

- **Staffing:** Based on service design staffing ratios (e.g., 1:3 for children under six, 1:8 for adolescents)
- **Wage assumptions:** Bureau of Labor Statistics (BLS) 90th percentile wages[11], plus 46.88% fringe benefits[12]
- **Inflation adjustment:** CMS Medicare Economic Index (MEI), projecting 13% inflation through 2027[13]
- **Operational costs:** Administrative overhead, training, occupancy and 15% indirect cost rate[14]
- **Service unit:** Per diem (daily) rate, consistent with peer states

Appendix C provides a detailed breakdown of the rate methodology, outlining staffing assumptions, wage and inflation factors and calculation logic.

[11] Wages at the 90th percentile were determined to be most appropriate given the market rate for each role in the staffing model, current compensation levels in Minnesota, peer state wage comparisons, and the high level of competition for healthcare workers.
[12] U.S. Bureau of Labor Statistics. (2025). *Employer Costs for Employee Compensation – June 2025* (USDL-25-0958). Retrieved from https://www.bls.gov/news.release/pdf/ecec.pdf.
[13] Centers for Medicare & Medicaid Services. (2025). *Market Basket Data*. Retrieved from https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-program-rates-statistics/market-basket-data.
[14] The de minimis indirect cost rate of 15% of modified total direct costs was applied, as permitted under 2 CFR § 200.414(f), given that this is a new service without a negotiated federal indirect cost rate. This approach is consistent with federal guidance and ensures consistent treatment of indirect costs across all applicable federal awards. Retrieved from https://www.ecfr.gov/current/title-2/subtitle-A/chapter-II/part-200/subpart-E/subject-group-ECFRd93f2a98b1f6455/section-200.414.

Partner engagement and BLS data revealed distinct regional variation in staffing costs across Minnesota. In response, the core rate methodology incorporates variable cost inputs that may be used to develop two distinct base reimbursement rates: a statewide base rate and an augmented base rate for use in regions with elevated costs.

An acuity-based rate modifier was developed in accordance with system partner input and peer state practices. This modifier may be applied to the base rate to reflect operational differences associated with serving youth with higher clinical needs.

Core rate methodology

DHS recommends a daily per diem, cost-based rate design that considers the following components:

- Clinically appropriate staffing ratio
- Wage assumptions (e.g., Bureau of Labor Statistics 90th percentile)
- Fringe and inflation adjustments
- Operational cost assumptions reflecting bed capacity
- Geography

As shown in Appendix C, the core rate methodology would allow for consideration of these rate components, for development of a base per diem rate.

Rate model customizations

The core rate methodology is designed to support predictable budgeting and administrative simplicity. However, the methodology may yield rates that underrepresent costs for providers operating in higher-cost regions or serving youth with elevated clinical needs. To address these potential disparities, additional rate customizations may be built into the core rate methodology or applied as add-on modifiers.

<u>Geographic rate tiering</u>

Due to significant variance in the operational costs across Minnesota – particularly between metropolitan areas and rural or northern areas – DHS recommends the development of geographically tiered base rates. These rates would be determined by the provider's billing zip code and reflect regional differences in staffing and facility costs.

Two initial tiers are proposed:

- State Base Rate: Applies to providers in Greater Minnesota; does not include a geographical cost adjustment.
- Metropolitan Base Rate: Applies to providers located within metropolitan areas; includes a geographic adjustment to reflect higher operational expenses.

Because the rate tier is determined by billing zip code, no additional claiming processes would be required of the CRCS provider. Geographic rate values would be built into the core methodology once the preferred number of tiers and associated regions are defined.

Full detail on the core rate methodology and tiered reimbursement recommendations is provided in the Rate Recommendations Report.

Customizable add-on modifiers

In addition to geographic tiering, further rate customization may be necessary to account for clinical acuity and the intensity of services required for youth with higher needs. Partner engagement and analysis of peer state models consistently emphasized that youth served in CRCS programs present with varying levels of clinical acuity, directly affecting the intensity of supervision, clinical oversight, and therapeutic supports required to ensure safety and stabilization.

Providers serving youth with higher clinical needs must maintain elevated staffing ratios, employ more experienced personnel, and deliver enhanced interventions – resulting in higher costs than those associated with lower-acuity placements. A uniform rate structure may not adequately account for these differences, potentially creating disincentives for providers to serve youth with more complex needs.

To address this concern, DHS recommends the inclusion of an acuity-based add-on modifier within the CRCS rate methodology. This modifier would be applied to the base rate for programs serving youth whose needs exceed the standard level of clinical support defined in the CRCS service model. At least one acuity-specific modifier is recommended to ensure reimbursement reflects the additional resources required to deliver appropriate care.

Clinical indicators used to differentiate low-intensity (or base rate) services from intensive (or modified rate) services are provided in Table 2, below.

Table 2. Service delivery levels and associated rate model

Service delivery	Clinical indicators	Rate model
Low	1. Clinical oversight and care delivery provided within the state defined staff ratio as outlined in statue and rule. 2. Requires no one-to-one staff support. 3. No indication of co-occurring disorders and/or diagnostic complexity 4. Does not require additional medical, or nursing staff support beyond initial assessments, screenings, or routine follow-up well checks to maintain safety and deliver clinical care. 5. Therapeutic Interventions include minimum required individual, group, and family therapy; crisis de-escalation; skill-building; trauma-informed interventions; behavioral support planning and as appropriate educational and/or vocational support. Services are required to facilitate safety and stabilization of the child, increase skills and development of the individual child or family unit or support the individual child and/or family with community reintegration. 6. Case coordination and discharge planning requires typical collaboration of care with family, school, child welfare, and community providers to ensure	**Tiered Base Rate**

	transition and continuity of care. Discharge planning does not require more than 10 outside touchpoints to develop a cohesive discharge plan.	
Intensive	1. Clinical oversight and care are provided at levels exceeding the state-mandated minimum staff-to-child ratios as defined in statute and rule (e.g., a 1:4 ratio). In specific cases, a higher staffing ratio, such as 1:2, may be required for an individual child to ensure stabilization and maintain safety. 2. Requires one-to-one staffing support for a child for a duration exceeding two hours. 3. Presence of co-occurring disorders and/or other diagnostic complexity 4. Requires additional medical, and/or nursing staff support to maintain safety and ensure ongoing clinical care beyond initial assessments, screenings, or routine follow-up well checks, including availability of on-call support. 5. Therapeutic interventions are required beyond the minimum required individual, group, and family therapy; crisis de-escalation; skill-building; trauma-informed interventions; behavioral support planning and as appropriate educational and/or vocational support. Services are required to facilitate safety and stabilization of the child, increase skills and development of the individual child or family unit or support the individual child and/or family with community reintegration. 6. Case coordination and discharge planning requires collaboration of care beyond the minimal contacts with family, school, child welfare, and community providers to ensure transition and continuity of care. Discharge planning requires more than 11 outside touchpoints to develop a cohesive discharge plan.	**Modified Rate – Tiered Base Rate + Modifier**

Program integrity & oversight

If CRCS transitions to an MA-covered benefit with customized reimbursement rates, it would become the only children's residential MA-covered benefit in Minnesota to incorporate acuity-based and geographically tiered rate adjustments. While these enhancements are designed to promote equity and sustainability, they represent a departure from existing rate methodologies used across the children's behavioral health continuum. This distinction underscores the need for enhanced integrity safeguards and thoughtful implementation planning.

DHS would complete the initial review and certification of all provider applicants who wish to establish a CRCS service. Application requirements would be developed by DHS, and would likely include an assessment of population need in the region of the proposed CRCS program.

To support program integrity and mitigate risks of fraud, waste, and abuse, use of the acuity-based modifier would be subject to documentation standards, clinically validated criteria, and oversight protocols. Providers would be required to demonstrate, through clinical documentation and service records, that youth receiving the modified rate meet established acuity thresholds and that corresponding staffing and therapeutic interventions were delivered as outlined in the individualized crisis treatment plan. Oversight mechanisms could include periodic audits, scheduled yearly retrospective audits, utilization reviews, and alignment with existing Medicaid integrity practices to ensure compliance and accountability. These safeguards are designed to ensure that enhanced reimbursement is tied to clearly defined service needs and verifiable care delivery.

Finalized reimbursement rates should be designed to support provider participation and program sustainability, while balancing the state's responsibility for program integrity, equitable access, and responsible stewardship of public funds. To ensure that reimbursement aligns with verified service intensity and clinical need, DHS would establish clear documentation standards, billing protocols, and audit procedures. These safeguards would include requirements for individualized treatment planning, acuity verification, and service delivery documentation, and would align with existing Medicaid integrity frameworks to mitigate risks of fraud, waste, and abuse.

Any services or activities provided to program recipients who are not eligible for Medicaid funding must be financed through other funding streams, which may include as appropriate, the private insurance, the Behavioral Health Fund, county funds, or federal and/or private grants.

In addition, implementation of customized rates – whether based on service location or daily client acuity – would require updates to Minnesota Statutes §245A.26 and Minnesota Rules, Chapter 2960. These updates should address provider qualifications, staffing ratios, documentation expectations, and facility standards consistent with the enhanced service model. DHS would also need to develop expanded licensing specifications and oversight mechanisms to support compliance and accountability.

B. Billing & coding structure

- **H0018** – Residential crisis stabilization, per diem
- **1001** – Room & board (bundled for Medicaid-eligible days)
- **Modifier HA** – Child/adolescent designation
- **Modifier TF** – Acuity designation
- **Modifier HN** – Clinical trainee
- **Unit of Service:** One day (midnight census)

C. Peer state comparisons

To place Minnesota's proposed CRCS rate options in context, reimbursement models from several peer states that operate similar crisis stabilization services for children and youth were reviewed. Table 3 summarizes these peer state comparisons, highlighting service types, reimbursement structures and key differences in scope and intensity. For a comparative summary of peer state service types, reimbursement levels and staffing intensity, see Appendix B.

Table 3. Peer state rate comparisons

State	Service type	Reimbursement	Notes
Maine	Medicaid crisis stabilization	$539/day	Length of stay up to 14 days; similar staffing intensity
Georgia	Crisis stabilization units	$203/day (2022)	Lower staffing; shorter length of stay; not exclusive to children
New York	Children's Crisis Residence	Up to $1056/day (downstate); $940/day (upstate)	Modified rate for intensive-level services; rates vary by county
North Carolina	Facility-based crisis	Up to $895/day	Higher cost, positioned as alternative to hospitalization
New Jersey	Hospital-embedded crisis intervention	Contract-based	Rates negotiated regionally; average length ≤30 days

D. Policy considerations for Minnesota

DHS has recommended a core rate methodology that can be customized to develop variable base rates in relation to service location. Rate customizations for acuity-based rate enhancements, via use of a modifier, are also available. The core rate methodology assumes the operational cost burden of low utilization, as the service is launched and bed capacity rates are stabilized. Utilization assumptions, as well as other base rate cost components (i.e., staffing ratios, wage and fringe assumptions, and inflation adjustments), could be adjusted as final reimbursement rates are developed prior to benefit finalization. Final program design and reimbursement rate decisions should be made in consideration of multiple priorities:

- **Rate adjustments and cost recognition:** The core rate methodology provides a consistent statewide rate based on core cost components. This model could be further delineated by provider location (i.e., zip code) to develop regional core base rates which reflect variable operational and staffing costs in certain locations. DHS must determine if regional base rate utilization is needed and determine which zip codes correspond with an inflated base rate.
- **Provider sustainability:** Minimum bed capacity assumptions are built into the core rate methodology to support program stand-up at time of roll out. As the program is established and provider cost and

utilization data is available, DHS may need to consider further minimum bed capacity assumptions for smaller/rural providers to maintain operations.

- **Health Equity:** Services are expected to be culturally and linguistically responsive to client needs to address historical disparities for youth of marginalized identities
- **Operational Equity:** The acuity-based modifier is designed to promote services to clients with varying levels of need, while the geography-based core rate component is designed to account for higher operational costs in metropolitan areas. As provider utilization and cost data becomes available, adjustment to regional scales, within the core rate model, and value of the acuity-based modifier would require consideration. DHS would also need to consider use of any additional modifiers needed to promote statewide access to CRCS.

E. Next steps

This analysis provides the Legislature with a core rate methodology that may be tiered to include: (1) a general statewide rate and (2) an enhanced rate for billing zip codes associated with higher service costs. The model also incorporates a rate modifier for intensive-level services to account for client acuity. Final rate model methodology, and associated rate reimbursement calculations, should be informed by:

- Budget availability and appetite for investment.
- Commitment to ensuring rural access.
- Desired balance of simplicity and cost recognition.
- Alignment with Minnesota's broader behavioral health reform strategy.

VII. Implementation considerations

Developing an enhanced service design and a reimbursement rate methodology for Children's Residential Crisis Stabilization Services (CRCS) is only the first step. Successful implementation would require careful attention to workforce availability, provider readiness, equity across Minnesota's diverse regions and ongoing monitoring of outcomes. The following considerations emerged through DHS analysis, peer state review and partner input.

A. Workforce capacity & readiness

The most significant implementation challenge is ensuring a trained, stable workforce. CRCS staffing models rely on:

- Licensed mental health professionals (LICSW, LPCC, LMFT)
- Mental health practitioners
- Registered nurses and prescribers for medication management
- Direct support professionals and youth care staff (who provide 24-hour supervision and other non-clinical support services)
- Peer support and family peer specialists

Challenges:

- Statewide shortages of licensed clinicians and nurses
- Recruitment difficulties in rural and frontier counties
- High turnover among direct support staff due to low wages and burnout
- Ensuring representation in hiring staff who reflect the cultural experiences of the clients receiving services

Opportunities:

- Partnerships with universities and technical colleges to build a pipeline for staffing
- Incentives for staff retention, such as loan repayment and differential pay for overnight shifts
- Expanded use of peer specialists and family support roles to diversify staffing

B. Provider readiness & system alignment

Most Minnesota providers experienced in crisis care operate adult residential stabilization or children's residential treatment facilities. Implementing a covered benefit for a short-term crisis stabilization level of care would require:

- Licensing adjustments under Minnesota Rules, Chapter 2960 and MN Statutes §245A.26
- Staff training in trauma-informed, developmentally specific care
- Billing system updates to support the H0018 per diem code and modifiers
- Integration with existing mobile crisis teams, child welfare and juvenile justice systems

System partners emphasized the need for DHS to provide clear guidance and technical assistance during implementation.

C. Geographic access & rural equity

Access to crisis stabilization must extend beyond the Twin Cities metro. Families in Greater Minnesota often face long travel distances or a lack of available beds. The implementation roadmap in Appendix E outlines steps for ensuring regional access and readiness by 2029.

Considerations:

- Regional service hubs may be needed in lower-population areas
- Minimum bed capacity rates are recommended to ensure financial sustainability for rural providers who cannot operate at full census
- Collaboration with counties, managed care organizations, social workers and care coordinators who can support equitable placement and referral pathways

D. Fiscal predictability & sustainability

The cost of CRCS depends not only on geographic location of providers and client acuity, but also on facility utilization rates. Long-term, rural providers may be more impacted by increased costs related to lower utilizations rates but in the short-term, as services are rolled out, there is a risk of increased costs related to low utilization rates for all providers, statewide. Legislators must weigh:

- **Utilization review:** Core rate methodology reflects lower utilization during start up period. Future considerations would need to be made for service utilization, including enhancements for rural areas.
- **Budget impact:** Low utilization assumptions during start-up period led to a higher per diem rate recommendation. This would need to be reviewed in future years.
- **Federal match:** Medicaid reimbursement ensures federal financial participation, reducing reliance on state funds.
- **Rate re-evaluation:** DHS should establish a formal three – five-year rebasing cycle to recalibrate rates based on verified provider cost reports, utilization trends, member outcomes, and inflationary adjustments, ensuring long-term sustainability and alignment with service needs.

E. Monitoring & evaluation

Implementation should include a robust monitoring framework to ensure CRCS achieves its intended outcomes. Recommended indicators include:

- **System outcomes:** Reduction in ED boarding for youth; reduction in out-of-state placements
- **Youth outcomes:** Improvements in clinical stability, family engagement and successful community transitions
- **Access measures:** Utilization by geography, race/ethnicity and payer type to track equity

- **Fiscal measures:** Rate adequacy, provider sustainability and overall Medicaid cost impact

If Minnesota implements an MA-covered benefit with customized reimbursement rates, it would become the only children's residential service in Minnesota to incorporate acuity-based and geographically tiered rate adjustments. This would represent a departure from existing rate methodologies used across the children's behavioral health continuum. It would require enhanced integrity safeguards and thoughtful implementation planning to mitigate risks of fraud, waste, and abuse. Use of the acuity-based modifier would be subject to documentation standards, clinically validated criteria, and oversight protocols, to ensure that enhanced reimbursement is tied to clearly defined service needs and verifiable care delivery. Additionally, to strengthen program oversight and accountability, post-payment reviews should be conducted to assess service quality, provider performance, and compliance with federal Medicaid requirements as part of the evaluation and monitoring process.

DHS would need dedicated resources to monitor CRCS utilization, outcomes, and fiscal trends and remain available to provide updates and respond to inquiries from the Minnesota Senate Committee on Health and Human Services.

F. Key policy questions

As DHS and the legislature finalize program design and reimbursement rates for CRCS, decisions should be made in alignment with Minnesota's budget capacity, equity priorities and commitment to building a sustainable statewide continuum of children's crisis services.

Implementing the enhanced service design recommendations would require:

- Legislative updates to **Minnesota Statute §245A.26**,
- Further review of provider standards and licensing requirements, and
- Updates to **Minnesota Rules, Chapter 2960** (governing licensing for providers of residential care, treatment, detention, or foster care for children in out-of-home placement) and **Minnesota Statute §256B.0624, Subdivision 1** (covering Crisis Response Services under Minnesota MA).

Also, early finalization of a rate methodology, including consideration of regional variances to base rates and add-on modifier rates, is critical to support rulemaking, provider readiness and system build-out for statewide launch in 2029. Implementation of the recommended acuity-based modifier would represent a novel billing component among children's behavioral health services in Minnesota. Special consideration is needed to assess the viability and potential outcomes of implementing this rate addition.

As Minnesota moves toward implementation, policymakers would need to consider:

- How should DHS support workforce development, particularly in rural areas?
- What level of investment in minimum bed capacity rates is necessary to ensure equitable access statewide?

- How should DHS align CRCS with existing crisis and children's residential services to create a seamless continuum?

G. Summary

Implementing an MA-covered benefit for children's residential stabilization services would require not only legislative authorization and appropriation of state Medicaid matching funds, but also coordinated action to address workforce shortages, provider readiness, geographic disparities and system-level evaluation. These steps are essential to ensure CRCS achieves its promise of reducing ED boarding, preventing unnecessary hospitalizations and supporting children and families in crisis.

VIII. Conclusion

Minnesota's children and families are facing an urgent and growing crisis. Emergency departments, child welfare shelters and other inappropriate settings are increasingly being used to house children in acute behavioral health crises due to the absence of a short-term stabilization option. This situation is costly, traumatic for families and unsustainable for providers and hospitals.

CRCS offers a targeted, evidence-informed solution. By providing a short-term, trauma-informed, family-centered residential service, CRCS would fill a critical gap between mobile crisis services and inpatient psychiatric treatment. With appropriate staffing, structured interventions and intentional discharge planning, CRCS can reduce ED boarding, prevent unnecessary hospitalizations and strengthen family and community stability.

This report provides the Legislature with:

- A **service design framework** that refines eligibility, required clinical elements, staffing standards and facility requirements for MA-funded services.
- A **rate design methodology** that balances administrative simplicity, fiscal predictability, provider sustainability and equity across rural and metro regions.
- **Implementation considerations** addressing workforce readiness, provider capacity, geographic access and monitoring of outcomes.

Moving forward, policymakers face key decisions about how to structure reimbursement and support provider readiness. These choices will determine how quickly CRCS could be implemented and how equitably it can serve children across Minnesota. Regardless of the rate methodology ultimately chosen, legislative action is required to authorize and fund this critical benefit. DHS will continue to review provider standards and licensing requirements to identify needed amendments. If the legislature authorizes a CRCS benefit, a state plan amendment must be prepared and submitted to the Centers for Medicare and Medicaid Services, to seek MA coverage.

CRCS represents a strategic investment in Minnesota's future. With legislative support, Minnesota can build a sustainable, nationally informed model of crisis stabilization that ensures children receive the right care, in the right place, at the right time. This reform will improve outcomes for youth and families, reduce pressure on emergency departments and hospitals, and strengthen the entire behavioral health continuum.

IX. Appendices

Supporting data and technical detail

This section provides supplemental information to support the Legislature's review of the proposed Children's Residential Crisis Stabilization Services (CRCS) benefit. While the main body of the report presents the system need, service design framework, reimbursement options and implementation considerations, these appendices contain supporting technical details, partner input and comparative data that informed this analysis.

The appendices are intended to:

- Summarize staffing ratios and workforce requirements across age groups.
- Provide peer-state benchmarks to place Minnesota's rate modeling in a national context.
- Outline the rate development methodology, including staffing assumptions, wage and inflation factors, and the resulting blended and minimum bed capacity rate options.
- Capture system partner engagement themes that shaped recommendations.
- Present an implementation roadmap showing how CRCS could be operational by 2029.

Appendix A. Staffing ratios & workforce model

Children's Residential Crisis Stabilization Services must be staffed in a way that ensures safety, trauma-informed care and therapeutic engagement tailored to developmental needs. Staffing models balance direct supervision with clinical oversight, nursing support and peer/family engagement. Tables A1 and A2 illustrate how CRCS staffing is structured to balance developmental supervision needs with clinical, nursing and peer support. Table A1 outlines staff-to-youth ratios by age group, while Table A2 details the primary functions and typical coverage assumptions for each staff role.

Table A1. Age-based staffing ratios and role expectations

Age group	Staff-to-youth ratio	Staffing mix (per shift)	Staffing considerations
Under 6	1:3	1 direct care staff for every 3 children; RN on-call; daily access to licensed mental health professional	Intensive developmental supports; high supervision needs; emphasis on therapeutic play
Ages 6–8	1:4	1 direct care staff for every 4 children; RN on call; daily therapy access	Structured routines; early learning support; significant caregiver engagement

Age group	Staff-to-youth ratio	Staffing mix (per shift)	Staffing considerations
Ages 9–11	1:6	1 direct care staff for every 6 children; RN on call; access to clinician and peer specialist daily	Group-based skill-building; increased independence; focus on family involvement
Ages 12–21	1:8	1 direct care staff for every 8 youth; RN on call; clinician and peer specialist available daily	Therapy and transition planning; independence building; preparing for reintegration

Table A2. Staffing model by role

Role	Primary functions	Typical coverage assumption
Licensed Mental Health Professional (LICSW, LPCC, LMFT)	Conduct intake and crisis assessments; lead therapy sessions; develop and update individualized treatment plans	At least 1 FTE per program; available daily
Mental Health Practitioners	Conduct intake and crisis assessments; provide therapy and skill-building under licensed staff supervision	Variable, based on census and program capacity
Clinical Trainees (under supervision)	Conduct intake and crisis assessments; support therapy and skill-building under licensed staff supervision	Variable, based on census and program capacity
Registered Nurse (RN) / Licensed Practical Nurse (LPN)/Nurse Practitioner (NP) with focus in psychiatry	Provide health screenings, medication administration review and monitor health needs	As needed and/or monthly (on-call)
Direct Support Professionals (Youth Care Staff) *May include Mental Health Practitioners and/or Clinical Trainees*	Provide 24/7 supervision, daily living support, de-escalation and recreational/skill-building activities, and other non-clinical services and support	Based on age-specific ratios (1:3 to 1:8)

Peer Specialists / Family Peer Specialists	Engage youth and families, provide advocacy, model recovery and support cultural responsiveness	At least 1 per program; integrated into care teams

Key takeaway:

This workforce model ensures that CRCS facilities maintain the developmentally appropriate staff-to-youth ratios required for safety and therapeutic care, while also incorporating clinical, nursing and peer/family expertise to support comprehensive stabilization and transition planning.

Appendix B. Peer state rate benchmarks

To contextualize Minnesota's proposed reimbursement models, similar children's crisis stabilization services in peer states were analyzed. In addition to reimbursement rates, Table B1 highlights service type, average length of stay and staffing intensity in these peer state services.

Table B1. Peer state comparisons

State	Service type	Reimbursement	Staffing intensity & service notes
Maine	Medicaid crisis stabilization	$539/day	Length of stay up to 14 days; 24/7 supervision; licensed clinician oversight daily; RN support available
Georgia	Crisis stabilization units (youth and adult)	$203/day (2022)	Lower staffing intensity; shorter stays (average 5–7 days); not exclusive to children; fewer clinical requirements
New York	Children's Crisis Residence	Up to $1056/day (downstate); $940/day (upstate)	Modified rate for intensive-level services; rates vary by county
North Carolina	Facility-based crisis for children and adolescents	Up to $895/day	Higher staffing levels; positioned as a hospital diversion; licensed clinicians and nursing

			present; typical stay ≤14 days
New Jersey	Hospital-embedded crisis intervention	Contract-based (varies by provider)	Rates negotiated regionally; daily clinical access; lengths of stay ≤30 days; embedded within hospital systems

Appendix C. Prospective rate modeling for CRCS

Children's Residential Crisis Stabilization (CRCS) would be a newly developed service; therefore, reimbursement rates were calculated using a **prospective**, **cost-based methodology** rather than relying on historical claims data. This forward-looking approach promotes transparency, sustainability and policy alignment with Medicaid, while accounting for the staffing, operational and geographic realities of Minnesota providers.

Key features of the methodology include:

- **Staffing as the primary cost driver:** Rates are built from staffing matrices tailored to developmental needs, including increased nursing coverage to support medication management and clinical oversight.
- **Competitive wage benchmarking:** Wages are benchmarked to the **90th percentile of Bureau of Labor Statistics (BLS)** data to support recruitment and retention. A **46.88% fringe adjustment** is applied to capture benefits and payroll costs.
- **Forward-looking sustainability:** A **13% inflation adjustment** based on the **CMS Medicare Economic Index (MEI)** projects costs through 2027, ensuring long-term viability.
- **Operational cost discipline:** Overhead and indirect costs are capped at **15% of Modified Total Direct Costs (MTDC)**[14], consistent with the federal **de minimis rate under 2 CFR §200.414(f)**, to ensure the majority of funding is directed toward direct care delivery rather than administrative expenses.
- **Per diem rate structure:** A **daily per-youth rate** simplifies administration and aligns with national best practices.
- **Minimum bed capacity rates** reflect the higher per-youth costs incurred when programs operate below a full census, a common scenario during start-up phases, in rural areas or in facilities serving younger children with higher staffing needs. These rates highlight the financial pressures providers may face and underscore the importance of supplemental supports such as start-up funding or rural incentives.

Table C1 outlines the foundational components and assumptions used to construct the CRCS reimbursement rates. Each element reflects a deliberate policy choice to ensure rates are developmentally appropriate, fiscally sustainable and aligned with Medicaid principles. These inputs collectively shape the per diem structure and support equitable access across provider types and geographies.

Table C1. Core Rate Methodology Components

Component	Description	Source/assumption
Staffing ratios	Developmentally appropriate ratios (e.g., 1:3 for under 6; 1:8 for adolescents)	Based on service design recommendations and licensing standards
Wage data	90th percentile wages for job classifications (e.g., direct care, clinicians, nursing)	U.S. Bureau of Labor Statistics (BLS), Occupational Employment and Wage Statistics (OEWS), May 2024
Fringe benefits	Added at 46.88% of base wages	BLS Series for Private Industry Healthcare and Social Assistance, June 2025; standard Medicaid rate-setting assumption
Inflation adjustment	13% increase applied to project 2027 costs	CMS Medicare Economic Index (MEI), First Quarter 2025
Operational costs	15% of Modified Total Direct Costs	2 CFR §200.414(f); de minimis indirect cost rate
Service unit	Per diem (daily rate, midnight census)	Consistent with peer states

Appendix D. Partner engagement themes

To inform the design and rate methodology for Children's Residential Crisis Stabilization Services, DHS engaged a broad range of system partners across Minnesota in 2025. Participants included county and tribal human services leaders, providers, managed care organizations and advocacy organizations. Attempts were made to gather insights from families with lived experience in crisis mental health care; however, no responses were received.

The following key themes emerged:

1. **Urgent need for timely access**
    - Partners emphasized long delays in finding appropriate placements, resulting in weeks of emergency department boarding.
    - Partners stressed the importance of rapid admission and clear referral pathways to CRCS.
2. **Family and caregiver involvement**
    - Parents and caregivers must be active partners in treatment and discharge planning.
    - Services should build family capacity to support the child's return home, reducing repeat crises.
3. **Cultural responsiveness and equity**
    - Providers and advocates highlighted disproportionate impacts on Black, Indigenous and youth of color, as well as LGBTQIA+ youth.
    - Services must be trauma-informed, culturally competent and accessible in multiple languages.
4. **Geographic access and rural sustainability**
    - Partners in Greater Minnesota described long travel distances to crisis beds.
    - Regional partnerships and adequate minimum-capacity rates will be essential to ensure sustainability in low-population areas.
5. **Workforce readiness and training**
    - Providers raised concerns about shortages of licensed clinicians, nurses and direct care staff.
    - Incentives for recruitment and retention, and training in trauma-informed, youth-specific care, were identified as priorities.
6. **Integration with existing services**
    - Partners stressed that CRCS must connect seamlessly with mobile crisis teams, outpatient therapy, schools and child welfare services.
    - Clear handoffs and coordinated discharge planning are critical to avoid fragmentation.

System partners across the state strongly support the development of CRCS as a critical addition to Minnesota's behavioral health continuum. They emphasized the importance of timely access, family involvement, cultural responsiveness, rural equity, workforce readiness and integration with existing services. These priorities have shaped the service design and rate recommendations presented in this report.

Appendix E. Implementation roadmap (2027–2029)

A phased approach would be necessary to implement CRCS across Minnesota. Table E1 presents a roadmap emphasizing that CRCS can be operational within two years if legislative action occurs in 2025.

Table E1. CRCS implementation roadmap

Timeline	Milestones
Late 2026 – Early 2027	Legislative briefings and partner engagement on the report; bill drafting and fiscal planning for the 2026 session (authorization, appropriations and direction on rate option)

Q2–Q3 2027	Legislative action: authorize CRCS benefit, select reimbursement approach, appropriate start-up funds (e.g., technical assistance, rural supports); DHS launches rulemaking/licensing guidance under Minnesota Statutes, section §245A.26 and Minnesota Rules, Chapter 2960
Q3–Q4 2027	Draft Medicaid State Plan Amendment (SPA) for CRCS; develop provider standards, enrollment criteria and quality/monitoring specifications; issue technical assistance materials; begin MCO contract amendment scoping
Q1 2028	Submit SPA to CMS; publish final billing guidance (H0018/HA, room & board), coding manuals and claims testing plan; open provider readiness cohorts and application/enrollment windows
Q2 2028	Draft 2029 MCO contract language; finalize statewide blended and minimum bed capacity rates and publish rate files; announce start-up and rural sustainability grants; release workforce toolkits
Q3 2028	Anticipate CMS SPA approval (subject to federal timelines); finalize licensing forms and survey protocols; begin user acceptance testing (UAT) for MMIS/claims; initiate provider staff training (clinical, documentation and billing)
Q4 2028	Provider licensure and contracting; site readiness and mock admissions; complete systems UAT and end-to-end claims tests; publish go-live checklist; finalize cross-system pathways (EDs, mobile crisis, child welfare)
Jan. 1, 2029	CRCS benefit go-live statewide. Begin daily operational monitoring and help-desk support for providers and MCOs
Q1–Q2 2029	First operational review: utilization by geography and age, access and equity indicators, initial fiscal run-rate vs. projections
2029–2030	Ongoing technical assistance; evaluate need for targeted rural supports; prepare for a formal rate rebase in years 3–5 using actual cost/utilization data

Equity and rural access strategies are embedded throughout the implementation timeline, including the use of minimum bed capacity rates during start-up and in low-census regions, paired with time-limited start-up grants

and technical assistance. Beginning in Q1 2029, DHS would also track access and outcomes by geography, race/ethnicity and Tribal affiliation to inform placement decisions and targeted supports.