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Minnesota Behavioral Health System Review

Report to Minnesota Legislature and Minnesota Department of Human Services

March 2024

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Contents

Executive summary

Overview

As Minnesota's largest state agency, the Department of Human Services (DHS) oversees an annual budget of $23B, representing 42 percent of state spending and employing about 7,000 staff. DHS serves as Minnesota's Medicaid agency and administers a broad range of programs and services including healthcare, economic assistance, mental health and substance use prevention and treatment, child welfare services, and services for older adults and people with disabilities that support Minnesota's citizens across the lifespan. Minnesota DHS has similar functions and responsibilities to other equivalent Human Service Departments.

The size and scope of DHS has prompted discussion over the years, and led to recent decisions by the Walz-Flanagan Administration to split Direct Care and Treatment's (DCT) 5,000-member staff to become its own agency led by a Governor-appointed board, and create a new Department of Children, Youth, and Families (DCYF) that would result in most programs for children moving out of DHS, including child care and early learning programs, Child Support, Child Safety and Permanency, and other family-focused community programs, family economic support, food assistance programs (Minnesota Food Assistance Program (MFAP), Supplemental Nutrition Assistance Program (SNAP)) and youth opportunity and older youth investments. There has also been consideration given to moving behavioral health services—currently managed by DHS—to its own state agency.

As a result of this discussion, the legislature enacted Minnesota Statutes 2022, Chapter 98, Article 6, Section 23, Subsection (a), mandating the Office of Addiction and Recovery (OAR) contract with a consultant to conduct an independent review of the structure and financing of behavioral health services within DHS, with a focus on substance use disorder (SUD) and mental health treatment access and service delivery. This review comes at a pivotal time, both in the examination and reorganization of DHS, as well as the growing shift for behavioral health system reform as multiple epidemics have converged and the need for mental health and substance use disorder services have surged.

Behavioral health services include, and should integrate, mental health, substance use, and co-occurring disorders across the continuum of care (promotion, prevention, harm reduction, treatment, and recovery). The delivery of behavioral health services includes a diverse array of agencies, divisions, and service providers who may describe or approach behavioral health and service delivery goals differently. Complexity is also heightened by the multitude of avenues through which individuals access behavioral health services. States have the flexibility to design their behavioral health system to address the unique needs of their residents, while meeting the minimum requirements set by the federal government. The structure and financing of behavioral health systems and services varies significantly from state to state and into counties, cities, and other jurisdictions.

In Minnesota, public behavioral health services are implemented through a collaborative and coordinated effort from state government, county authorities and sovereign Minnesota Tribes. Currently, while primarily managed by a dedicated Behavioral Health Division, administration of behavioral health policies and services touch many administrations within DHS as well as within other Minnesota state agencies.

Minnesota is one of 24 states that has a state-supervised, county-administered structure for behavioral health services. In this structure, DHS provides oversight, establishes and disseminates statewide policies, and sets standards for behavioral health services. Counties support this model through administering and tailoring these services to meet the unique needs of their local communities, acting as the local mental health authority, processing applications, determining eligibility, providing case management and delivering and/or contracting direct services. There are 11 sovereign Minnesota Tribes that ensure the well-being of American Indian citizens throughout the state of Minnesota including the delivery of mental health and substance use disorder services within their jurisdictions. This sovereignty is recognized and protected by federal law. Tribal Nations in Minnesota have a unique and important role in the access and delivery of mental health and substance use disorder services within their respective communities. The relationship between Tribal Nations and the state of Minnesota in these areas is guided by a combination of federal laws, state regulations, and Tribal sovereignty.

This state-supervised, county-administered structure allows for a balance between statewide standards and locally responsive care, ensuring that behavioral health services are both consistent and adaptable to the diverse needs of Minnesota's population. Currently, while primarily managed by a dedicated Behavioral Health Division, administration of behavioral health policies and services touch many administrations within DHS as well as within other Minnesota state agencies. This is the context in which findings should be reviewed.

Scope of work

The Governor's Office of Addiction and Recovery and Minnesota DHS' Commissioner's Office (the State) contracted Public Consulting Group (PCG) to conduct an independent review of Minnesota's behavioral health system within DHS under Minnesota Statutes 2022, Chapter 98, Article 6, Section 23, Subsection (a). This review will inform the path forward to better support individuals with behavioral health, substance use, or co-occurring disorders, and improve collaboration and coordination of treatment and recovery services and outcomes—both from an organizational and economic perspective.

To assess the organizational structure and financial strategy, PCG conducted a comprehensive document review of nearly 50 documents, engaged more than 40 partners through interviews, and conducted benchmarking analysis of three peer states selected by DHS: Colorado, Connecticut, and North Carolina.

This report is organized as follows:

1. **State-level organization of Behavioral Health Services**
    a. An assessment of the current organizational structure of behavioral health services in Minnesota and DHS based on the results of the organizational review.
    b. A comparison of Minnesota's state-level organization of behavioral health services with other states, including other states with county administration of services, including strengths and weaknesses of different structures.
2. **Financing of Behavioral Health Services**
    a. An assessment of Minnesota's current financing strategy for behavioral health services, with a focus on the dependence on grant funding.

b. Benchmarking analysis of Minnesota's approach to financing of behavioral health services with the approach of benchmark states, including how Minnesota is different or like other states in its financing approaches, and an analysis of the strengths and weaknesses of different approaches.

Findings

Strengths

- DHS has taken significant steps to enhance and fortify Behavioral Health in Minnesota. They achieved this by restructuring DHS, consolidating three divisions that focus on SUD and mental health policy into the single Behavioral Health Division. This restructuring aims to enhance efficiency, facilitate knowledge exchange, streamline processes, and foster stability within the unit. Additionally, the revamped structure has the potential to increase visibility to external partners and establishes a clearer chain of command within the Behavioral Health domain.
- Advocates as well as staff at local, county, and state levels are committed to improving the behavioral health system to support all Minnesotans.
- DHS has a clear and easy to follow strategic plan.
- The Behavioral Health Division collects valuable data that can be used to inform behavioral health needs across Minnesota.
- Certified peer specialists are widely regarded as a valuable support for the behavioral health system and help to address some workforce gaps.
- Minnesota offers a comprehensive behavioral health benefits package for constituents of all income levels, including a comprehensive behavioral health benefit set for Medical Assistance enrollees, behavioral health care services through MinnesotaCare's Basic Health Program, and the Behavioral Health Fund that covers specific substance use disorder (SUD) services to individuals, regardless of whether they have insurance coverage. The Walz-Flanagan Administration's budget includes behavioral health initiatives that aim to improve access to mental health care, support Minnesotans with substance use disorders, and increase housing stability.
- The Walz-Flanagan's $3.3B Infrastructure Plan dedicated 14 percent to housing and homelessness and 16 percent to community and equity, spending categories aimed at positively affecting social determinants of health associated with behavioral health outcomes.

Weaknesses

- Significant workforce shortages across the continuum of care limit the number of behavioral health providers, in turn impacting the availability of services for Minnesotans.
- Communication across the continuum is lacking, contributing to less shared knowledge among providers and other behavioral health partners about priorities and service availability across the state.

- DHS' complex organizational structure impacts its ability to administer a cohesive behavioral health system and oversee service delivery and program fidelity.
- Cultural disparities in service access and care delivery persist within Minnesota's behavioral health system.
- Minnesota's behavioral health "system" is not well defined and is not achieving intended impacts on key performance indicators.
- Insufficient behavioral health reimbursement rates and inefficient grant allocations are a barrier to providers offering necessary services.

Additional findings from this review are organized into organizational and financial challenges facing DHS as they continue efforts to improve internal organization to benefit mental health and substance use disorder services. **Table 1** and **Table 2** below summarize the most important organizational and financial challenges identified during the document review, DHS partner interviews, and peer state benchmarking.

Organizational challenges

The organizational challenges listed below are aggregated from all data sources, including perceptions of challenges recounted by behavioral health partners during the majority of interviews. Some challenges described are specific to DHS, while others reference the overall behavioral health system.

Table 1. Organizational Challenges

No.	Organizational Challenge	Data Source
1	Numerous behavioral health leadership changes and reorganization in recent years have caused inconsistencies and disorganization resulting in a lack of a shared vision, and lack of clarity for roles, responsibilities, and the decision-making hierarchy in the behavioral health system.	Interviews, Document Review
2	Interviewees reported that DHS' agency culture is negatively impacted by inconsistent expectations across administrations and siloed operating procedures that have contributed to attrition, loss of institutional knowledge, and loss of trust between key partners with DHS. It was also expressed by some that the loss of confidence extends to trust in DHS leadership as well.	Interviews
3	A significant portion of the work within Minnesota's behavioral health sector, both internal and external to DHS, operates among distinct silos observed in areas such as legislative development, inter-agency and inter-team communication, county-led initiatives, and the separation of mental health and substance use efforts, among others.	Interviews, Document Review
4	The current state of the behavioral health system does not constitute a seamless continuum, demonstrated by numerous service gaps, such as residential and hospital beds for mental health and substance use disorder necessitating out of	Interviews, Document Review

No.	Organizational Challenge	Data Source
	state placements and lack of community-based resources resulting in Minnesotans receiving inadequate levels of care.	
5	Workforce shortages were reported by interviewees at local, county, and state levels. Interviews highlighted that contributing factors included high turnover, insufficient billing rates, and administrative burdens. Notably, interviewees shared that they perceived there to be a lack of professionals from diverse backgrounds and a lack of behavioral health professionals with adequate skills and years in the field.	Interviews. Document Review
6	Interviewees reported inconsistent communication practices and collaboration among behavioral health providers and partners within the continuum, coupled with workforce shortages, resulting in insufficient warm handoffs, ultimately leading to individuals slipping through the cracks in the system.	Interviews
7	Interviewees shared that the system needs to acquire staff faster through agile hiring processes and build educational pathways to facilitate the recruitment of personnel for behavioral health programs throughout the system.	Interviews
8	Interviewees noted that since the pandemic, there has been a lack of DHS behavioral health presence at the local level, including low or no DHS participation at association, county, and provider meetings.	Interviews
9	Behavioral health legislation is frequently crafted in isolation across all policy makers, both within DHS and externally, lacking a comprehensive statewide perspective and assessment of feasibility. This approach has resulted in policies that cannot be implemented as originally intended.	Interviews, Document Review
10	Many DHS behavioral health staff have limited policy development and legislative process knowledge to effectively create, orchestrate, and manage programs.	Interviews
11	There are prohibitive clinical regulations and/or policies limiting access to behavioral health services. For example, there is a requirement to conduct a diagnostic assessment to gain access to behavioral health services which poses a barrier for many to access necessary services.	Interviews, Document Review

Financial challenges

The financial challenges listed below are aggregated from all data sources, including perceptions of challenges recounted by behavioral health partners during the majority of interviews.

Table 2. Financial Challenges

No.	Financial Challenge	Data Source
1	There was concern expressed during interviews that some providers are advising individuals to disenroll from Medicaid to attain reimbursement through the Behavioral Health Fund, which is perceived by some providers to be more efficient.	Interviews
2	Interviewees shared that there is no centralized data system for individuals receiving services. For instance, the Behavioral Health Fund data is not integrated into Minnesota's Medicaid Management Information System (MMIS).	Interviews
3	DHS financial data is dispersed across various sources, lacking standardization and a centralized data system posing challenges for compliance and reporting tasks. Access to crucial information such as program ownership, fiscal year, and grant initiation details is not easily attainable.	Interviews, Document Review
4	Value-based payment models utilized by payers to encourage improved health outcomes and more efficient care are not yet widely understood and resulted in the perception shared during interviews that publicly funded payments for care are still predominately paid on a fee-for-service basis.	Interviews
5	Care quality policies regarding equitable, clinically appropriate care are inconsistent across Medicaid, the Behavioral Health Fund, Managed Care, and grant-funded programs.	Interviews, Document Review
6	Adult Mental Health Initiatives are allocating financial resources primarily for routine service care and delivery instead of the funding's intended purpose to pilot innovative services and enhance collaboration of mental health services within their respective regions.	Interviews, Document Review
7	Grant administration initially meant for promoting innovation in behavioral health services is primarily being utilized for long-term service delivery rather than fostering innovation as intended. Prolonged reliance on these grants disrupts the creation of a sustainable system. Additionally, the administrative workload placed on DHS staff for grant administration is disproportionately high.	Interviews, Document Review
8	Interviewees shared that DHS' recently conducted rate study found that publicly funded behavioral health rates are too low, and it will take time to adjust them upward across multiple service categories to help providers supply quality care.	Interviews
9	Interviewees shared their perspective that DHS' current methodologies for making funding distribution decisions do not consistently incorporate the input or involvement of individuals receiving services, including providers and other partners.	Interviews

No.	Financial Challenge	Data Source
10	Both audit findings and interviewees noted that DHS behavioral health grant administration policies lack transparency, consistency, and standardization on how funding decisions are made.	Interviews, Document Review
11	Interviewees expressed concern that DHS is not able to capitalize on all federal grant dollars available since DHS' grant initiation process is ineffective and inefficient.	Interviews
12	Without clear guidance, the usage of various state funding streams for behavioral health can create confusion, operational inefficiencies, and challenges for individuals using services, staff, advocates, and providers due to multiple nuances and complexities resulting in waste and misuse of funding.	Interviews, Document Review
13	Interviewees reported that limited availability of behavioral health services in some areas causes individuals to extend their stays in emergency departments and inpatient care unnecessarily, which ultimately results in higher costs covered by state resources.	Interviews
14	Insufficient funding for prevention services leads to increased downstream costs for state resources.	Interviews, Document Review
15	Interviewees reported that administratively burdensome policies, particularly related to grants administration, licensing, and provider reimbursement, place a time strain on providers and restrict funds that could be more effectively utilized for service delivery.	Interviews
16	Interviewees noted that DHS behavioral health staff often lack the fiscal knowledge and resources to effectively create, orchestrate, and manage financial and grant programs.	Interviews
17	Across the 87 counties that each act as a local mental health authority, there is notable variation in available financial resources and approaches employed to address behavioral health issues.	Interviews, Document Review

Opportunities

The eighteen opportunities identified through this effort support a broad vision for a path forward that may or may not be actionable or realistic for the Department. These opportunities were identified through the document review, partner interviews, and benchmarking exercises. **Table 3**, **Table 4**, and **Table 5** summarize actionable organizational opportunities for DHS. Data sources for each opportunity are noted, as well as the associated goal of that opportunity mapped from DHS's 2023–2027 Strategic Plan. The tables arrange these opportunities according to their alignment with the sequence in the DHS Strategic Plan.

Table 3. Organizational and Financial Opportunities Relative to DHS Agency Strategic Plan Outcome A: People in Minnesota Thrive

No.	Opportunity	Opportunity Type	Data Source(s)	DHS Strategic Plan Goal
1	Develop a best practice model to provide guidance on how to expand access to and delivery of prevention and early intervention services to reduce downstream spending.	Financial	Interviews	A.2 *Promote adult and children's safety and wellbeing with easy access to behavioral health supports and optimal living situations.*
2	Evaluate waiver opportunities to maximize federal match dollar funds for service provision, thereby developing more sustainable financing mechanisms.	Financial	Interviews	A.3 *Champion a service continuum that centers justice, equity and choice, supporting people with disabilities and older adults to lead meaningful lives in the community.*
3	Deepen behavioral health expertise, including clinical knowledge, in DHS/BHD leadership to strengthen guidance to staff and partners to improve services across both mental health and substance use.	Organizational	Interviews, Benchmarking (NC)	A.3

No.	Opportunity	Opportunity Type	Data Source(s)	DHS Strategic Plan Goal
4	Address workforce shortages by eliminating barriers to accessing behavioral health workforce employment opportunities. This could involve initiatives such as forming strategic partnerships to create or support behavioral health career pipelines, broadening scholarship offerings that either fully cover or reduce examination fees, eliminating the master's degree requirement where feasible, and further examining opportunities for background studies reform.	Organizational	Interviews	A.4 *Invest in home, community, and facility-based care workforce and strengthen Minnesota's network of caregiving.*

Table 4. Organizational and Financial Opportunities Relative to DHS Agency Strategic Plan Outcome B: People Experience High-Quality Human Services

No.	Opportunity	Opportunity Type	Data Source(s)	DHS Strategic Plan Goal
1	Increase investment in financial data infrastructure system to optimize DHS financial operations and contract management for services provided under the Behavioral Health Fund, Medicaid, and behavioral health grants.	Financial	Interviews	B.2 *Administer programs effectively and efficiently through streamlined processes and reduction of errors, fraud and waste.*
2	Work with partners to continue to expand coverage of ASAM-approved treatment options under all payment mechanisms at a minimum annually. Examine billing and coding practices that support this effort. Continue to expand alternative payment methodologies.	Financial	Interviews, Literature Review	B.2

No.	Opportunity	Opportunity Type	Data Source(s)	DHS Strategic Plan Goal
3	Enhance the Behavioral Health Fund appropriations, policy legislation, and enrollment methodology to ensure eligible Medicaid individuals are enrolled in Medicaid and the BHF is optimized. • Develop a BHF centralized data infrastructure, incorporating the MMIS system, to better track individuals, service utilization, and funding and ensure eligible Minnesotans are being enrolled in Medicaid. • Develop incentive payments for providers and counties who identify Medicaid-eligible members who are currently enrolled in the BHF and help them (re)enroll in Medicaid.	Financial	Interviews	B.2
4	Provide incentive payments to providers who enroll consumers into Medicaid programs, provide quality care and patient satisfaction.	Financial	Interviews, Literature Review	B.2
5	Expand opportunities for innovation within Adult Mental Health Initiatives to test research informed practices to be scaled and implemented across the state.	Financial	Document Review, Interviews	B.2
6	Continue to improve the grant management and grant initiation process with the objective of optimizing efficiency. This review should include an assessment of the feasibility of implementing umbrella contracts to foster workload reduction of grants administration and oversight.	Organizational	Interviews	B.2
7	Standardize and streamline data collection and reporting for behavioral health services funded through the Behavioral Health Fund, Medicaid, and behavioral health grants to one central statewide system for comprehensive claims and administrative data to inform decision-making and quality improvement initiatives.	Organizational	Benchmarking (CT)	B.2
8	Empower Mental Health and Substance Use Disorder Licensing staff in the Licensing Division to expand oversight and management of administration and delivery of services to improve programmatic fidelity and monitoring for continuous quality improvement.	Organizational	Interviews, Document Review	B.2

No.	Opportunity	Opportunity Type	Data Source(s)	DHS Strategic Plan Goal
9	Create mechanisms for partner inclusion in funding distribution methodologies and/or decisions. • Prioritize diversity and equity in grant awards and disbursement • Prioritize diverse representation in the grant selection committee • Create training and capacity development opportunities for diverse businesses to apply for grants and to attain necessary licenses	Financial	Interviews	B.4 *Build capacity to engage with community and amplify voices in decision-making processes.*
10	Review DHS's behavioral health communication strategy to ensure it: • Includes sufficient opportunity for partner engagement • Fosters a two-way feedback loop for continuous improvement • Includes an educational element highlighting DHS' ongoing initiatives • Includes a strategy to enhance participation in external events and conferences	Organizational	Interviews, Benchmarking (CO)	B.4
11	Review existing processes for developing a process to ensure BHD evaluates proposed policies for operational feasibility before they are presented to legislators. Ensure people with lived experience, external partners, and BHD subject matter experts are included throughout the process.	Organizational	Interviews	B.4

Table 5. Organizational and Financial Opportunities Relative to DHS Agency Strategic Plan Outcome C: People at DHS Thrive in an Inclusive Environment

No.	Opportunity	Opportunity Type	Data Source(s)	DHS Strategic Plan Goal
1	Revise the organizational structure within DHS to require Directors to be formally involved, actively engaged, and accountable to	Organizational	Benchmarking (CT, NC)	C.2 *Create an organizational culture where employees experience inclusion,*

No.	Opportunity	Opportunity Type	Data Source(s)	DHS Strategic Plan Goal
	multiple administrations within the agency, facilitating knowledge sharing and bridging gaps between divisions.			*psychological safety, respect, wellbeing and joy.*
2	Review job functions and expertise needed by role to match skills and resources to organizational needs. For example: • Identify grant management skill set and capacity gaps. • Work with the legislature and Human Resources to prioritize hiring for behavioral health grant management resource needs, employing an agile hiring process to accelerate staff acquisition.	Organizational	Interviews	C.3 *Build career pathways and create ways for staff to grow in their job.*
3	Improve collaboration and coordination of behavioral health efforts being implemented by various state and local entities by assigning roles, responsibilities, and action items to drive progress. This can be achieved by OAR continuing to act as an organizing body.	Organizational	Interviews, Benchmarking (CO and CT)	C.4 *Be a collaborative partner in the creation of separate state agencies while supporting employees and continuity of operations.*

Options

Three overarching pathways surfaced from this review for the future of how administrative responsibility for behavioral health could be organized and financed in Minnesota. These courses of action were gleaned from interviews and best practice review and research, including benchmark states Colorado, Connecticut, and North Carolina. Each option is accompanied by the associated benefits and challenges and supporting evidence from the review (detailed in **Table 6**, **Table 7**, and **Table 8**). These three options can be pursued independently or in concert with each other.

Option 1: Retain Behavioral Health within DHS and Continue Innovations

Keep behavioral health within DHS while continuing to innovate, improving collaboration and coordination among existing and new collaborative partners.

Table 6. Benefits and Challenges of Option 1

Benefits (Pros)	Challenges (Cons)
• Maintains strong connection between behavioral health and Minnesota's Medicaid program. • Leverages current momentum and appetite for advancing parity in behavioral health services. • Allows time to "let the dust settle" on the changes that have already been made within DHS and assess for improvement. • Continuing to house behavioral health and Medicaid within the same agency allows for centralized data and shared administrative functions (*e.g.,* Budget and Finance, Compliance, Human Resources, IT). • Allows time to implement opportunities outlined in this report to see if it shores up the system before making a disruptive and costly change. • Provides an opportunity for DHS to review their job descriptions and staffing plans, allowing for the precise determination of the appropriate staffing composition and skillsets. • Least disruptive and lowest-cost option.	• Oversight of operations and funding within such a large agency will continue to be a challenge. • Requires continued and expanded investment of significant time and resources for coordination and collaboration to gain alignment across DHS administrations and collaborative partners. • Behavioral health priorities and operational needs will require ongoing advocacy among DHS strategic goals. • Reduced ability to respond quickly to growing or changing behavioral health needs that require significant collaboration among administrations due to ongoing competing priorities within DHS.

Key findings

The retainment of behavioral health within the purview of DHS was overwhelmingly supported. Reasons included:

- Promote parity among behavioral health services and other healthcare services.
- Retain BHD, Mental Health Licensing, and Substance Use Disorder Licensing within DHS, under the same administrative leadership and strategic vision.
- Sustain a well-defined, transparent, and easy to understand decision hierarchy.
- Preserve a single authority figure with one strategic vision.
- Reduce challenges for data sharing and reporting.
- Focus on improved internal communication and collaboration.
- Prevent confusion to an already complex system.
- Empower the BHD with more autonomy to foster nimbleness and innovation.
- Lead an all-encompassing, interdisciplinary effort to formulate a unified vision and strategy, mirroring the approach employed during the COVID-19 pandemic, to tackle Minnesota's behavioral health needs.
- Bridge gaps within DHS and among partners.
- Understand past efforts, current situations, and forecast future behavioral health system needs.
- Observe the outcomes of separating DCT and Children, Youth, and Families and utilizing lessons learned to form prudent approach for continued coordination and collaboration among remaining DHS administrations.
- Capitalize on this opportune moment of DHS’ reorganization to initiate internal restructuring within DHS to effectively address any identified gaps.

Option 2: Develop a Blueprint for a Cohesive Behavioral Health System

Led by DHS, along with its partners, develop a formalized strategic plan and/or blueprint for behavioral health that charts a path towards a cohesive system, incorporating broader and deeper partner engagement and generating large-scale buy-in for action.

Table 7. Benefits and Challenges of Option 2

Benefits (Pros)	Challenges (Cons)
• Allows for more widespread buy-in and builds a "mandate" for action on how to build a more cohesive organizational and financing system for behavioral health. • Can include evaluating Options 1 and 3 as potential paths forward, creating tests of change for viability. • Formalizes system-wide change to synchronize efforts among counties, regional initiatives, Tribal Nations, DHS, Medicaid, and other public and private partners. • Provides assessment of infrastructure and resources to establish a systematic, efficient, and sustainable system of care. • Gives Minnesota time to continue to study outcomes from other states' reorganization of behavioral health staff and policies.	• Consumes additional resources and delays implementation when the system is under strain now. • Data saturation may have already been reached and new information may not emerge. • Innovation can be sacrificed when searching for thoroughly validated alternatives.

Key findings

In Colorado and North Carolina, there have been recent investments in behavioral health system reform and infrastructure modifications. Colorado recently split behavioral health from DHS, investing in a strategic process to develop a blueprint for behavioral health reform which resulted in the Behavioral Health Administration as a new entity. Both states acknowledged it is still premature to ascertain the benefits or unforeseen consequences of these structural changes, underscoring the potential need for a formalized behavioral health strategic plan to help maximize the benefits of coordinated efforts and minimize unintended consequences. Minnesota's DHS has already created a clear strategic plan for 2023–2027 referenced throughout this report and could benefit from undergoing this same visioning process for the future of behavioral health.

Rather than advocating for the separation of behavioral health from DHS, partners proposed further strategic investigation, which should encompass:

- A five-year strategy that outlines attainable goals and aspirational outcomes of efforts to create a more cohesive behavioral health system.
- Assessing practices and ensuring the workforce is representative of populations that are served.
- Perceptions that there has not been a behavioral health system infrastructure created post deinstitutionalization; rather, there has just been a patchwork created to provide services and address needs. Further partner engagement and creation of a blueprint for reform will allow the opportunity to take a step back and build a comprehensive, efficient and sustainable system that elevates what is working and transforms what has not worked.
- Watching Colorado to see if their Behavioral Health Administration restructure results improves outcomes before Minnesota makes substantive decisions.

Option 3: Remove the Behavioral Health Division from DHS and Create a Separate Behavioral Health Agency

Create a dedicated behavioral health agency to be responsible for overseeing coordination and collaboration across all collaborative partners, centralizing the majority of administrative tasks to address behavioral health needs of Minnesotans. Oversight for all Medicaid funded services would remain with DHS.

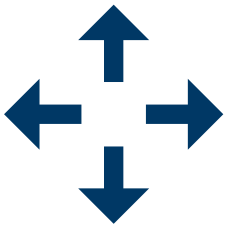


Table 8. Benefits and Challenges of Option 3

Benefits (Pros)	Challenges (Cons)
• Serves as the safety net administrator for uninsured and underinsured. • Provides organizational and financial structures that inherently prioritize behavioral health. • Clarifies ownership of behavioral health strategy and oversight. • Behavioral health leadership has more autonomy and agility to make decisions in collaboration with Medicaid. • Manages and provides oversight of the Behavioral Health Fund and behavioral health grants for increased accountability. • Legislative, finance, legal and compliance team would specialize and understand the nuances of behavioral health. • Can serve as the statewide coordinator for all state, local, and sovereign Minnesota Tribes, providers and organizations to ensure high quality of care, coordination and innovation of behavioral health services. • Opportunity to rebuild collaborative partner trust through redesigning behavioral health delivery to include partner input. • Natural opportunity for staff to change roles and elevate strong performers when hiring for positions in the new organization.	• Infuses more change into a system that is already in flux. • Requires formalized strategies for coordination and alignment across behavioral health services. • Creates opportunities for misalignment in priorities, data and health care coverage between the new behavioral health "agency" and Medical Assistance (Medicaid) when Medicaid funded behavioral health program and services stay within DHS. • Risk of eroding the parity among behavioral health, physical health conditions, and reduced coordination of care across other healthcare services. • Potential for unclear authoritative structure for matters that extend across different agencies. • Multiple agency decision makers could result in less clear accountability, slower decisions, and lack of understanding of roles and responsibilities. • Multiple agencies may cause confusion for providers needing support, individuals receiving services, the general public and other partners.

Key findings

If Minnesota chooses to separate behavioral health into a distinct organization, effective communication and coordination between the behavioral health organization, DHS (Medicaid and other administrations), counties, Tribal Nations, and other partners and associations is paramount. Planning, policies and procedures, staffing, funding and administration need to be clearly outlined leaning into collaboration and coordination to reduce duplication and improve efficiency. Having a change management process and plan in place is also critical to guide the separation to foster buy-in and continuity.

Beyond standing up the Behavioral Health Administration, which serves almost exclusively as a coordinator and contractor, Colorado is actively working towards fostering a provider-friendly state, a collaborative culture, and eliminating unnecessary administrative and financial barriers for providers. Their provider engagement model, characterized by continuous bidirectional communication, a commitment to addressing provider feedback as a priority, dedicated mailing lists, scheduled email correspondence, standing forums, a clear and advertised grievance process, transparent and easily accessible rate information, and proactive provider education on regulations and payment methodologies, has proven highly effective. This model ensures that providers are involved in every step of the policy-making process, contributing to the success of the transition.

There was both support for and apprehension about having behavioral health operate as its own organization. Reasons included:

- Opportunity to create a fresh start and rebuild trust with individuals receiving services, agencies, and community partners.
- Allows for specialization and keeps behavioral health a priority since it has a dedicated team and focus.
- Concerns stemming from lingering unanswered questions (*e.g.,* What happens with appeals? Do they want to build their own appeals division, or should DHS keep appeals? What about contracts? How would you restructure teams; how do you split one supervisor?).
- Absence of a strategic plan for executing this transformation.
- Apprehensions that the parity of behavioral health with other medical diagnoses may diminish if Behavioral Health is no longer integrated with other Medicaid medical services.
- Concerns regarding the division of positions that currently support both Behavioral Health and other administrations and teams that would remain within DHS.
- Apprehension that the separation between DHS and Behavioral Health into two different agencies would result in additional administrative burdens.

Legislation

Minnesota Statutes 2022, Chapter 98, Article 6, Section 23[i] directs the Office of Addiction and Recovery to conduct this review in subsection (a):

Sec. 23. Review of Human Services Structure; Recommendation for 2023 Legislative Session.

(a) No later than September 1, 2022, the addiction and recovery director must contract with a consultant to conduct an independent review of the structure of the Department of Human Services, with a focus on substance use disorder and mental health treatment access and service delivery. The review must be completed no later than December 31, 2022.

Effective Date. This section is effective the day following final enactment.

This report was paid for in part by the Minnesota Department of Human Services under the oversight of the Minnesota Office of Addiction and Recovery.

Introduction

Overview

The Department of Human Services (DHS) utilizes the federal Substance Abuse and Mental Health Services Administration's (SAMHSA) definition of behavioral health as "the promotion of mental health, resilience and wellbeing; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities." Behavioral health systems include, and should integrate, mental health, substance use, and co-occurring disorders. The delivery of behavioral health services almost always includes a diverse array of departments, agencies, and service providers who may describe or approach behavioral health and service delivery goals differently. There are multiple system entry points, including virtual options. This can complicate access to appropriate services, and coordination and communication across services, as many individuals move throughout the continuum.

There are rising numbers of people seeking and using behavioral health services, which, combined with a nationwide workforce shortage, have put a strain on systems to meet the ever-growing need.[ii] Recent data from the National Council for Mental Wellbeing indicates that more than roughly 40 percent of Americans did not receive the behavioral health care that they needed.[iii] In addition, those involved in the provision of behavioral health services are considering behavioral health in the context of social determinants of health, such as stable housing, employment status, and social networks. This further emphasizes the need to address behavioral health with greater intra- and interagency collaboration across a comprehensive and nuanced environment.

States have the flexibility to design their behavioral health system to address the unique needs of their residents, while meeting the minimum requirements set by the federal government. The structure and financing of behavioral health systems and services varies significantly from state to state and in counties, cities, and other jurisdictions. In Minnesota's state supervised county administered system, the state is partnered with both counties and Tribes throughout the state—87 counties act as local behavioral health authorities and 11 Tribal governments respond to their constituents' behavioral health needs.

Some behavioral health systems rely heavily on federal funding sources such as such as Medicaid, SAMHSA, and U.S. Centers for Disease Control and Prevention (CDC). Federal funds can account for upwards of fifty percent or even all behavioral health system funding. Other states may have an almost equal amount of federal and state funding dedicated toward behavioral health services, depending on their state budgets. There are also differences in whether states decide to separate their children, youth and families from the adult population, both in operational and financing structures. The influx of funding in the wake of the COVID-19 pandemic specific to behavioral health affected finance models and remains an area of unknown sustainability as states plan for the future.[iv]

Scope of work

Given this complex landscape, the Governor's Office of Addiction and Recovery and Minnesota DHS ("the State") contracted Public Consulting Group (PCG) to conduct an independent review of Minnesota's behavioral health system under DHS, as required by under Minnesota Statutes 2022, Chapter 98, Article 6, Section 23, Subsection (a). This review will help the state to develop a path forward to better support individuals with behavioral health, substance use, or co-occurring disorders, and improve collaboration and coordination of treatment and recovery services and outcomes—both from an organizational and economic perspective.

This report is organized as follows:

1. **State-level organization of Behavioral Health Services:**
    a. An assessment of the current organizational structure of behavioral health services in Minnesota and DHS based on the results of the organizational review.
    b. A comparison of Minnesota's state-level organization of behavioral health services with other states, including other states with county administration of services, including strengths and weaknesses of different structures.
2. **Financing of Behavioral Health Services:**
    a. An assessment of Minnesota's current financing strategy for behavioral health services, with a focus on the dependence on grant funding.
    b. A benchmarking analysis of Minnesota's approach to financing of behavioral health services with the approach of benchmark states, including how Minnesota is different or like other states in its financing approaches, and an analysis of the strengths and weaknesses of different approaches.

Methods

To assess the organizational structure and financial strategy, PCG conducted a document review, engaged partners through interviews, and conducted benchmarking analysis. The following sections describe the methods utilized for each component.

Document Review

PCG requested and reviewed materials with relevant information related to understanding the legal requirements shaping the current DHS organizational structure, the strategic decisions shaping DHS behavioral health services, and how DHS finances behavioral health services. These included the documents outlined in **Table 9**.

Table 9. Summary of Documents Reviewed

Category	Purpose	Information/Document(s)
Legislative Proposals	Understand recent legislative efforts to separate parts of DHS and form new agencies to help better manage required management and oversight.	• 89th Session: H.F. 2832 / S.F. 2676 • 90th Session: S.F. 3643 • 91st Session: S.F. 1586 • 92nd Session: H.F. 1024, S.F. 4041, S.F. 132 • 93rd Session: S.F. 341, S.F. 376
Strategic and Compliance Plans	Understand the strategic decisions shaping DHS behavioral health services and efforts being made to better achieve DHS' mission, especially as it relates to behavioral health.	• DHS Strategic Plan 2023-2027 • DHS Strategic Plan 2020-2022 • DHS Strategic Plan 2018-2020 • MN 2012 Capital Budget Requests • 2023 Health, Safety, and Housing Fact Sheet • MN Governor's Budget 2024-2025
Audits and Reports Analyzing DHS' Organizational Structure	Understand previous work analyzing DHS' organizational structure in reference to legal and regulatory compliance and what the outcomes may indicate for organizational or financial structures.	• DHS: Behavioral Health Grants Management – Internal Controls and Compliance Audit • Managed Care Organizations (MCO): Personal Care Assistance Services Encounter Data and Oversight Performance Audit • Managed Care Organizations: Reporting of Dental and Mental Health Encounter Data • Department of Human Services: Homelessness and Housing Support Grants Performance Audit • Behavioral Health Division Special Review Final Report • Certified Community Behavioral Health Clinics (CCBHC) Payment Review • Mental Health (MH) Rate Enhancements • Mini Grant Process- Mini Grant Applicant and Official Grant Award Notification • State Opioid Response (SOR) Award Report • SOR Eligible Expenses
Financial Information	Understand how DHS finances behavioral health services and the relative size of behavioral health services revenues and expenditures compared to DHS.	• SOR Grant Application • SOR Grant Descriptions • Bi-annual block grant application • OERAC & settlement distribution • Adult Mental Health Initiative Fact Sheet • CCBHC Overview • 1115 SUD waiver – status and trajectory • DAANES overview • MN Medicaid State Plan • Basic Health Program Blueprint • MCO Model Contracts • Minnesota Management and Budget Program Summaries • Behavioral Health Fund (BHF) Eligibility

Category	Purpose	Information/Document(s)
		• Grantees and contracted entities for various DHS grants
Legal Requirements	Understand the framework of legal requirements shaping the DHS' behavioral health organizational structure.	• Chapter 245, Department of Human Services • Adult Mental Health, Sections 245.461 – 245.4863 • Children's Mental Health Act, Sections 245.487 – 245.4888 • Chapter 254A, Substance Use Disorder • Chapter 256B, Medicaid and MinnesotaCare as payers for behavioral health services • Chapter 254B, Behavioral Health Fund • Chapter 253B, Civil Commitment • Chapter 246, Direct Care and Treatment for state operated services • Regulation of behavioral health services: • Chapter 245A, DHS Licensure Overarching • Chapter 245I, Uniform Mental Health Service Standards • Chapter 245G, Substance Use Disorder • Chapter 245F, Withdrawal Management

Partner engagement

PCG conducted 39 individual and small group interviews with state parties, Tribal partners, professional associations, and other identified partners. Interviews focused on three high level components: 1) a review of the behavioral health organizational structure within DHS; 2) a review of the way Minnesota finances behavioral health; 3) a review of Minnesota's behavioral health continuum of care with a particular focus on substance use disorder. The associated agencies and organizations that participated in interviews are listed in **Table 10** below. The interview protocol can be found in *Appendix A: Interview Protocol*. Additionally, partners provided visions for the future state of Minnesota's behavioral health system which can be found in *Appendix B: Partner visioning.*

Table 10. Partner Engagement Summary

Collaborative Partners Interviewed
AspireMN
MN Management and Budget
DHS Agency Effectiveness
DHS Behavioral Health, Housing and Deaf and Hard of Hearing Services
DHS Contracts Attorney
DHS County Relations
DHS Executive Team
DHS Health Care Administration/Medicaid
DHS State Advisory Council on Mental Health
DHS American Indian Mental Health Advisory Council
DHS Substance Use Disorder & 1115 Substance Use Disorder System Reform Team
Minnesota Alliance of Recovery Community Organizations (MARCO)
Minnesota Association of Resources for Recovery and Chemical Health (MARRCH)
Association of Minnesota Counties
Minnesota Hospital Association
MN Association of Children's Mental Health (MACMH)
MN Association of Community Mental Health Programs (MACMHP)
MN Management and Budget
Native American Community Clinic
MN Association of County Social Service Administrators (MACSSA)
National Alliance on Mental Illness (NAMI) MN

Collaborative Partners Interviewed
Stearns County
Crow Wing County
Southwest Health and Human Services

Peer state selection and benchmarking

Peer state selection and benchmarking was conducted, comprising of three components: 1) a peer state selection table was created to aid Minnesota in selecting three states, 2) an in-depth analysis was conducted to learn best practices in organizational structure and finances for behavioral health services, and 3) interviews were conducted with behavioral health and Medicaid leadership from the selected states.

Peer state selection table

To select benchmarking states, DHS and PCG ranked states for similarity to Minnesota based on their demographic indicators (*e.g.,* population size, race, method of mental health service administration). Additionally, states were ranked based on nine unique mental health performance indicators selected by PCG and DHS that help frame how states are faring in their behavioral health systems. Based on analysis of the two ranking processes above, and preferences expressed through partner interviews, DHS chose to further examine **Colorado, Connecticut, and North Carolina.**

Peer state landscape review

PCG conducted a literature review for each of the three identified benchmark states, searching online for publicly available data about their organizational structure and financial structure, such as organizational charts, state budgets, reports, connections to other state programs, enabling statutes, and Medicaid State Plans, noting findings in a content review document.

Peer state interviews

To gain a deeper understanding of the benchmark states, PCG interviewed a behavioral health and a Medicaid leader from each of the benchmark states. These one-hour interviews provided an opportunity to dive deeper into how the benchmark state's behavioral health systems were developed, structured, and maintained and the elements that truly make a difference in outcomes.

Following completion of the literature review and analysis, PCG worked with the State to prioritize organizational and financial model elements that Minnesota may benefit from adopting or adapting, along with an analysis of their strengths and weaknesses.

Limitations

Limitations for this review included the following:

- This is an ambitious scope, executed within a limited timeframe (7/1/2023–11/3/2023) using resources available within that timeframe.

- Interviewees, while carefully selected to contain a representative sample, will not include every voice. The wide-ranging perspectives from the variety of partners included did not necessarily generate cohesive options for the state.
- Interviewee perspectives that were shared in the majority of interviews and reviewed with OAR were included in this report; findings were validated using document review as time allowed within this limited timeframe.
- While multiple attempts were made to include Tribal Nation partners, only two interviews were conducted with Tribal Nation partners; 11 were planned.
- The document review relied on DHS and partners providing relevant materials and does not represent every relevant document to the behavioral health system.
- Financial data provided to PCG for DHS spending were for Fiscal Year (FY) 2022, the most recent complete FY available, which was an unusual year due to the COVID-19 pandemic. Data on payments for behavioral health services were limited to DHS funding sources and expenditures and do not account for payments made by private or commercial insurance.

How to use the report

To minimize length of this review key topics are included in the body and supported by relevant detailed materials in the appendices. The report concludes with opportunities and options to enable the State to make data informed decisions for the best path forward to better support individuals with behavioral health, substance use, or co-occurring disorders, and improve collaboration and coordination of treatment and recovery services and outcomes—both from an organizational and economic perspective.

History of past work

Minnesota DHS is responsible for overseeing a wide range of programs and services aimed at supporting the well-being and health of individuals and families in the state. This includes behavioral health services, which encompass mental health and substance use treatment and supports. The organizational structure of DHS has changed over time and has been influenced by various legal and regulatory requirements.

Throughout Minnesota's history there has been an ever-changing landscape of funding and service delivery for mental health and substance use services. While changes to the mental health services and care in the years leading up to the late 1980s were primarily guided by Federal Acts, starting in 1987 Minnesota created a pair of Acts focused on the mental health of its citizens. The push for deinstitutionalization in the 1980s led to a decrease in individuals in Minnesota hospitalized for mental health conditions, which began a shift in moving funding away from the medical institutions to multi-county Adult Mental Health Initiatives (AMHIs). These community mental health centers expanded services offered to the public and fulfilled the new mandate for community mental health centers; however, Children's Mental Health Services did not see the same influx of community funding.

The funding and service delivery continued to shift through the 1990s, from being delivered by organizations at a county level to a more complex model which includes a web of Medicaid, State, Local and Federal actors. During this time, some health care organizations adopted a fee-for-service model of funding creating stand-alone providers under Community Mental Health Organizations. These organizations at times operate without direct government subsidies but are often contracted by counties to be the point of service provider for sliding-scale mental health services. Mental Health became a focus of reform in the early 2010s which were marked by state laws expanding services, funding, and focusing on establishing a reliable workforce. Over the next decade there was a push for Medicaid Reform and eventually expansion, which was also coupled with behavioral health systems transformation.

In 2016, Governor Mark Dayton created the Task Force on Mental Health which ultimately developed a final report of recommendations for the state system.[v] The report concluded that availability of services varied by region, services were focused on downstream treatment rather than prevention and delivery and funding were disjointed. Since that report, there have continued to be administrative changes in the oversight and delivery of these services.

In 2018, there was a merger of the Alcohol & Other Drug Abuse (ADAD) and the Children's and Adult Mental Health divisions to form the Behavioral Health Division (BHD).[vi] Previously each had their own deputy director, and both left during the transition, leaving a vacant position for the deputy director role. During this time, BHD was responsible for the management of more than 150 grants. More recently behavioral health was integrated with Housing and Deaf and Hard of Hearing to form Behavioral Health, Housing and Deaf and Hard of Hearing Services Administration, and a new Assistant Commissioner was appointed. There have also been leadership changes to ensure adequate representation for both mental health and substance use disorder.

In 2023, the Walz-Flanagan Administration proposed that the state separate DCT services, which operate state behavioral health hospitals and other facilities, into its own agency. In addition, a second proposal focused on the creation of a new DCYF which would oversee childcare and early learning programs, child support, child safety, permanency and family focused community programs, economic and food assistance programs, and youth programs. These programs and personnel who oversee them would no longer be under DHS, but instead

would operate independently and be merged with other children and youth focused services from the Departments of Education, Public Safety and Health. **Table 11** below illustrates the evolution of mental health care in Minnesota over time, highlighting the most significant factors in developing the current system.

Table 11. Timeline of Mental Health Care in Minnesota

Year:	Milestone
Era:	**Institutionalization**
1866	State hospitals were created to provide centralized care.
1963	President Kennedy signed the Community Mental Health Act which aimed to create a system of care to provide therapy and medicine.
1965	Creation of Medicaid.
1981	Funding was significantly cut for the Community Mental Health Act.
1982	The Commitment Act revised the involuntary commitment process, updating the language and ensuring commitments were related to the likelihood of physical harm.
Era:	**Changing Structure and Laws**
1987	Adult Mental Health Act was signed into law leading to the creation of new community services and dedicated funding for mental health.
1989	MN created the Children's Mental Health Act, which focused on emergency and outpatient services, screening and identification, case management and residential treatment
Era:	**Medicaid Reforms and Economic Uncertainty**
2002–07	Medicaid mental health benefits were expanded.
2007	Mental Health Act was signed in MN and included Model Mental Health Benefits under Medicaid, supportive housing, respite services, school mental health linkages, and Community Behavioral Health Hospitals.
2009	Wellstone-Domenici Mental Health Parity and Addiction Equity Act was signed by Present Bush to support equitable insurance coverage for mental health and substance use disorders.
2008–09	Recession leads to budget cuts for services and delayed implementation.

Year: / Era:	Milestone / System Change
2013, 2015	MN enacts mental health reforms including funding expansion, increased services, and addressing workforce shortages.
2016	Governor created a Task Force on Mental Health to create recommendations for the mental health system.
2017	Creation of the MN Behavioral Health Planning Council to advise the DHS Behavioral Health Division on how to use the Mental Health and Substance Use Block Grant.
2018	Merger of the Alcohol & Other Drug Abuse division and the Children's and Adult Mental Health division to create the Behavioral Health Division.
2019	DHS payment errors identified leading to the exploration of scope of the department.
2022	MN created the Opioid, Substance Use, and Addiction Subcabinet to focus on service provision. The Comprehensive Mental Health Acts were revised.
2023	Two proposals were put forward by the Walz-Flanagan Administration to separate Direct Care and Treatment into its own agency and create a new Department of Children Youth and Families.

Relevant audits

Much of the previous work analyzing DHS' organizational structure has been memorialized in audits conducted by Minnesota's Internal Audits Office (IAO) or the Office of the Legislative Auditor (OLA). Nine audits have been conducted on topics related to whether DHS remains in compliance with expected management duties and oversight of grants and program delivery. Seven of the nine audits had substantiated findings, underscoring a need for additional oversight. These reports identified noncompliance by DHS-contracted Medicaid managed care organizations (MCOs), and inadequate internal controls within DHS to ensure compliance of BHD to meet legal and state policy requirements. Internal compliance concerns were also cited by IAO around housing support grants and the State Opioid Response (SOR) grants. The audits and their results are summarized in *Appendix C: Summary of DHS Audit Findings*.

Relevant statutes and legislation

Minnesota state laws and regulations play a significant role in shaping the organizational structure of the DHS, including its BHD. These laws outline the specific responsibilities of the department, the creation of specific units or divisions within the department, and the qualifications and requirements for staff members. For example, the Minnesota Comprehensive Adult Mental Health Act governed by Chapter 245, Sections 245.461-245.4863, not only defines the mission of adult mental health services that must be fulfilled by the DHS Commissioner and

County Boards, it also includes a housing mission statement so that housing services are considered integral to a comprehensive mental health service system, mandates that mental health conditions are defined by established diagnostic codes, and requires and mandates that DHS seek and apply for federal and other nonstate, nonlocal government funding to maximize nonstate, nonlocal dollars for these services. Similarly, the Minnesota Comprehensive Children's Mental Health Act is governed by Chapter 245, Sections 245.487–245.4889, and Chapter 254A creates an Alcohol and Other Drug Abuse Section within DHS. For more statutes relevant to DHS reviewed by PCG, refer to *Appendix D: Relevant Statutes and Regulations*.

The state regulation of behavioral health services is constantly evolving. Several mental health services are currently unlicensed but will be moving into licensure within various Minnesota statutes. There is also ongoing work to simplify overlapping regulations to improve outcomes and consistency in services, among other goals. Efforts include work on overarching DHS licensure within Chapter 245A, the Uniform Mental Health Service Standards within Chapter 245I, Substance Use Disorder within Chapter 245G, and Withdrawal Management within Chapter 245F.[vii]

Since the 89th Legislative Session (January 6, 2015, to January 2, 2017), several bills have been introduced to influence DHS statutes and relate to the creation or the transferring of duties once held by DHS to another agency or board to allow for clearer duties within the agency and improve program delivery. **Table 12** below summarizes recent legislative efforts to alter the structure of DHS, including the session, bill number, title, and how far the bill made it through the legislature in its session. Note that none of them, including those in the current 93rd Session, have been enacted as of the writing of this report in December of 2023 and will need to be reexamined over time.

Table 12. Recent Legislative Efforts to Alter the Structure of DHS

Session	Bill No.	Title	Status
89th Session (2015–2017)	**H.F. 2832**	A bill for an act relating to state government; creating a Health and Human Services Coordinating and Financing Board to coordinate health and human services programs; restructuring the Department of Human Services by establishing a Department of Health Care Services, Department of Forensic Services, Department of Direct Care Services, and Office of Eligibility Services.	Health and Human Services Reform Committee, March 10th, 2016.
89th Session (2015–2017)	**S.F. 2676**	A bill for an act relating to state government; creating a Health and Human Services Coordinating and Financing Board to coordinate health and human services programs; restructuring the Department of Human Services by establishing a Department of Health Care Services, Department of Forensic Services, Department of Direct Care Services, and Office of Eligibility Services.	Health, Human Services, and Housing Committee, March 14th, 2016.

Session	Bill No.	Title	Status
90th Session (2017–2019)	**S.F. 3643**	A bill for an act relating to human services; establishing a working group to make recommendations on restructuring the Department of Human Services.	Health and Human Services Finance and Policy Committee, March 21st, 2018.
90th Session (2017–2019)	**S.F. 2023**	A bill for an act relating to human services; establishing a working group to make recommendations on restructuring the Department of Human Services.	Health and Human Services Finance and Policy, March 13th, 2018.
91st Session (2019–2021)	**S.F. 1586**	A bill for an act relating to state government; creating a Department of Direct Care and Treatment and Office of Inspector General.	Adopted as amended on March 28th, 2019, and then was referred back to the Rules and Administration Committee, and the Human Services Reform Finance and Policy Committee.
91st Session (2019–2021)	**H.F. 2783**	A bill for an act relating to state government; creating a Department of Direct Care and Treatment and Office of Inspector General.	Human Services Reform Finance and Policy committee, April 1st, 2019.
92nd Session (2021–2023)	**H.F. 1024**	A bill for an act relating to early childhood care and learning; establishing a Department of Early Childhood.	Adopted as amended on and re-referred to the Human Services Finance and Policy Committee, February 25th, 2021.
92nd Session (2021–2023)	**S.F. 2170**	A bill for an act relating to early childhood care and learning; establishing a Department of Early Childhood.	Education Finance and Policy Committee, March 18th, 2021.
92nd Session (2021–2023)	**S.F. 4041**	A bill for an act relating to state government; creating a Health and Human Services Coordinating and Financing Board to coordinate health and human services programs; restructuring the Department of Human Services by establishing a Department of Health Care Services, Department of Forensic Services, Department of Direct Care Services, and Office of Eligibility Services.	Human Services Reform Finance and Policy Committee, March 16th, 2022.

Session	Bill No.	Title	Status
92nd Session (2021–2023)	**H.F. 4545**	A bill for an act relating to state government; creating a Health and Human Services Coordinating and Financing Board to coordinate health and human services programs; restructuring the Department of Human Services by establishing a Department of Health Care Services, Department of Forensic Services, Department of Direct Care Services, and Office of Eligibility Services.	Human Services Finance and Policy Committee, March 23rd, 2022.
92nd Session (2021–2023)	**S.F. 132**	A bill for an act relating to state government; creating Department of Direct Care and Treatment and Office of Human Services Licensing and Integrity.	Human Services Reform Finance and Policy Committee, January 14th, 2021.
92nd Session (2021–2023)	**H.F. 1242**	A bill for an act relating to state government; creating Department of Direct Care and Treatment and Office of Human Services Licensing and Integrity.	Human Services Finance and Policy Committee, February 18th, 2021.
93rd Session (2023–2025)	**S.F. 341**	A bill for an act relating to human services; transferring childcare assistance program fraud investigation unit from Department of Human Services to Department of Public Safety.	Health and Human Services Committee, January 17th, 2023.
93rd Session (2023–2025)	**S.F. 376**	A bill for an act relating to state government; creating Department of Direct Care and Treatment and Office of Human Services Licensing and Integrity.	State and Local Government and Veterans Committee, January 17th, 2023.
93rd Session (2023–2025)	**H.F. 1703**	A bill for an act relating to state government; creating Department of Direct Care and Treatment and Office of Human Services Licensing and Integrity	Human Services Policy Committee, February 13th, 2023.

Strategic plans

Minnesota has completed significant work to identify gaps relative to behavioral health services and address these gaps within their DHS Agency Strategic Plan and One Minnesota Budget priorities.

The 2023–2027 DHS Agency Strategic Plan explicitly names behavioral health within Goal A.2 to help people in Minnesota thrive, namely “Promote adult and children’s safety and wellbeing with easy access to behavioral

health supports and optimal living situations."[1] Metrics, milestones, and strategies relative to Goal A.2 are described in **Table 13** below. A visual representation of the 2023–2027 DHS Agency Strategic Plan can be found in *Appendix E: DHS Agency Strategic Plan 2023–2027.* The Strategic Plan also cites several other goals relevant to behavioral health services, including,

- Advancing policies and programs that support equity, justice and stability in food, housing, income, childcare and health care (Goal A.1);
- Transform and strengthen the service delivery experience to be equitable, accessible, caring and responsive (Goal B.1);
- Administer programs effectively and efficiently through streamlined processes and reduction of errors, fraud, and waste (Goal B.2);
- Build capacity to partner with Tribal Nations and counties to envision a human services system that works for the people in Minnesota (Goal B.3);
- Equip partners and providers with resources and technical assistance to maintain program integrity and deliver better services (Goal B.5); and
- Be a collaborative partner in the creation of separate state agencies while supporting employees and continuity of operations (Goal C.4).

Table 13. Goal A.2 in the 2023–2027 DHS Agency Strategic Plan

Sample Metrics and Milestones	Select Strategies
• Increase the proportion of youth and adults with mental health disorders and substance use disorders (SUD) who get treatment in MN • Decrease the proportion of Black, Brown and Indigenous children in MN experiencing out-of-home placement • Decrease the percentage of SUD and mental health recipients experiencing homelessness • Reduce the number of fatal opioid overdoses	• **People experiencing mental health and/or substance abuse needs:** Ensure people receive integrated, culturally responsive care in the most appropriate setting, in every corner of the state. • **People experiencing a behavioral health crisis:** Expedite and streamline the process to receive mental health and substance abuse disorder services, including telehealth. • **Children needing behavioral health services:** Invest in expansion of children's mental health providers and service options, including screening and prevention in primary care and school settings. • **Black, Brown, and Indigenous children and families:** Focus on mitigating the need for out-of-home placement by

[1] Note at the time of writing, the 2023–2027 DHS Agency Strategic Plan was provided to PCG in draft form.

Sample Metrics and Milestones	Select Strategies
	supporting population specific child welfare infrastructure. • **People experiencing opioid use disorder:** Deploy dedicated funds and resources to combat the opioid crisis focusing on disproportionately impacted communities.

In a DHS overview document from 2021, *Minnesota's Behavioral Health System: An Overview*, several gaps were identified, including crisis services, opioid crisis, inequitable access among Black, Indigenous, and People of Color (BIPOC) communities, support for long-term recovery, workforce shortages, unique challenges posed by the pandemic, uniform service standards, and community-based behavioral health rates. The *2023 Health, Safety, and Housing Fact Sheet* that details the changes aimed at addressing many of these behavioral health system gaps through One Minnesota Budget funding priorities including but not limited to:

- **Removing health care access barriers**, such as improving accessibility and readability of information, application and enrolment processes, enhancing coverage information for children with disabilities, and extending MinnesotaCare coverage to undocumented children younger than 19.
- **Improving access to mental health care**, including paying for room and board services at residential facilities, a 50 percent increase in the adult day treatment rate, increased funding to help people exit institutional settings, and funding an online tool to better match people to behavioral health programs.
- **Expanding mental health crisis and early intervention services**, addressing gaps in the mental health care continuum, expanding mobile crisis services, and increasing First Episode Psychosis services.
- **Supporting Minnesotans with substance use disorders**, including allocating more resources to disproportionately impacted communities and investments in data and evaluation infrastructure.
- **Improving sober housing**, including establishment of a certification program for sober homes that receive state funding and voluntary certification for privately funded sober housing programs.
- **Promoting mental health**, including funding for community-based organizations and local health departments to develop and implement community-identified solutions for communities most impacted by COVID-19.
- **Supporting stable housing and successful reentry**, investing in proven practices that support an individual's ability to establish stable housing and reintegrate into life outside prison.
- **Increasing emergency shelter and housing**, including more funding for a number of established programs and one-time funding to acquire, build, or renovate emergency shelters.
- **Helping Minnesotans keep their Medical Assistance (MA) and MinnesotaCare coverage** through funding for policy updates, administrative support, and funding navigator organizations to help enrollees with renewal paperwork.

There have also been mental and behavioral health assessments conducted by the Minnesota Hospital Association (MHA) that identify persistent challenges and gaps. In 2015, the MHA developed a report following

the infusion of a $51M investment of public funding from the 2015 legislative session. Findings cited that despite this infusion of funds, capacity was lacking to keep up with the growing demand for mental health and substance use disorder services and needs of Minnesotans without additional funding, clinical innovations and policy reform.[viii]

Recommendations from this report included decrease stigma and increase awareness; reduce variations that impede optimal care; implement evidence-based practices; leverage telemedicine technology; create statewide assessment standards or tools; maximize capacity of unique services provided by the state; improve access to care at community behavioral health hospitals; repurpose unused capacity in rural hospitals for mental health. In 2022, they produced a *Workforce Report*, which indicated rebuilding the health care workforce is MHA's top focus area; it cites 8,861 open positions in the state's hospitals and health systems, representing almost a 225 percent increase over the past year.[ix]

It is worth noting that many reports have been cited as evidence leading to legislative initiatives and policy changes.

State-level organization and benchmarking of behavioral health services

As the State's largest agency, DHS oversees an annual budget of $23B, representing 31 percent of state spending and employs about 7,000 staff. DHS administers a broad range of programs and services including healthcare, economic assistance, mental health and substance use prevention and treatment, child welfare services, and services for the elderly and people with disabilities that support Minnesota's most vulnerable populations across the lifespan. In reviewing other peer states, Minnesota DHS has similar functions and responsibilities to other equivalent Human Service Agencies.

The size of DHS and scope of DHS services has been a frequent area of focus and scrutiny with the state, heightened in recent years through DHS payment errors found in audits, and has led to various legislative proposals to separate DHS into what are considered more manageable agencies and administrations. These proposals would remove certain services from DHS and create separate commissioner-led state agencies to improve visibility and priority for those services. Traction has been made recently through the Walz-Flanagan Administration to split Direct Care and Treatment's 5,000-member staff (DCT) to become its own agency led by a Governor-appointed board, and create a new Department of Children, Youth, and Families (DCYF) that would result in most programs for children, including public assistance programs, moving out of DHS and combined with other children's programs from the Minnesota Department of Education (MDE), the Minnesota Department of Public Safety (DPS) and the Minnesota Department of Health (MDH). Additionally, moving behavioral health to its own agency has also been discussed.

Currently, while primarily managed by a dedicated Behavioral Health Division, administration of behavioral health policies and services touch many administrations within DHS as well as within other Minnesota state agencies. This review comes at a pivotal time, both in the examination and reorganization of DHS, as well as the growing shift for behavioral health system reform as multiple epidemics have converged and the need for mental health and substance use disorder services have surged.

A well-organized behavioral health agency or division should have strong leadership, dedicated and sustainable funding, a multidisciplinary and competent staff, comprehensive and streamlined services across the continuum, and a commitment to collaboration and data-driven decision-making. By addressing these key aspects, States can better serve the needs of their communities and improve the overall well-being of individuals struggling with behavioral health challenges.

The first section of this report comprises an assessment of the organization of Minnesota's behavioral health system within DHS and among partners, considering key partners' roles, legislation, and their collaboration and coordination. This is followed by a comparison and benchmarking of organizational structures and implementation of behavioral health services that was conducted across three states (Colorado, Connecticut, and North Carolina) identifying strengths and weaknesses as well as similarities and differences to Minnesota.

Current organizational structure of behavioral health services

This section outlines Minnesota's current organizational structure of behavioral health, examining its composition and operations across state, county, and Tribal entities and the collaboration and coordination within and among them.

Department of Human Services (DHS)

DHS holds the principal role in overseeing the management and regulation of behavioral health services in Minnesota.

DHS collaborates with community providers, advocates, and partners to develop and implement policies that promote equitable access to care, improve service delivery, and enhance the overall well-being of the state's residents. Additionally, DHS is the single state agency that oversees administration of the Medicaid program. In the 2023–2027 DHS Agency Strategic Plan, DHS's stated outcomes of their ongoing efforts within the Department are that a.) people in Minnesota thrive, b.) people experience high-quality human services, and c.) people at DHS thrive in an inclusive environment.

DHS operates within the executive branch of the state government and is one of 20 executive agencies overseen by a commissioner who is appointed by the governor and approved by the state Senate. DHS is separated into three organizational components: The Commissioner, the Deputy Commissioner of Agency Culture and Relations, and the Deputy Commissioner of Agency Effectiveness (**Figure 1**). Further information about the human service administrations is available in *Appendix F: Minnesota DHS Human Service Administrations*.

Figure 1. DHS Organizational Components

Commissioner	Deputy Commissioner of Agency Culture and Relations	Deputy Commissioner of Agency Effectiveness
• Aging and Disability Services • Behavioral Health, Housing and Deaf and Hard of Hearing Services • Children and Family Services • Direct Care and Treatment • General Counsel's Office • Health Care Administration • Office of the Inspector General • Office of Strategy and Performance	• Communications Office • Community Relations • County Relations • Employee Culture • Equity and Inclusion • Federal Regulations • Legislative Relations • Office of Indian Policy	• Compliance Office • Financial Office • Management Services Division • Business Solutions Office • Chief Service Transformation Officer • Operations Director of Equity and Inclusion • Minnesota IT (MNIT) Services

Behavioral health system collaborative partners

In addition to the administrations described above, other state agencies are also directly involved in Minnesota's behavioral health system, with nearly all agencies having some kind of interaction due to the breadth of behavioral health services. DHS noted that the following agencies contribute to the behavioral health system:

- **Department of Health** – Provides prevention through a public health lens (*e.g.*, the 988-suicide hotline and overdose prevention services); workforce development (*e.g.*, loan forgiveness); and oversight and regulation of settings that provide behavioral health care or serve people with behavioral health needs (*e.g.*, hospitals, nursing facilities).
- **Department of Commerce** – Regulates health insurance parity.
- **Housing Finance Agency** – Provides rental assistance and other supports for people with mental illnesses (*e.g.*, Bridges).
- **Department of Agriculture** – Administers a small grant program to support the behavioral health needs of farmers and farming communities.
- **Health Licensing Boards** – Each behavioral health discipline has a separate licensing board that regulates individual licensed providers.

Regional Initiatives Counties, and Tribal Nations

Regional initiatives, counties, and Tribal Nations also play a vital role in Minnesota's behavioral health continuum of care, contributing to the state's comprehensive and integrated approach to promoting mental health and well-being.

Regions

Adult Mental Health Initiatives (AMHI)

In the early 1990s, the closure of Minnesota's Regional Treatment Centers prompted the state to encourage counties to develop partnerships with neighboring counties to plan for and develop acute care and community-based mental health treatment for individuals who had been served by the Regional Treatment Centers.

Following the partnerships that were formed during this initiative, legislation was passed in 1996 to expand grant funding for regional AMHIs. These partnerships foster ongoing planning and service expansion efforts. Minnesota currently has 18 AMHIs that include regional county and tribal initiatives. For a map of these AMHIs, see *Appendix G: Adult Mental Health Initiatives Map*.

AMHIs are collaborative endeavors, who continually assess, evaluate and adjust their service models, overseeing adult mental health services and funding for counties and Tribal governments in their respective regional areas.[x] The duties of each AMHI are unique, allowing for customized service delivery designs tailored to the specific needs of each region. This flexibility enables even small or sparsely populated counties to develop services that would otherwise be beyond their capacity. The AMHIs serve as mechanisms for regional collaboration, helping to build community-based mental health services in Minnesota.

Each AMHI has a board that is tasked with ensuring all eligible individuals are not denied services. Additionally, the board is required to furnish the Commissioner of Human Services with pertinent information and reports in a timely manner. This involves submitting mental health plans and plan amendments, providing social services expenditure and grant reconciliation reports, and participating in data submission and evaluation.

In summary, Minnesota's AMHIs serve as regional entities that coordinate, plan, fund, and oversee the delivery of mental health and substance use disorder services. Their role is multifaceted, involving collaboration, customization, and continuous improvement to meet the diverse mental health and substance use needs of the communities they serve.

Currently, DHS is collaborating with regions to reform AMHIs, aiming to maximize the utilization of available resources, develop person-centered services based on individual and cultural strengths, employ data to evaluate service impact on health outcomes, and foster partnerships for comprehensive mental health support.

In a DHS document, *Adult Mental Health Initiatives,* from 2020, the document does note that, "when the initial legislation passed, AMHIs were considered pilot projects to provide alternatives or enhance coordination of mental health services. While this has happened to some extent across the regions, many of these dollars have become part of the base funding for a region's mental health delivery services."[xi]

Local Mental Health Advisory Councils (LACs)

In Minnesota, the presence of LACs is also mandated in all counties—though compliance throughout the state varies widely[xii]. LACs are typically established by the county board and provide individuals, parents, families, and providers with a tangible avenue to influence the delivery of mental health care within their community. They also offer county and state policymakers the insights derived from people's firsthand experiences. LACs should ideally consist of diverse groups of individuals who accurately represent the community they serve.

The primary aim of LACs is to leverage the collective knowledge of a diverse group of individuals to enhance mental health services. Legislation mandates specific membership requirements, including individuals who have received mental health services, their family members, and mental health professionals. Many LACs find it beneficial to involve community leaders, representatives from diverse communities, tribal members, schools, law enforcement, crisis responders, mental health center organizations, advocacy groups, and individuals interested in public policy.

Multi-county and regional LACs are also allowed but need to ensure that individuals with lived mental illness experience and family representation are present from each county.

Counties

Minnesota's Comprehensive Mental Health Act established and governs the framework for Minnesota's publicly provided mental health system, which is under the oversight of the Department of Human Services and is operated at the county level. Counties also act as the **local mental health authority.**

Counties are responsible for providing or contracting for sufficient infrastructure to address the mental health and substance use disorder needs of their residents. This includes assessing the needs of the community, identifying gaps in the service continuum, and coordinating with providers to fill those gaps. Counties must prioritize and implement evidence-based services and seek continuous improvement for their behavioral health programs, which includes continued assessment and evaluation of services to ensure they meet the needs of their residents.

Counties receive funding from both state and federal sources and are responsible for distributing these funds to local service providers. Counties contract with a network of mental health and substance use disorder service providers to ensure that services are available to residents. This involves selecting qualified providers through a competitive bidding process and monitoring their performance to ensure quality and compliance with state and federal regulations. When applicable, counties must also incorporate state facilities and resources into their community mental health infrastructure.

Counties are responsible for ensuring that crisis services are available to individuals experiencing mental health or substance use crises. This may involve funding crisis hotlines, crisis stabilization programs, or crisis intervention teams.

Counties often engage in public awareness campaigns and educational initiatives to reduce stigma, increase awareness of available services, and promote mental health and substance use disorder prevention.

In summary, counties in Minnesota play a vital role in the access and delivery of mental health and substance use disorder services to their residents. They are responsible for planning, funding, coordinating, and monitoring services to ensure that individuals in their communities have access to the care and support they need. County-level involvement is critical for tailoring services to the specific needs of local populations while operating within the broader framework of state and federal regulations.

Tribal Nations

There are 11 sovereign Minnesota Tribes that ensure the well-being of American Indian citizens throughout the state of Minnesota including the delivery of mental health and substance use disorder services within their jurisdictions.[xiii],[xiv] This sovereignty is recognized and protected by federal law. Tribal Nations in Minnesota have a unique and important role in the access and delivery of mental health and substance use disorder services within their respective communities. The relationship between Tribal Nations and the state of Minnesota in these areas is guided by a combination of federal laws, state regulations, and Tribal sovereignty. Key aspects of the Tribal Nation's role in mental health and substance use disorder services include:

- Many Tribal Nations in Minnesota operate their own tribal health systems, which include clinics, hospitals, and behavioral health programs. These systems are often responsible for providing a wide range of healthcare services, including mental health and substance use disorder treatment, to Tribal members.
- Tribal Nations often engage in education and prevention efforts aimed at reducing substance use and misuse and promoting mental wellness within their communities; initiatives include awareness campaigns, workshops, and outreach programs.
- Tribal Nations may have their own crisis response teams or services to address mental health and substance use crises within their communities.

It's important to note that the role of Tribal Nations in mental health and substance use disorder services is shaped by their unique histories, cultures, and needs. Collaboration and respect for Tribal sovereignty are key principles in ensuring that services are effective and culturally sensitive. Additionally, the federal government has a trust responsibility to provide healthcare services to Tribal Nations. The trust responsibility is a legal and moral obligation the U.S. federal government has towards Native American tribes. This obligation is rooted in historical treaties, agreements, and laws that recognize the sovereignty of Tribal Nations and the government's responsibility to protect and support them. The focus on healthcare services implies that the federal government has a duty to ensure the well-being and health of Native American populations. This includes addressing the unique healthcare challenges faced by tribal communities, such as disparities in access to quality healthcare, higher rates of certain health conditions, and historical factors contributing to health inequalities. The responsibility further underscores the importance of federal support in this context.

Interagency collaboration

Behavioral health in Minnesota encompasses a varied array of entities, encompassing different DHS divisions, service providers, advocacy agencies, counties and Tribal Nations each offering unique perspectives on behavioral health and service delivery goals. There are several entry points to access behavioral health care and often numerous care transitions for someone moving along the continuum, underscoring the critical importance of a shared vision for whole person care through fostering transparent communication, aligning common objectives, cultivating mutual respect, and maintaining a steadfast commitment to collaborative efforts. These elements are essential to enhance the overall service provision for people receiving behavioral health services and building a more cohesive behavioral health system. While the vertical systems of governance are described in the section above, this section details horizontal work—that is, work accomplished across DHS administrations.

Internal DHS collaboration

Promoting internal collaboration and breaking down silos and/or barriers within DHS for optimal improvement of organizational performance and behavioral health outcomes is of paramount importance for DHS. At present, DHS staff engage in both formal and informal collaborations across all divisions of DHS. For example, the Medicaid Leadership team convenes regularly to comprehensively discuss Behavioral Health topics across the agency. Additionally, the introduction of Division Process Control Champions serves as a mechanism for champions to lead regular cross-divisional meetings where audit findings are addressed, risks are identified, and barriers are discussed.

External DHS collaboration

In the current landscape, DHS often leads efforts to enhance collaboration with external partners. Collaboration should extend beyond conventional behavioral health services partners to include housing, transportation, and employment partners due to their significant impact on outcomes for people. Ongoing initiatives involve behavioral health workgroups and task forces focusing on diverse areas, such as priority admissions, commitments reform, and Certified Community Behavioral Health Clinics (CCBHC).

External collaboration extends to trade organization meetings, discussions on rural and health disparities, training, education, conferences, and meetings with Tribal Nations, fostering a comprehensive problem-solving approach. External meetings that feature DHS' collaboration include the following examples highlighted during interviews:

Addressing Gaps Initiative

The mission of DHS's Addressing Gaps Initiative is to establish connections between partners and resources, with the aim of enhancing access to equitable, culturally sensitive, and linguistically appropriate services for the residents of Minnesota. For the purposes of this initiative, "services systems" encompass home and community-based services (HCBS) as well as the spectrum of community mental health services and supports. The Addressing Gaps Initiative is dedicated to maximizing and disseminating existing resources and initiatives related to four key service priority areas. It accomplishes this by identifying connections and fostering collaborative partnerships among a wide array of partners, including DHS, counties, Tribal Nations, MCOs, service providers, consumers, and local community members.

American Indian Advisory Council on Chemical Dependency

This 17-member American Indian Advisory Council[xv] is responsible for setting policies and procedures for American Indian chemical dependency programs. Additionally, it evaluates and offers recommendations for funding proposals. The council comprises representatives, with one member from each of the 11 reservations, two from Minneapolis, two from St. Paul, one from Duluth, and one from International Falls. Meetings are conducted every other month, rotating between reservations for hosting. The Commissioner of Human Services appoints members through the open appointments process and the American Indian SUD team within DHS' Behavioral Health Division attends each of these meetings

American Indian Mental Health Advisory Council

The 15-member American Indian Mental Health Advisory Council provides guidance to BHD for policies and procedures concerning American Indian mental health services and programs in Minnesota. The council includes individuals from each of the seven Ojibwe bands, four Dakota communities, and four representatives from the urban American Indian populations of Duluth, St. Paul, and Minneapolis. The appointment of representatives is carried out by the governing body of each tribal and urban community.

Minnesota Association of County Social Service Administrators (MACSSA)

MACSSA,[xvi] established in 1946, is a statewide association comprising county public social service directors and other administrative designees. Representing all 87 counties in Minnesota, the Association plays a crucial role in fostering collaboration and communication among its members.

Opioid Epidemic Response Advisory Council (OERAC)

The Opiate Epidemic Response bill was signed into law by Governor Tim Walz in 2019, creating OERAC,[xvii] a statewide committee whose primary aim is to review local, state, and federal efforts in education, prevention, treatment, and services for individuals and families affected by opioid use disorder. OERAC works to establish priorities to combat the state's opioid epidemic and recommends initiatives for funding, consulting with various commissioners to ensure alignment with other funding sources. The goal is to achieve a coordinated state effort with measurable outcomes, determining the effectiveness of allocated funds to prevention and treatment priorities, including harm reduction. The committee also proposes an administrative and organizational framework for the sustainable allocation of funds collected from the Opiate Epidemic Response.

Benchmarking analysis: Organization

To augment the review of Minnesota's organization of behavioral health system, three benchmark states (Colorado, Connecticut and North Carolina) were selected for review of their strengths and weaknesses and compared to that of Minnesota. This section considers the behavioral health organizational structure, notable regulation and legislation that influences behavioral health, and Medicaid behavioral health policy and administration in the benchmark states.

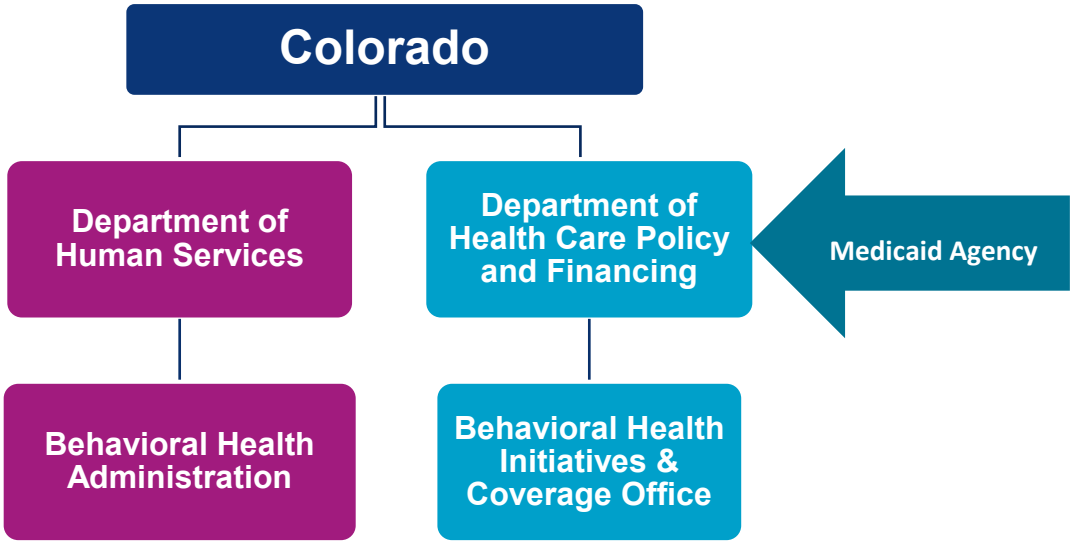
Organizational structure

The organizational structure, hierarchy, roles, and relationships within the organization vary from state to state, shaping how behavioral health services are provided, managed, and coordinated. This section provides a closer look at the structure of the identified benchmark states.

Colorado

In Colorado, behavioral health is primarily operated across two primary organizations, the Behavioral Health Administration (BHA) and the Department of Health Care Policy and Financing (HCPF). The BHA, a new cabinet-level agency established in July 2022, is the single entity responsible for driving coordination and collaboration across state agencies to address behavioral health needs across Colorado while HCPF oversees Health First Colorado, the state's Medicaid program.[xviii] The BHA was created as a result of a recent restructuring based on direction from Governor Jared Polis. The Colorado Department of Human Services (CDHS) established Colorado's Behavioral Health Task Force, which developed a plan to improve the behavioral health system in the state. **Figure 2** shows the location of the BHA, currently within CDHS and the Medicaid Agency, within the Department of Health Care Policy and Financing.

Figure 2. Behavioral Health Entities in Colorado



The BHA temporarily exists within CDHS, and its permanent location will be determined by or before November 2024. The BHA assures behavioral health priorities across the state are aligned. While building this new behavioral health system, there has been a focus on understanding and considering all perspectives, especially those that may have historically fallen through the cracks. When the BHA is fully operational, there will be roughly 180 staff across six divisions. These divisions will be responsible for administering behavioral health programs across the state, which will include SAMHSA- and state-funded programs and crisis care coordination.

The BHA currently contracts with:

- **Community Mental Health Centers** that provide mental health treatment services to individuals and families with a low income or who are not covered by insurance throughout Colorado,
- **Administrative Services Organizations (ASOs)** that provide a network of crisis care services in their regions, and
- **Managed Service Organizations (MSOs)** that manage and monitor substance use treatment services for adults and adolescents who are uninsured or under-insured in seven state Sub-State Planning Areas.

Moving forward, the BHA plans to consolidate ASOs and MSOs into regional entities that are responsible for the provider network of mental health, substance use, and crisis services as well as care coordination. These entities will be referred to as **Behavioral Health Administrative Service Organizations (BHASOs)**.[xix]

The BHA is advised by the BHA Advisory Council, comprised of people with lived experience who were selected through an application process to ensure there is public accountability and transparency across the activities of the BHA.[xx]

Connecticut

The Department of Mental Health and Addiction Services (DMHAS) is the state health care agency tasked with addressing the unique and varied behavioral health needs of Connecticut residents.[xxi] Led by a Commissioner and organized by programs and services across five defined human services districts,

DMHAS promotes and administers a range of recovery-centered mental health treatment and substance use prevention and treatment services. While DMHAS' primary focus is on supporting residents with psychiatric and substance use disorders, additional programmatic areas include addressing the needs of special populations such as those with problem gambling, criminal justice involvement, and co-occurring disorders.

DMHAS' scope includes operating direct services, funding community-based programs and coalitions, and performing oversight and monitoring of non-state operated services and programs. Services and programs are organized into **Local Mental Health Authorities (LMHAs)**.[xxii] LMHAs are the regional bodies operated by DMHAS that administer state operated and private non-profit mental health, substance use disorder, crisis, problem gambling, and other services across catchment areas. The Community Services Division at DMHAS serves an integral role in providing monitoring, compliance and technical assistance services to providers to ensure quality and mitigate concerns of providers from all sectors.

To guide programs, policies, and strategy, DMHAS leadership engages regularly with advisory boards and constituents. One such stakeholder group is the legislatively mandated State Advisory Board of Mental Health and Addiction Services.[xxiii] The State Advisory Board convenes monthly and includes appointees by the Governor and representatives from the five **Regional Behavioral Health Action Organizations (RBHAO)**. Recent agenda items included rotational report outs from RBHAOs, spotlight presentations from provider organizations, and Commissioner updates. Established in 2018, RBHAOs serve as coordination bodies to guide and lead the strategic direction and coordination of mental health and substance use disorder services across regions.[xxiv] Their scope includes cross-continuum of prevention to treatment, and community engagement services. They serve an important purpose in being a voice to elevate regional needs directly to DMHAS.

North Carolina

North Carolina's Department of Health and Human Services (DHHS) oversees the delivery of health- and human-related services in the state. The Department consists of 33 divisions and offices that fall under the six overarching service areas: Health, Opportunity and Well-Being, Medicaid, Operational Excellence, Policy and Communications, and Health Equity. The Division of Mental Health, Developmental Disabilities and Substance Use Services (DMH/DD/SUS), within DHHS provides support to achieve self-determination for individuals with intellectual and/or developmental disabilities and services to promote treatment and recovery for individuals with mental illness and substance use disorders.[xxv] DMH/DD/SUS collaborates closely with the Chief Deputy Secretary for Health to develop public policy and programs serving individuals with mental health, developmental disabilities, traumatic brain injury, and substance use needs in North Carolina.

Along with the Division of Health Benefits within DHHS, DMH/DD/SUS also oversees six **Local Management Entities (LMEs)/MCOs** that are responsible for delivering mental health, intellectual and developmental disabilities, substance use disorders, and traumatic brain injury services to individuals enrolled in Medicaid and those who are uninsured.

The Commission for Mental Health, Developmental Disabilities and Substance Use Services (Commission) has the authority to adopt, amend, and repeal rules to be used in the implementation of state and local mental health, developmental disability, and substance use service programs. The Commission also has the authority to modify specific storage, security, transaction limits and record keeping requirements that apply to particular pseudoephedrine products.[xxvi]

Notable regulation and legislation

To better understand a state's behavioral health system, it is important to consider the notable regulation and legislation that may have played an important role. The following section highlights key behavioral health regulation and legislation for each of the benchmark states.

Colorado

The Behavioral Health Recovery Act **(SB21-137)** was passed in 2021 by the Colorado General Assembly. Through this bill, $550M of American Rescue Plan Act (ARPA) funds were allocated specifically to creating transformational change in the behavioral health system in Colorado. This was expected to be done through the establishment of the Behavioral Health Task Force, which would issue a report with policy recommendations to create transformational change and recommendations for the use of these funds. Additionally, this bill included $26M in funding for care coordination. This support was intended to increase the number of Coloradans able to access behavioral health care by creating a centralized gateway for information for patients and providers that facilitates access and navigation of behavioral health care services and support. CDHS, the BHA, and the Department of Health Care and Policy and Financing (HCPF) were expected to work together using the funding to create a website and a mobile application to help Coloradans initiate care and navigate to the correct benefits and supports, including local resources such as food and housing assistance. Individuals are able to connect to Colorado Crisis Services for immediate and free behavioral health help.

During the 2022 regular legislative session, **HB22-1278**, Concerning the Creation of the Behavioral Health Administration, and, in Connection Therewith, Making and Reducing and Appropriation was passed by the Colorado General Assembly to create the BHA.[xxvii]

Upon its establishment, the BHA was expected to oversee and be aligned with **SB19-222**: Comprehensive Plan to Strengthen and Expand the Behavioral Health Safety Net System. Implementation of the Safety Net System was intended to expand community-based services that can help prevent the need for institutionalization and ensure proper supports are in place to maintain wellness and recovery, as well as ensuring treatment access. Under this model, comprehensive safety net providers are required to serve individuals with mental health and substance use needs, as well as those who have co-occurring conditions.[xxviii]

Table 14 displays the key behavioral health bill number, title, and progress.

Table 14. Colorado Behavioral Health Legislation

Session	Bill No.	Title	Progress
2019 Regular Session	SB19-222	Individuals At Risk of Institutionalization: Concerning the improvement of access to behavioral health services for individuals at risk of institutionalization, and, in connection therewith, making an appropriation.	Governor signed 5/20/2019
2021 Regular Session	SB21-137	Behavioral Health Recovery Act: Concerning the "Behavioral Health Recovery Act of 2021," and, in connection therewith, making an appropriation.	Governor signed 6/28/2021

Session	Bill No.	Title	Progress
2022 Regular Session	HB22-1278	Behavioral Health Administration: Concerning the creation of the behavioral health administration, and, in connection therewith, making and reducing an appropriation.	Governor signed 5/25/2022

Connecticut

In 1995, the Department of Mental Health and the Department of Public Health and Addiction Services were reorganized to be the DMHAS as it stands today. The duties of the Commissioner of Mental Health and Addiction are outlined in Title 17-210a, most recently updated in 2015.[xxix]

An Act Concerning Social Services and Public Health Budget Implementation Provisions (**HB-7000 PA05-280**), and later An Act Concerning the Behavioral Health Partnership (**SB-402 PA10-119**), outline the responsibilities of the Department of Social Services (DSS), Department of Children and Families (DCF), and DMHAS to institute the Connecticut Behavioral Health Partnership (CTBHP).[xxx] The CTBHP is a collaboration to implement an integrated behavioral health service system for Medicaid members to improve access and quality of care. The legislation included the creation of the **Behavioral Health Partnership Oversight Council**, which includes required membership of representatives from each participating state department, community leadership, treatment providers, individuals with lived experience and their family members, and policy experts. The Oversight Council seeks to advise the Behavioral Health Partnership on planning and implementation, including procedural definitions and updates, rate methodology and modification, clinic management guidelines, and benefit coordination policies. Additional legislation in 2015 (**HB-6987 PA 15-242**), An Act Concerning Various Revisions to the Public Health Statutes, added membership of appointees from the Department of Public Health.[xxxi]

Table 15 displays the key behavioral health bill number, title, and progress.

Table 15. Connecticut Behavioral Health Legislation

Session	Bill No.	Title	Progress
2005 Special Session	HB-7000 PA05-280	An Act Concerning Social Services and Public Health Budget Implementation Provisions	Governor signed 7/13/05
2010 Regular Session	SB-402 PA10-119	An Act Concerning the Behavioral Health Partnership	Governor signed 6/07/10
2015 Regular Session	HB-6987 PA 15-242	An Act Concerning Various Revisions to the Public Health Statutes	Governor signed 6/30/2015

North Carolina

The Commission was created as part of the Executive Organization Act of 1973, which is detailed in North Carolina General Statute **§143B-147**. This statute granted the Commission the power and duty to adopt, amend, and repeal rules to be followed in the conduct of state and local mental health, developmental

disabilities, and substance use programs. The powers and responsibilities of the Commission were expanded through the Mental Health, Developmental Disabilities, and Substance Abuse Act of in North Carolina General Statute **§122C-26**. Additionally, Session Law 2001-437, **House Bill 381**, An Act to Phase in Implementation of Mental Health System Reform at the State and Local Level, also referred to as the Mental Health Reform Legislation, further amended the powers and duties of the Commission.[xxxii] The Commission established the Rules Committee as well as the Advisory Committee to carry out its two primary functions: rulemaking and serving in an advisory capacity to the Secretary of the North Carolina DHHS.[xxxiii]

During the 2023–2024 Session, **House Bill 891**, Achieve Better Mental Health Recovery Results, was filed and written to be effective July 1, 2023. This Bill creates the position of Mental Health Recovery Policy Chief within the DMH/DD/SUS to prioritize the integration of mental health recovery values and outcomes into state policy and involve individuals with lived experience and external experts to provide insight and guidance to the DMH/DD/SUS.[xxxiv] **Table 16** displays the key behavioral health bill number, title, and progress.

Table 16. North Carolina Behavioral Health Legislation

Session	Bill No.	Title	Progress
2001 Regular Session	House Bill 381	An Act to Phase in Implementation of Mental Health System Reform at the State and Local Level, also referred to as the Mental Health Reform Legislation	Governor signed 10/15/2001
2023–2024 Session	House Bill 891	Achieve Better Mental Health Recovery Results	Filed 4/25/2023

Medicaid behavioral health policy and services administration

Medicaid is a significant payer for behavioral health services across states, which makes coordination between behavioral health administration and Medicaid crucial. This section highlights the Medicaid agency and their role in the three benchmark states.

Colorado

Health First Colorado, Colorado's Medicaid program, is housed under the Department of Health Care Policy and Financing (**HCPF**), separate from the Behavioral Health Administration (BHA). While the agencies are separate, there have been a number of collaborative opportunities intentionally put in place to assure work is not occurring in silos. HCPF created the Behavioral Health Initiatives & Coverage Office within the department. Leadership between HCPF and the BHA encouraged collaboration and implementing strategies to breakdown silos. Various teams from the two agencies meet several times per month to ensure alignment.

HCPF created, designated and contracted with seven **Regional Accountable Entities (RAEs)** across the state to provide oversight for primary care and eligible behavioral health services. RAEs are also expected to create a statewide network of providers to deliver these services, which are reimbursed at a capitated rate, per month/per member. All Health First Colorado members are assigned to a RAE that manages their physical and behavioral health care and require no-copays for behavioral health services.[xxxv]

When examining Medicaid coverage for behavioral health and substance use services, Health First Colorado offers a broader range of benefits compared to Minnesota. This includes services like 23-hour observation, medically monitored intensive inpatient care, and injectable naltrexone. These additional services present opportunities to enhance clinical outcomes, increase treatment effectiveness, and prevent overdoses.

Connecticut

DSS is the single state agency for the administration of Medicaid and the Children's Health Insurance Program (CHIP), known as the HUSKY Health program. HUSKY has four components (A, B, C, and D) and provides medical, dental, and behavioral health to its members. Almost $8B are allocated to the HUSKY Health program in the Governor's most recent budget proposal, which will be spent to serve in-need children and adults.[xxxvi] HUSKY Health is a unique Medicaid model that does not utilize a Health Maintenance Organization (HMO) or MCO for payments; it is a fee-for-service program that utilizes an **Administrative Service Organizations (ASO)** for each bucket of services: medical, dental and behavioral health services.[xxxvii] The ASOs manage data, payments, member and provider supports, and technical assistance through a performance-based contract that monitors defined benchmarks to support improved health outcomes and patient satisfaction.

DSS works collaboratively with the DMHAS and the DCF, the other state departments that serve HUSKY enrolled residents, as part of the CTBHP. The CTBHP is coordinated by Carelon Behavioral Health, the ASO contracted for behavioral health services to manage payments, clinical operations, and support community-based access and practice improvement. As part of their contracted agreement, Carelon Behavioral Health also provides regular data briefs, utilization reports, and program evaluations.[xxxviii] The most recent utilization reports, which includes interactive Tableau dashboards, show they serve more than one million HUSKY Health members.

When examining Medicaid coverage for behavioral health and substance use services, HUSKY Health offers a more comprehensive range of benefits compared to Minnesota. This includes services like 23-hour observation, substance use disorder partial hospital and medically monitored intensive inpatient services, and injectable naltrexone. These additional services provide opportunities to enhance clinical outcomes, increase treatment success, and prevent overdoses effectively.

North Carolina

North Carolina DHHS is the single state agency responsible for the administration of Medicaid. In 2015, the North Carolina General Assembly enacted legislation instructing DHHS to transition Medicaid from a fee-for-service model to managed care. Outlined in Session Law 2015-245 House Bill 372 is the Structure of Delivery System which granted DHHS full authority to manage the State's Medicaid and NC Health Choice For Children (CHIP) programs. Additionally, a new Division of Health Benefits within DHHS was created with the responsibility for planning and implementing the Medicaid transformation. North Carolina Session Law 2022-74 directed NC DHHS to combine the NC Health Choice Program with the NC Medicaid benefit plan. In April 2023, all eligible NC Health Choice beneficiaries moved to Medicaid, granting them access to Medicaid services, including enhanced behavioral health services that were not covered under NC Health Choice.[xxxix]

Additionally, North Carolina DHHS plans to launch Medicaid Expansion on December 1, 2023, allowing more than 600,000 North Carolinians to apply for health coverage through NC Medicaid. To prepare individuals for the expansion and understand eligibility, DHHS created a new website containing a toolkit of resources for organizations to inform their communities.[xl]

While the Division of Health Benefits is responsible for NC Medicaid transformation, DMH/DD/SUS works closely with the Division of Health Benefits to assist in writing and disseminating clinical coverage policies, working with them on their 1115 Substance Use Disorder Waiver, as well as facilitating training to provider groups. The two divisions collaborate regularly through knowledge-sharing, and they are working to improve collaborative strategic planning. The Division of Health Benefits has gone through a drastic transformation and is stretched thin in North Carolina; however, they are working on better coordination with strategic planning and maximizing each other's strengths.

When evaluating Medicaid coverage for behavioral health and substance use disorder services, NC Medicaid offers a broader array of services compared to Minnesota. This includes 23-hour observation, substance use disorder partial hospital and medically monitored intensive inpatient services level of care, and injectable naltrexone. These additional services provide opportunities to enhance clinical outcomes, increase treatment success, and prevent overdoses effectively.

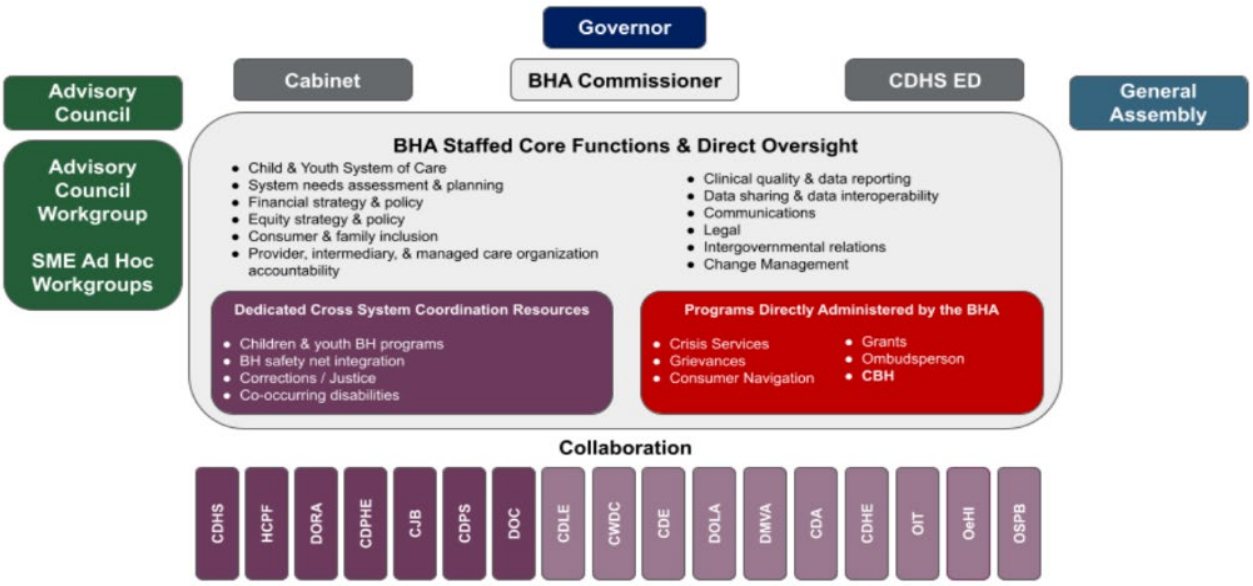
Coordination for effective administration of behavioral health services and innovations

Generally, behavioral health services are offered across various state and local agencies. Collaboration and coordination across these different entities is vital to effective administration of behavioral health services. The following section takes a closer look at the coordination and collaboration occurring across behavioral health-related entities in each of the benchmark states.

Colorado

With the establishment of the BHA, Colorado put collaboration with key partners at the center of its efforts. This agency intends to coordinate behavioral health efforts across the state ensuring transparency and keeping stakeholders informed and on the same page. Prior to the establishment of the agency, the proposed BHA structure specifically outlined the various state agencies and programs they anticipated the BHA would be coordinating and working with to create a more seamless delivery of behavioral health services (**Figure 3**).[xli] As the BHA becomes fully operational and builds these connections, staff across the BHA are attending many meetings. These meetings are helping the BHA to gain a full understanding of what is happening across the state and allowing them to think through an approach to get partners in alignment. It is anticipated that, in the near future, there will be discussions about how to be more efficient and effective with meetings being held across the state.

Figure 3. Proposed BHA Functions and Partners



See page 40 of the Colorado Plan for the Creation of the Behavioral Health Administration document for an additional view of Figure 3.

Two notable collaborations identified in the *Plan for the Creation of the Behavioral Health Administration* (a legislative report) are housing support and Medicaid. [xlii] The BHA will collaborate with HCPF on Medicaid by:

- Meeting several times per month to discuss overlapping efforts and populations;
- Partnering on assessment of population needs, service gaps, and identification of opportunities for new or expanded programming within the continuum;
- Supporting expansion of the behavioral health network, including the Medicaid provider network, and providing training and capacity development of the workforce to enhance quality of care;
- Identifying opportunities to maximize federal dollars through Medicaid;
- Reporting on access and quality across payers and providing data on provider quality metrics, access to care, and additional performance management of behavioral health;
- Working to incorporate the BHA into the Medicaid Management Information System (MMIS) to assess capacity and need across the state;
- Leveraging and aligning with Colorado's Health IT Roadmap initiatives, investments, and projects to support data, reporting, and information needs;
- Coordinating on population-specific programs (*e.g.*, child welfare and crisis services);
- Connecting providers and communities to available social determinant of health services and support (as outlined in the Prescriber Tool for Health First Colorado);

- Collaborating with other agencies and stakeholders to develop and implement a Master Contract that governs more consistent utilization review, access, performance, and accountability standards;
- Building State expertise about each agency and federal policy as it applies to Medicaid and CDHS through cross-agency training; and
- Jointly partnering with other agencies to provide information, education and explanation about the limitations of federal dollars.

The BHA and HCPF plan to collaborate with the Department of Local Affairs (DOLA) and other agencies to address homelessness. Specifically, this collaboration with DOLA will assist local governments in providing housing supports and homeless outreach. It is worth noting that through its Substance Use Network and federal grants, the BHA has money set aside to help people with rent for sober living homes, recovery residences, and other housing options for people who use substances.

Connecticut

Coordination and collaboration among state departments serving Connecticut enrolled in HUSKY Health is the premise of the CTBHP. Leadership from DSS, DCF, and DMHAS participate in the Oversight Council, as well as experts, community members and providers, to advise on the strategic direction.

In addition to coordination among state departments, Carelon Behavioral Health supports CTBHP's connections with parallel social elements that affect HUSKY Health members utilizing behavioral health services. One such connection is with the first of its kind initiative, Connecticut Housing Engagement and Support Services (CHESS). CHESS was launched in 2019 as a multidisciplinary team dedicated to integrating Medicaid enrollment with supportive housing benefits for individuals with mental health and substance use disorders who are struggling with homelessness and housing insecurity. It brings together stakeholders across each of these overlapping, and complicated, systems to manage the challenges in navigation faced by the target population to be able to access this benefit.[xliii]

CTBHP plays an integral role in coordination and management of CHESS and improving processes to identify HUSKY Health members who will benefit. Carelon Behavioral health has taken the lead in combining datasets from across systems that serve an overlapping population (*e.g.*, Medicaid enrollment, homeless service utilization, health care utilization) to identify members that may be eligible for CHESS. Data agreements across systems hold opportunity to predict and respond to the needs of members, especially those most in need for certain supports. Hearing from stakeholders in CHESS collaborative meetings, CTBHP was able to update certain documents to better track homeless indicators to improve cross-system collaboration. Specific efforts like training behavioral health providers to complete the billing codes associated with homelessness on enrollment forms, providing technical assistance to homeless service providers, and presenting case studies of CHESS use cases take a comprehensive approach to better integration of care for the population. In annual program evaluation reports, specific performance targets are defined that outline CTBHP's progress, challenges, and action plans to continue to support homeless residents.[xliv,xlv]

North Carolina

North Carolina DMH/DD/SUS has established numerous connections with other agencies and created Councils and Committees to ensure effective administration of behavioral health services in the State. The Mental Health Planning Council, appointed by the NC DHHS Secretary, serves as an advocate for adults with

serious mental illness, children with serious emotional disturbance, and other individuals with mental or emotional challenges. Council members are comprised of families of children with serious emotional disturbances, representatives of adults with serious mental illness, representatives of families of adults with mental health needs, representatives of state agencies, and representatives of public and private entities concerned with need, planning, operation, funding, and use of mental health services.[xlvi]

Additionally, the DMH/DD/SUS has a Community Engagement and Empowerment team that offers education, training and technical assistance to both internal and external organizations and groups. This team aims to promote community inclusion and meaningful engagement of individuals with lived experience across DHHS policy making, program development, and service delivery systems. One of the team's guiding principles is to engage in the community in a way that communication flows both ways, from the department through the division, through their team and back.[xlvii]

The DMH/DD/SUS collaborates with multiple state agencies, public officials at the local, state, and federal level, consumers, advocates, providers, and other key stakeholders to ensure the effective development and implementation of policies. The division has well-established relationships with both prevention and treatment provider systems in the state. As noted previously, the DMH/DD/SUS and the Division of Health Benefits work closely to develop and disseminate clinical policies and train providers across the state. Furthermore, the Division of Health Benefits collaborates with the North Carolina Department of Justice to identify and prosecute fraud, waste, and abuse of Medicaid in the State.[xlviii] The DMH/DD/SUS also collaborates with adult corrections transition and diversion programs and with providers to implement medication-assisted treatment in prisons.

Furthermore, North Carolina DHHS has a Chief Psychiatrist and Deputy Chief Medical Officer who provides psychiatric leadership for the department and prioritizes behavioral health and resilience. This position works collaboratively with all the divisions within the department.

Comparison of behavioral health services covered by Medicaid, 2022

An analysis was conducted of Minnesota's Medicaid covered services in comparison to the three benchmark states as reported in the Kaiser Family Foundation's (KFF) 2022 Behavioral Health Survey of state Medicaid programs.[xlix] As of the time of writing, these were the most recent survey data available. The analysis shows that Minnesota aligns with 48 out of 55 survey areas across the behavioral health continuum.[2] Minnesota indicated the absence of Medicaid coverage for the following seven behavioral health and/or substance use disorder services:

1. 23-hour observation within inpatient psychiatric units
2. Psychosocial Rehabilitation
3. American Society of Addition Medicine (ASAM) Level 2.5 Partial Hospitalization Services
4. ASAM Level 3.7 – Medically Monitored Intensive Inpatient Services

[2] The list below of services not covered under Medicaid in Minnesota reflects DHS responses reported at the time of writing and may not reflect current work being done under the 1115 SUD waiver project. Other updates may be needed to reflect more current coverage.

5. ASAM Level 4 – Medically Managed Intensive Inpatient Treatment
6. Naloxone Coverage Provided for Family Members or Friends Obtaining a Naloxone Prescription on Enrollee's Behalf[3]
7. Behavioral Health Services: Collaborative Care Model Service

Note that DHS received a large, five-year grant from SAMHSA to cover collaborative care model services, listed as number seven in the list above. More detailed information is available in *Appendix H: Minnesota and Benchmark Medicaid Covered Behavioral Health Services*, reflecting all 55 survey answers.

Behavioral health key indicators

States and organizations use key performance indicators to assess and track quality and performance metrics. PCG used data from the KFF Medicaid State Fact Sheets, 2022 to compare Minnesota with CO, CT and NC.

Among the three benchmark states, the analysis revealed that Minnesota is in alignment with most key performance indicators out of 50 studied. Areas where Minnesota performed less favorably than the other benchmark states included:

- Increased rates of adults with symptoms of anxiety or depression who reported unmet needs for counseling or therapy during COVID-19
- Increased rates of adolescents reporting a Major Depressive Episode in the past year
- Increased suicide rates in the general population
- Disproportionately high rates of suicide and opioid deaths rates among people who identify as Indian/Alaskan Native and people who identify as Asian in Minnesota.
- Lower rates of Medicaid enrollment (*e.g.*, Minnesota covered 17.8% of the population under Medicaid, compared to peer states Colorado, who cover 26.5%, and Connecticut who cover 20.9%).

More detailed information can be found in **Table 17** below.

Table 17. Peer State Behavioral Health Key Indicators

Category	Key Indicator	MN	CO	CT	NC
Unmet Need for Counseling or Therapy Among Adults Reporting Symptoms of Anxiety and/or Depressive Disorder During the COVID-19 Pandemic	Among Adults with Symptoms of Anxiety and/or Depressive Disorder, Percent Who Reported an Unmet Need for Counseling or Therapy	30.6%	23.2%	28.7%	18.3%

[3] As of 2014, Minnesota State Statute 604A.05 ("Steve's Law") allows doctors and pharmacists to prescribe naloxone to anyone, not just people at risk of an opioid overdose. Minnesota Statute 604A.05 Good Samaritan Overdose Medical Assistance.

Category	Key Indicator	MN	CO	CT	NC
Adolescents Reporting a Major Depressive Episode in the Past Year by Sex	Adolescents Reporting a Major Depressive Episode in the Past Year	17.0%	13.8%	12.5%	18.6%
Adolescents Reporting a Major Depressive Episode in the Past Year by Sex	Adolescent Males Reporting a Major Depressive Episode in the Past Year	10.7%	8.5%	7.4%	10.2%
Adolescents Reporting a Major Depressive Episode in the Past Year by Sex	Adolescent Females Reporting a Major Depressive Episode in the Past Year	23.6%	19.3%	17.8%	27.1%
Total Suicide Deaths and Age-Adjusted Suicide Rate	Suicide Rate per 100,000 Individuals	13.9	10	22.8	13.2
Suicide Deaths and Rate by Race/Ethnicity	American Indian/Alaska Native	29	N/A	N/A	13
Suicide Deaths and Rate by Race/Ethnicity	Asian	37	N/A	25	20
Individuals Reporting Past Year Opioid Misuse	Past Year Opioid Misuse	3.7%	3.2%	4.7%	3.6%
Adults Reporting Unmet Need for Mental Health Treatment in the Past Year Because of Cost	Adults Reporting Unmet Need for Mental Health Treatment	226,000	147,000	408,000	525,000
Adults Reporting Unmet Need for Mental Health Treatment in the Past Year Because of Cost	Adults Reporting Unmet Need for Mental Health Treatment Who Did Not Receive Care because of Cost	85,000	37,000	170,000	255,000
Adults Reporting Unmet Need for Mental Health Treatment in the Past Year Because of Cost	Share of Adults Reporting Unmet Need for Mental Health Treatment Who Did Not Receive Care because of Cost	37.8%	24.8%	41.8%	49.5%

Category	Key Indicator	MN	CO	CT	NC
Total Alcohol-Induced Death Rate	Alcohol-Induced Deaths	18.0	12.6	26.5	13.4
Total Drug Overdose Deaths by Race/Ethnicity	American Indian/Alaska Native	130	N/A	39	110

A more in-depth investigation of quality care indicators and their influence on care delivery will be a focal point of exploration in Deliverable Part B of the systemic review.

Organizational benchmarking among peer states

Table 18 outlines each state's top strengths and weaknesses relative to the organizational analysis described in the previous sections.

Table 18. Top Benchmarking Organizational Strengths and Weaknesses

State	Strengths	Weaknesses
MN	• Staff at local, county, and state levels are committed to improving the behavioral health system to support all Minnesotans. • DHS has a clear and easy to follow strategic plan. • BHD collects valuable data that can be used to inform behavioral health needs across Minnesota. • Certified peer specialists are widely regarded as a valuable support for the behavioral health system and help to address some workforce gaps.	• Significant workforce shortages across the continuum of care limit the number of behavioral health providers, in turn impacting the availability of services for Minnesotans. • Communication across the continuum is lacking, contributing to less shared knowledge among providers and other behavioral health partners about priorities and service availability across the state. • DHS' size impacts its ability to administer a cohesive behavioral health system and oversee service delivery and program fidelity • Data shows cultural disparities exist within Minnesota's behavioral health system.

State	Strengths	Weaknesses
CO	• The BHA is an umbrella agency designed with focus on coordination and collaboration, ensuring behavioral health priorities across the state are aligned. • The BHA is working to create BHASOs, which are similar to Medicaid's RAEs, located regionally. • The BHA has established an intentional partnership with Medicaid with their teams collaborating regularly on behavioral health policy, technology, priority population needs and challenges, among other topics.	• This system is still being developed so it's unclear how successful this reformative effort will be. • With the development of a new system, a significant amount of time is being spent in meetings to ensure alignment and that everyone is on the same page. • There are challenges within the continuum of care due to lack of providers and occasionally have to send people out of state to obtain appropriate care.
CT	• The CTBHP is a legislatively mandated coordination and collaboration entity which includes adult behavioral health, children's mental health, and Medicaid that has been in place for over a decade. • The CTBHP is managed by the contracted behavioral health ASO; this organization has insights across the entirety of the behavioral health system and can implement policy changes as defined by state departments. • Accountability and performance measures are built into behavioral health ASO contract. • The CHESS initiative is an innovative approach to connecting housing benefits to eligible individuals, through collaboration with the CTBHP.	• Cross-departmental shared leadership of the CTBHP can be challenging to navigate. • Each state department collects, and holds, its own data set; difficult to have a comprehensive sense of social determinants of health, which exist across departments.
NC	• DHHS has a Chief Psychiatrist who provides psychiatric leadership for the department. • DHHS has a Deputy Chief Medical Officer who works across multiple divisions to foster inter-agency collaboration. • The DMH/DD/SUS works closely with the Division of Health Benefits to write and disseminate clinical coverage policies.	• As DHHS undergoes Medicaid transformation, the DMH/DD/SUS and the Division of Health Benefits will have to prioritize a shared vision and strategic planning. • The lack of provider diversity in the state inhibits marginalized groups from accessing treatment.

Organizational challenges and opportunities

Table 19 displays common organizational challenges cited as part of this review.

Table 19. Organizational Challenges

No.	Organizational Challenge	Data Source
1	Numerous behavioral health leadership changes and reorganization in recent years have caused inconsistencies and disorganization resulting in a lack of a shared vision, and lack of clarity for roles, responsibilities, and the decision-making hierarchy in the behavioral health system.	Interviews, Document Review
2	Interviewees reported that DHS' agency culture is negatively impacted by inconsistent expectations across administrations and siloed operating procedures that have contributed to attrition, loss of institutional knowledge, and loss of trust between key partners with DHS. It was also expressed by some that the loss of confidence extends to trust in DHS leadership as well.	Interviews
3	A significant portion of the work within Minnesota's behavioral health sector, both internal and external to DHS, operates among distinct silos observed in areas such as legislative development, inter-agency and inter-team communication, county-led initiatives, and the separation of mental health and substance use efforts, among others.	Interviews, Document Review
4	The current state of the behavioral health system does not constitute a seamless continuum, demonstrated by numerous service gaps, such as residential and hospital beds for mental health and substance use disorder necessitating out of state placements and lack of community-based resources resulting in Minnesotans receiving inadequate levels of care.	Interviews, Document Review
5	Workforce shortages were reported by interviewees at local, county, and state levels. Interviews highlighted that contributing factors included high turnover, insufficient billing rates, and administrative burdens. Notably, interviewees shared that they perceived there to be a lack of professionals from diverse backgrounds and a lack of behavioral health professionals with adequate skills and years in the field.	Interviews. Document Review
6	Interviewees reported inconsistent communication practices and collaboration among behavioral health providers and partners within the continuum, coupled with workforce shortages, resulting in insufficient warm handoffs, ultimately leading to individuals slipping through the cracks in the system.	Interviews
7	Interviewees shared that the system needs to acquire staff faster through agile hiring processes and build educational pathways to facilitate the recruitment of personnel for behavioral health programs throughout the system.	Interviews
8	Interviewees noted that since the pandemic, there has been a lack of DHS behavioral health presence at the local level, including low or no DHS participation at association, county, and provider meetings.	Interviews
9	Behavioral health legislation is frequently crafted in isolation across all policy makers, both within DHS and externally, lacking a comprehensive statewide perspective and assessment of feasibility. This approach has resulted in policies that cannot be implemented as originally intended.	Interviews, Document Review

No.	Organizational Challenge	Data Source
10	Many DHS behavioral health staff have limited policy development and legislative process knowledge to effectively create, orchestrate, and manage programs.	Interviews
11	There are prohibitive clinical regulations and/or policies limiting access to behavioral health services. For example, there is a requirement to conduct a diagnostic assessment to gain access to behavioral health services which poses a barrier for many to access necessary services.	Interviews, Document Review

The organizational opportunities described below are a summation of key findings explored throughout this section and aim to help DHS target efforts to employ internal organizational improvements to improve administration, oversight, and delivery of behavioral health services. **Table 20**, **Table 21**, and **Table 22** below summarize these actionable organizational opportunities for DHS. They include references to the data sources for each opportunity and align them with the corresponding goals outlined in DHS's 2023–2027 Strategic Plan. The table arranges these opportunities according to their alignment with the sequence in the DHS Strategic Plan.

Table 20. Organizational Opportunities for DHS Agency Strategic Plan Outcome A: People in Minnesota Thrive

No.	Organizational Opportunity	Data Source(s)	DHS Strategic Plan Goal
1	Continue to improve the grant management and grant initiation process with the objective of optimizing efficiency. This review should include an assessment of the feasibility of implementing umbrella contracts to foster workload reduction of grants administration and oversight.	Interviews	B.2 *Administer programs effectively and efficiently through streamlined processes and reduction of errors, fraud and waste.*
2	Standardize and streamline data collection and reporting for behavioral health services funded through the Behavioral Health Fund, Medicaid, and behavioral health grants to one central statewide system for comprehensive claims and administrative data to inform decision-making and quality improvement initiatives.	Benchmarking (CT)	B.2.
3	Empower Mental Health and Substance Use Disorder Licensing staff in the Licensing Division to expand oversight and management of administration and delivery of services to improve programmatic fidelity and monitoring for continuous quality improvement.	Interviews, Document Review	B.2.

No.	Organizational Opportunity	Data Source(s)	DHS Strategic Plan Goal
4	Review DHS's behavioral health communication strategy to ensure it: • includes sufficient opportunity for partner engagement; • fosters a two-way feedback loop for continuous improvement; • includes an educational element highlighting DHS' ongoing initiatives; and • includes a strategy to enhance participation in external events and conferences.	Interviews, Benchmarking (CO)	B.4 *Build capacity to engage with community and amplify voices in decision-making processes.*
5	Review existing processes for developing a process to ensure BHD evaluates proposed policies for operational feasibility before they are presented to legislators. Ensure people with lived experience, external partners, and BHD subject matter experts are included throughout the process.	Interviews	B.4.

Table 21. Organizational Opportunities for DHS Agency Strategic Plan Outcome B: People Experience High-Quality Human Services

No.	Organizational Opportunity	Data Source(s)	DHS Strategic Plan Goal
1	Deepen behavioral health expertise, including clinical knowledge, in DHS/BHD leadership to strengthen guidance to staff and partners to improve services across both mental health and substance use.	Interviews, Benchmarking (NC)	A.3 *Champion a service continuum that centers justice, equity and choice, supporting people with disabilities and older adults to lead meaningful lives in the community.*
2	Address workforce shortages by eliminating barriers to accessing behavioral health workforce employment opportunities. This could involve initiatives such as forming strategic partnerships to create or support behavioral health career pipelines, broadening scholarship offerings that either fully cover or reduce examination fees, eliminating the master's degree requirement where feasible, and further examining opportunities for background studies reform.	Interviews	A.4 *Invest in home, community, and facility-based care workforce and strengthen Minnesota's network of caregiving.*

Table 22. Organizational Opportunities for DHS Agency Strategic Plan Outcome C: People at DHS Thrive in an Inclusive Environment

No.	Organizational Opportunity	Data Source(s)	DHS Strategic Plan Goal
1	Revise the organizational structure within DHS to require Directors to be formally involved, actively engaged, and accountable to multiple administrations within the agency, facilitating knowledge sharing and bridging gaps between divisions.	Benchmarking (CT, NC)	C.2 *Create an organizational culture where employees experience inclusion, psychological safety, respect, wellbeing and joy.*
2	Review job functions and expertise needed by role to match skills and resources to organizational needs. For example: • Identify grant management skill set and capacity gaps. • Work with the legislature and Human Resources to prioritize hiring for behavioral health grant management resource needs, employing an agile hiring process to accelerate staff acquisition.	Interviews	C.3 *Build career pathways and create ways for staff to grow in their job.*
3	Improve collaboration and coordination of behavioral health efforts being implemented by various state and local entities by assigning roles, responsibilities, and action items to drive progress. This can be achieved by OAR continuing to act as an organizing body.	Interviews, Benchmarking (CO and CT)	C.4 *Be a collaborative partner in the creation of separate state agencies while supporting employees and continuity of operations.*

Financing and benchmarking of behavioral health services

It is estimated that in 2020, $280B were spent on behavioral health services in the U.S.—85 percent on mental health; 15 percent on substance use disorder—with more than one-half of mental health spending and about three-quarters of substance use treatment spending from public payers Medicaid and Medicare.[l,li] Medicaid funding is by far the largest payer for behavioral health services, which are also subsidized by federal grants, state, and local funds. There is a critical need to ensure there is sustainable and reliable funding for behavioral health services to meet the growing demand for services across the continuum. This matter grows more complicated looking beyond the top lines, to the complexities of provider reimbursements, which have been seen as less competitive for Medicaid.

Behavioral health funding through the state originates in the One Minnesota Budget, the administration's comprehensive budget built to support children and families, invest in the future of Minnesota's economy, ensure the health and safety of its residents, and provide tax reductions for Minnesotans across the state. The Walz-Flanagan Administration's budget includes mental health and substance use disorder initiatives that aim to improve access to mental health care, support Minnesotans with substance use disorders, and increase housing stability.[lii] Additionally, the Walz-Flanagan's $3.3B Infrastructure Plan dedicated 14 percent to housing and homelessness and 16 percent to community and equity, spending categories aimed at positively affecting social determinants of health associated with behavioral health outcomes.

The second component of this report focuses on behavioral health financing. This section assesses Minnesota's current financing strategy for behavioral health services from available funding sources. Benchmark states were also reviewed to understand their funding strategies and how they are similar or different from Minnesota.

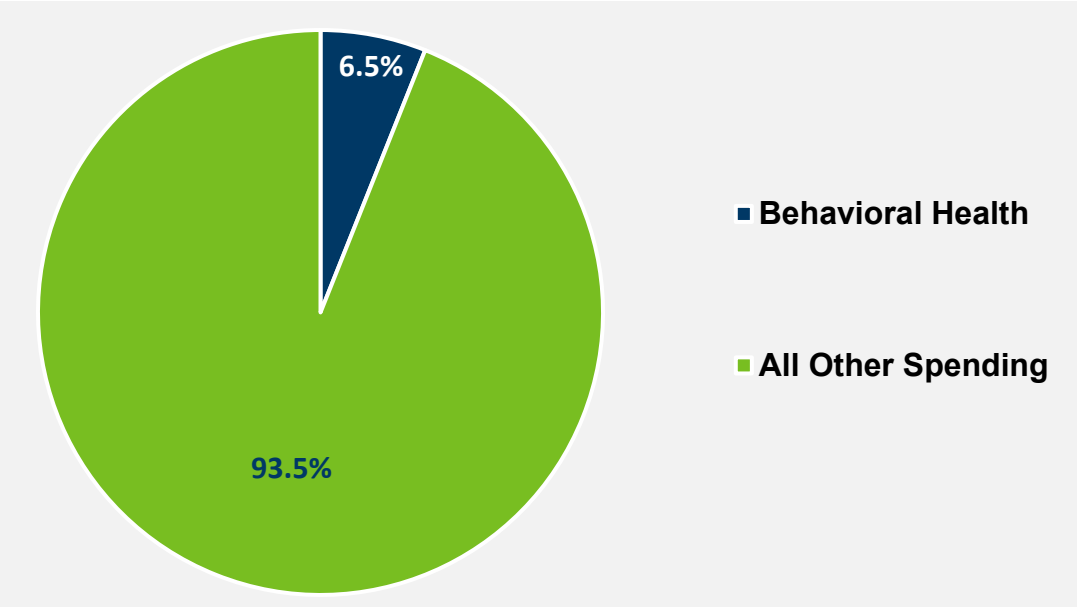
Minnesota's current financing strategy for behavioral health services

Overview

This section provides an overview of Minnesota's behavioral health spending by source, focusing on FY22, the latest available data.

Figure 4 below shows that DHS spent $23B in FY22, of which $1.5B was spent on behavioral health services, representing six and a half percent of DHS' total spending.

Figure 4. FY22 Behavioral Health Spending as a Proportion of DHS Overall Spending



In FY22, mental health services spending accounted for $1.1B, representing three-quarters (76%) of the total $1.5B spent on behavioral health. Meanwhile, substance use disorder services spending accounted for $363M, representing about one-quarter (24%) of the behavioral health budget.

The primary funding sources for behavioral health were as follows: federal funding constituted 59 percent, state funding contributed 39 percent, and counties and insurance premiums collectively made up approximately one percent.

The vast majority of public behavioral health funding, as reported by DHS to PCG, was spent through Medicaid, totaling about $1.3B—almost 3.5 times greater than the combined spending across the other three categories. As shown below in **Figure 5**, Medicaid spending accounted for $1.3B in spending in FY22, while grant spending totaled $166M, spending from the BHF totaled $168M, and MinnesotaCare accounted for $36M. Medicaid represents 78 percent of all spending.

Minnesota's largest behavioral health spending categories within Medicaid were on outpatient mental health and mental health case management at $794M, mental health prescriptions totaling $154M, outpatient substance use disorder and room and board at $151M, and substance use disorder prescriptions at $126M.

Funding sources

Behavioral health services and programs in Minnesota are funded through multiple sources including Medicaid, the BHF, MinnesotaCare, and federal and state grants. This section explores each of these funding sources in greater detail.

Medicaid

In 1966, Minnesota implemented its Medicaid program, known as Medical Assistance (MA), which has since grown to provide coverage for about one in every five residents in the state and makes up approximately 16 percent of Minnesota's health insurance market.[liii] Medicaid accounted for $1.3B in behavioral health spending in FY22, and its coverage of both mental health and substance use disorder services are governed within Minnesota Chapter 256B. MA is financed through a combination of state general funds, the health care access fund, federal Medicaid funds, and local shares for various services.

The majority of Minnesotans enrolled in MA receive healthcare services through health plans or MCOs. The remaining enrollees receive services through the traditional fee-for-service system, where providers are compensated directly by DHS for each service they provide to an enrollee.[liv] DHS serves as the Medicaid authority for the state and collaborates with all 87 Minnesota counties and multiple Minnesota Tribal Nations to administer MA. DHS contracts with health plans and health care providers throughout the state to provide essential healthcare services to MA enrollees.[lv]

Eligibility is based on household income, family size, age, disability status, and citizen or immigration status, and enrollees are required to confirm their program eligibility on an annual basis. At the start of the COVID-19 pandemic, Congress passed the Families First Coronavirus Response Act (FFCRA), which mandated that Medicaid programs maintain continuous enrollment for individuals through the end of the COVID-19 public health emergency. States were given federal funding to ensure enrollees did not lose coverage; however, the Consolidated Appropriations Act of 2023 was signed into law in December 2023, which separated the continuous enrollment provision from the public health emergency, beginning March 31, 2023.

Medicaid enrollments grew significantly during this time, although uninsured rates are expected to grow as states begin to disenroll individuals who no longer meet state requirements.[lvi] As a result of the continuous coverage provisions, enrollment in MA and MinnesotaCare increased by more than 360,000 individuals, totaling to more than 1.5M Minnesotans covered. To minimize health insurance coverage loss as eligibility renewals resume, DHS will follow strategies to prevent the loss of coverage for eligible persons resulting from a failure to submit documents to verify eligibility that were approved by the Centers for Medicare and Medicaid Services. The state received an additional $300M in federal funds during this transition time. Specific strategies utilized by DHS include the following:[lvii]

1. Add more user-friendly ways to complete the renewal process, including by phone or by submitting documents online.
2. Make it easier to complete the paper-based renewal forms.
3. Renew coverage automatically for more enrollees, allowing them to skip the paperwork and renew their coverage based on trusted alternative data sources that show they continue to qualify.
4. Maintain coverage for enrollees who have disabilities, are blind or are age 65 or older and in the first batch of enrollees due for renewal – the July 2023 cohort – for all reasons other than an ineligibility determination.
5. Minimize unnecessary hurdles to the renewal process that cause enrollees to temporarily lose program eligibility, reapply for it and regain eligibility in a short amount of time.
6. Work with contracted managed care health plans to maintain coverage for eligible enrollees.
7. Check enrollees losing coverage for eligibility under other eligibility categories.

8. Ensure up-to-date enrollee contact information.
9. Make extra effort to reach enrollees before closing their coverage for returned mail.

DHS is in the process of developing a comprehensive plan for carrying out the needed work to resume eligibility reviews, minimize the loss of eligible coverage, and help ineligible individuals receive alternative health care coverage options. DHS is committed to working with both eligible and ineligible Minnesotans to ensure that coverage is retained, or individuals are connected with other coverage options. Other state agencies will be key partners in this work, and DHS plans to meet regularly with these agencies to facilitate collaboration efforts to support individuals across the state. Additionally, DHS will collaborate closely with MNsure, Minnesota's health insurance marketplace, to facilitate smooth transitions in coverage for enrollees deemed ineligible for MA but seek to obtain coverage through the state's health insurance exchange.[lviii]

In Minnesota, Medicaid beneficiaries often receive their services through MCOs that are responsible for managing and coordinating care for their enrollees, including access to mental health and substance use services through a network of providers.

Medicaid expansion

Medicaid expansion under the Affordable Care Act (ACA) expanded Medicaid eligibility to nearly all adults with incomes up to 138 percent of the Federal Poverty Level, offering states an enhanced federal matching rate for those covered through expansion. Minnesota began expanding Medicaid coverage to adults in 2011 and concluded this expansion of coverage in 2014.[lix]

As of June 2023, nearly 1.4M individuals were enrolled in Minnesota Medicaid, accounting for approximately 18 percent of the state's population. The expansion of Medicaid in Minnesota has led to a significant decrease in uninsured rates from 10 percent in 2013 to five percent in 2021.[lx] Additionally, 43 percent of non-elderly Medicaid enrollees in the state are people of color including Black, Hispanic, Asian/Native Hawaiian and Pacific Islander, American Indian/Alaska Native, and multiple races.[lxi] In early 2023, nearly 295,000 individuals in Minnesota were enrolled in expanded Medicaid.[lxii]

Medicaid – 1115 Demonstrations

Minnesota has implemented three 1115 demonstration waivers to expand access to high quality substance use disorder treatment, using the ASAM levels of care. These included:

- **Minnesota Reform 2020**
    - Under the authority of section 1115 (a) of the Social Security Act, this demonstration waiver incorporates payments for Residential Treatment for individuals with substance use disorder receiving short-term treatment (less than 30 days) in facilities that meet the definition of an Institution for Mental Diseases (IMD). Additionally, the waiver enhances behavioral and mental health services provided to Medicaid beneficiaries through Certified Community Behavioral Health Clinics (CCBHCs).
    - State law enacted by the 2019 Minnesota Legislature provides a framework for the broader implementation of the demonstration statewide over time, including clarifying state law, providing resources for implementation, and creating incentives for participating providers.
- **Substance Use Disorder System Reform Demonstration**

- This demonstration waiver incorporates the ASAM criteria to establish specific residential and outpatient levels of care for substance use disorder treatment services for MA under the authority of section 1115 (a) of the Social Security Act.
- Legislation in the 2021 session made substance use disorder waiver participation by provider mandatory effective January 2024. Rate enhancements for substance use disorder waiver participation were increased from 15 percent to 25 percent for residential treatment; from 10 percent to 20 percent for non-residential treatment, effective January 2022. Net State savings for these changes were projected at about $3M in FY24 and $4M in FY25.

Behavioral Health Fund (BHF)

The BHF funds fee-for-service substance use disorder treatment for individuals who meet the necessary clinical and financial eligibility requirements. These include not being enrolled with Medicaid, treatment costs not being covered 100 percent by commercial insurance, or not being enrolled in a state contracted MCO for the dates of treatment. Eligible substance use disorder treatments include residential treatment, residential treatment room and board, non-residential treatment, MAT, treatment coordination, and peer recovery support and withdrawal management. The fund also pays administrative allowances for counties and Tribal Nations that are calculated annually using a formula based on local expenditure of BHF dollars. The BHF is governed by Chapter 254B and accounted for $42M in FY22 spending. Revenue sources for the BHF include:

- **Federal Revenue:** More than 80 percent of the BHF is federally matched. These payments are part of the MA program, with the distinction that the state share comes from the BHF rather than the MA account.
- **County Revenue:** Substance use disorder treatment that is not federally matched has a county share of 22.95 percent.
- **Federal Block Grants:** Per DHS, for many years $9M from the federal SAMHSA block grants has been transferred to the BHF annually to support substance use disorder service costs. This value is not specified in law but continues to be forecasted based on the longstanding practice.

Local agencies, including contracted Tribal Nations and Minnesota counties, are responsible for determining BHF financial eligibility. Individuals are determined eligible for and entitled to services paid for by the BHF in one of two ways. The first way is by meeting eligibility standards for any one of the three programs below. Enrollment is not required.

- **Minnesota Family Investment Program** (Minnesota Statutes, chapter 256J)
- **Medical Assistance** (Minnesota Rules, parts 9505.0010 to 9505.0150)
- **General Assistance, general assistance medical care, or work readiness** (Minnesota Rules, parts 9500.1200 to 9500.1318).

The second way is when a local agency determines an individual's eligibility using the household size and household income limitations, per Minnesota Statutes, chapter 256B.056. Subd.4. This subdivision references only household size and household income limitations, not complete and entire Medicaid eligibility criteria.[lxiii]

MinnesotaCare

While MA is available for Minnesotans with household incomes up to 138 percent of poverty, residents of the state with incomes above 138 percent of poverty, up to 200 percent of poverty are eligible for MinnesotaCare.

MinnesotaCare is the state's Basic Health Program (BHP), which provides health care for low-income Minnesotans and is governed within Chapter 256B.

Representing $36M in spending in FY22, MinnesotaCare is funded through multiple sources, including a state tax on Minnesota hospitals and health care providers, BHP funding, and enrollee premiums and cost sharing. To receive coverage, individuals must be a Minnesotan resident, a U.S. citizen or have lawful presence in the country, meet the income limit, not be enrolled in or have access to Medicare Part A or B, and not be incarcerated except in cases where you are awaiting disposition of charges.

The majority of MinnesotaCare enrollees pay a monthly premium based on family size and income; however, certain populations do not have a premium including children younger than the age of 21, American Indians and Alaska Natives and their households, members of the military and their households who become eligible within 24 months after completing active duty, and households with income less than 35 percent of the FPL. MinnesotaCare covers an extensive list of services that includes substance use and disorder services, inpatient and outpatient hospital visits, mental health care, and prescriptions and medication therapy management.[lxiv] All enrollees of MinnesotaCare receive services through managed care.[lxv]

Federal and state grants

Grants accounted for $166M in spending during FY22, with the state funding the majority of grant dollars through the state's General Fund at $109M and federal funds providing the next highest level of funding at $52M. Other state funds and the Opioid Epidemic Response Fund represent about $3M and $2M each respectively. **Figure 5** below displays the totals for each of the four main funding sources for behavioral health grants, while **Figure 6** illustrates these totals as a proportion of overall grant spending, with the General Fund accounting for 65 percent of grant funding.

Figure 5. FY22 Behavioral Health Grant Spending by Funding Source

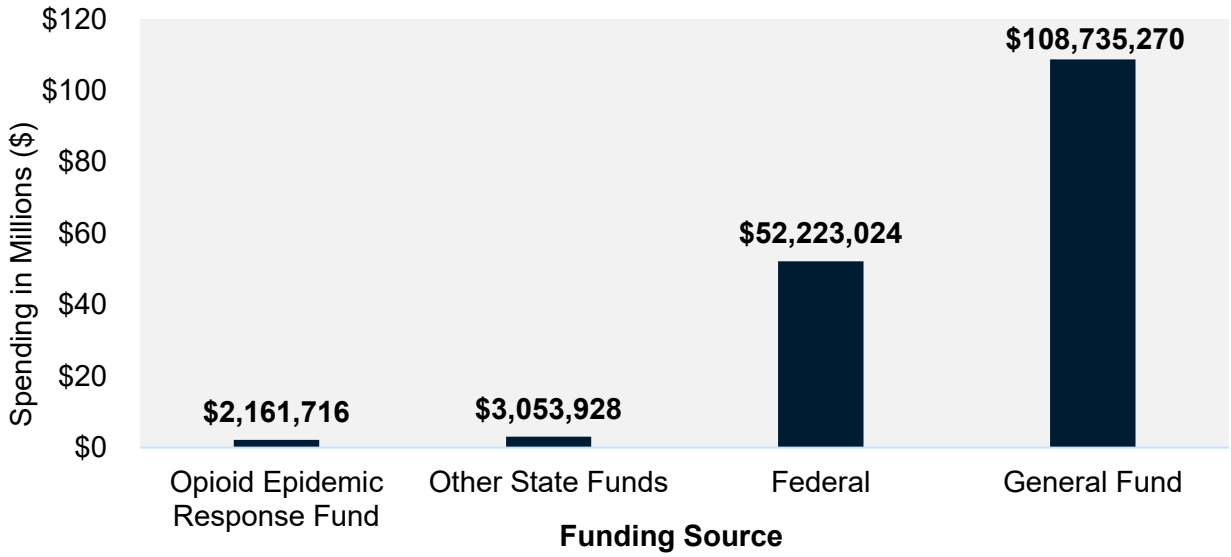
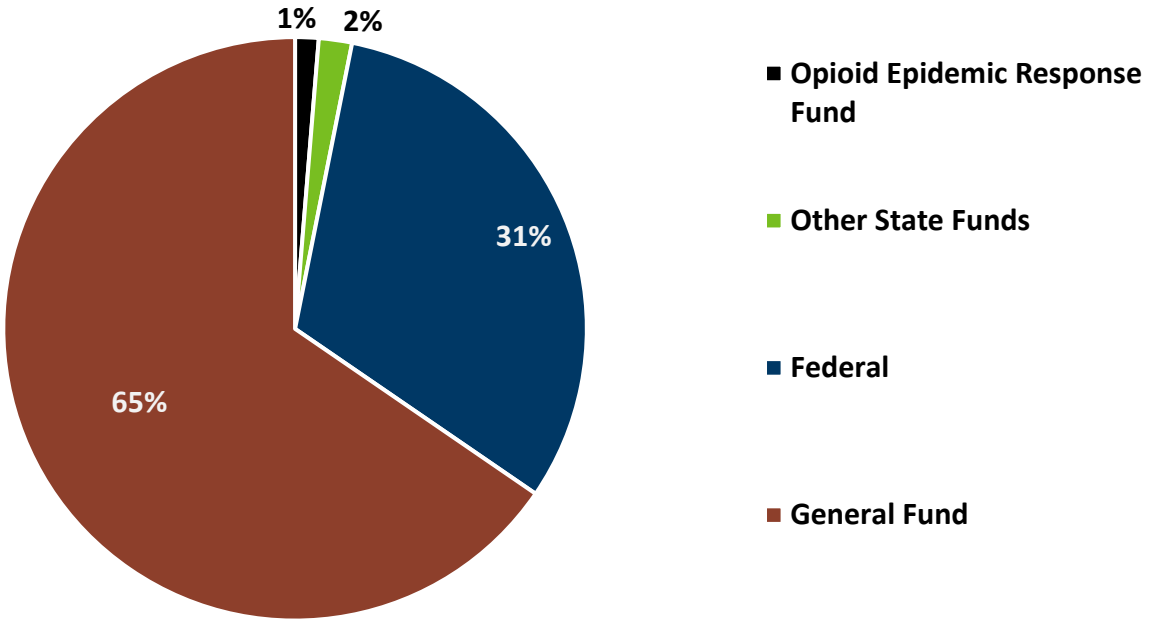


Figure 6. FY22 Behavioral Health Grants Proportions by Funding Source



DHS reported a total of 57 grant programs that actively funded behavioral health services during FY22 that represent approximately 852 grantees and subawards as of 2023 (Elyse Bailey, personal communication, October 26, 2023).[lxvi] Of these 57 grant programs funded, six were greater than $10M, totaling $109M, and account for 70 percent of all grants spending. Nearly all grants are disbursed through sub-recipients and require significant management and oversight by DHS.

Table 23 below provides greater detail about these larger dollar grants, including their name, a brief description, their funding source, and individual grant totals. For more information on the 57 grant programs the DHS reported as actively funding behavioral health services in FY22, please see *Appendix I: Minnesota DHS FY22 Behavioral Health Grant Programs*.

Table 23. Minnesota's Largest Behavioral Health Grant Programs in FY22

Grant Name	Summary/Description of Grant	Source	Total
Adult Mental Health Integrated Fund	Grants to counties for Adult Mental Health Initiatives including crisis response and case management services. For most counties, this includes integrated administration of Adult MH Community Support Grants and Residential Treatment Grants.	State General Fund	$34,597,916
Rule 78 Adult Mental Health Grant	Grants to counties for community support services to adults with serious and persistent mental illness.	State General Fund	$19,539,689

Grant Name	Summary/Description of Grant	Source	Total
Mobile Crisis Services Grants	Grants to counties in regional partnerships to build psychiatric crisis response capacity, including mobile crisis intervention and follow-up stabilization services.	State General Fund	$17,866,046
Children's Mental Health (CMH) – Capacity School Based Services	Grants to provider agencies to integrate mental health service capacity into the non-stigmatized natural setting of children's schools and to cover direct clinical and ancillary services for uninsured and under-insured children.	State General Fund	$15,053,262
2020 SOR Grants	The purpose of this program is to address the opioid overdose crisis by providing resources to states and territories for increasing access to FDA-approved medications for the treatment of opioid use disorder (MOUD), and for supporting the continuum of prevention, harm reduction, treatment, and recovery support services for opioid use disorder (OUD) and other concurrent substance use disorders.	Federal	$11,393,121
Federal CD Block Grant – CFDA	The Substance Abuse Prevention and Treatment Block Grant (SUBG) Program was authorized by Congress through the American Rescue Plan Act (ARPA) to provide funds to States, Territories and Tribes for the purpose of planning, implementing and evaluating activities dedicated to preventing and treat substance abuse within Minnesota.	Federal	$10,280,824

Federal grants

Block grants

Minnesota receives SAMHSA's Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) and the Community Mental Health Services Block Grant (MHBG). The goal of the SUBG is to plan, implement, and evaluate activities related to substance use prevention and treatment. States have the flexibility to distribute the funds across various entities. However, 20 percent of the funding must be used toward primary prevention efforts.[lxvii] Minnesota's spending plan for 2021–2025 ARPA SUBG funding cites spending 20 percent of the awarded $19.5M awarded on prevention services, or $3.9M.[lxviii] The goal of the MHBG is to support the states in carrying out plans for providing comprehensive community mental health services. Similar to the SUBG funds, states have flexibility with MHBG funds, and they can be distributed to local government entities and non-governmental organizations.[lxix]

State Opioid Response (SOR) grants

In September 2018, the SAMHSA awarded more than $930M in SOR grants to support efforts to respond to the opioid epidemic and increase access to opioid treatment and recovery support services. The grants aim to increase access to medication-assisted treatment for opioid use disorder using the three Food and Drug Administration (FDA) approved medications, decrease unmet treatment need, and reducing opioid overdose

fatalities by implementing prevention, treatment, and recovery services throughout the country. Funding was distributed to states based on a funding formula, with 15 percent dedicated for the top ten states with the highest drug overdose death rates. Minnesota did not fall within these ten states. An additional $50M was allocated for tribal communities through additional funding.[lxx]

SAMHSA awarded Minnesota more than $11.2M in SOR grants that were distributed among 27 counties, tribes, and community agencies. The funding for these grants ran from September 2018 to September 2020, with a focus on administration of Naloxone, expansion of medication-assisted treatment, efforts to address health disparities, and confrontment of the ongoing shortage of substance use disorder professionals. Additionally, the federal government awarded Minnesota with an additional $4.26M from an SOR supplemental grant in 2019 for ongoing Naloxone and prevention support, in addition to culturally responsive American Indian, African American, and African-born opioid use disorder treatment.[lxxi] During FY22, $11.4M in SOR grants were paid out to counties through SAMHSA.

State grants

State mental health grants

Adult Mental Health grants are governed within Chapter 245, Section 245.4661. The largest of these grants, the Adult Mental Health Integrated Fund, pays for crisis response and case managements services, and includes integrated administration of Adult Mental Health Community Support grants and Residential Treatment grants for most counties. This grant is disbursed from the General Fund and totaled about $35M in FY22—the largest state grant for that FY. The Rule 78 Adult Mental Health Grant includes grants to counties for community support services to adults with serious and persistent mental illness and totaled $20M during FY22 and was Minnesota's second largest grant for that FY.

Children's Mental Health grants are governed within Chapter 245, Section 245.4889. During FY22, the General Fund expended $15M for Children's Mental Health Capacity School Based Services. This funding aims to help provider agencies integrate mental health service capacity into the non-stigmatized natural setting of children's schools and to cover direct clinical and ancillary services for uninsured and under-insured children.

Opioid settlement funds

In July 2021, Minnesota joined a multistate coalition in achieving nationwide settlements with the three leading opioid distributors: Amerisource Bergen, Cardinal Health, and McKesson, as well as opioid manufacturer Johnson & Johnson. The companies independently agreed to participate in the settlement following thousands of opioid-related lawsuits and will collectively pay up to $26B over 18 years, with substantial payments frontloaded in the first five years. As part of the agreement, Minnesota may receive up to $337M.[lxxii] In December 2022, Minnesota joined additional opioid settlements with opioid manufacturers Teva Pharmaceuticals and Allergan and retail pharmacy chains Walmart, Walgreens, and CVS, totaling $20.4B. These settlements would have resulted in an additional $235M for Minnesota. In 2023, the agreement with cities and counties was amended to apply to the settlements above and may bring the total received by Minnesota to over $500M.

Prior to 2019, all settlement and lawsuit recoveries were directed to the state's General Fund; however, in 2019 Minnesota passed opioid legislation, HF 400, mandating that all funds acquired by the state from opioid-related settlements or lawsuits be used for opioid abatement efforts. Additionally, this legislation established the Opioid

Response Advisory Council (OERAC), which is responsible for the oversight and distribution of a portion of opioid settlement funds.[lxxiv] Minnesota passed legislation SF 4025 and was signed into law on May 11, 2022, which allocated 75 percent of the funding to local governments and 25 percent of the funding directed to the state. This law maintained the licensing and distribution fees through 2031 and created two separate accounts within OERAC, one for licensing and distribution fees and another for national settlement dollars.

Additionally, funding allocations were preserved in SF 4025 and will continue through 2031. OERAC currently serves as the statewide entity that oversees the distribution of the state's portion of the opioid settlement funds and coordinates the funds between local government and the state. The Association of Minnesota Counties (AMC) and affiliate organizations such as the Local Public Health Association, MACSSA, and the Minnesota Association of Corrections Act Counties will continue to work collaboratively with the BHD, OERAC and grantees to bolster efforts at the local level and enhance impacts in communities across the state.[lxxv]

Benchmarking analysis: Financing

This section examines the three benchmark states' (Colorado, Connecticut, and North Carolina) financing strategy, identifying the financing model used by each state and key funding sources.

Financing Model Overview

Colorado

The Department of Health Care Policy and Financing (HCPF) serves as the single State agency responsible for Health First Colorado and the Children's Health Insurance Program (CHIP). HCPF pays for all eligible behavioral health services for Medicaid-enrolled Coloradans. As mentioned previously, HCPF contracts with seven Regional Accountable Entities (RAEs) across the state to provide oversight for primary care and eligible behavioral health services offered by their network of providers. Also noted above in the Organizational Structure Benchmarking section, the Behavioral Health Administration (BHA) is in the process of establishing Behavioral Health Administrative Services Organizations (BHASOs) that will be located in each of the existing Medicaid regions.

The BHA will contract with BHASOs to provide a continuum of behavioral health safety net services and care coordination and will be expected to interface and align with the RAEs.[lxxvi] The BHA pays for behavioral health services for uninsured and underinsured Coloradans in addition to covering non-Medicaid eligible behavioral health services for those enrolled in Health First Colorado. The BHA also manages Substance Abuse and Mental Health Services Administration (SAMHSA) grants as well as other federal and state funds appropriated to behavioral health services. That said, the BHA serves in some capacity as a contract management agency, managing hundreds of contracts for grantees across the state to implement behavioral health efforts.

HCPF and the BHA are currently working to integrate the BHA enrollees and data into the Medicaid Management Information System (MMIS) to improve understanding of capacity and better monitoring of Medicaid and non-Medicaid spend.

Colorado has placed great emphasis on coordination of care but is still experiencing gaps in their continuum of care due to lack of providers, like many states across the nation. This has led to some individuals seeking care outside the state. This challenge is due in part to insufficient reimbursement rates for behavioral health providers to serve the BHA and Medicaid populations.

Connecticut

Connecticut's Department of Mental Health and Addiction Services (DMHAS) manages SAMHSA-funded initiatives and state budget-funded initiatives to address behavioral health and improve the behavioral health system. DMHAS is regularly awarded a variety of multi-year SAMHSA awards, including for prevention, access to care, and service provision.[lxxvii] Other state agencies, such as the Department of Children and Families (DCF) and the Department of Education, also manage both federal- and state-funded initiatives that include behavioral health services.

As previously mentioned in the Organizational Structure Benchmarking section, the Connecticut Department of Social Services (DSS) is the state Medicaid and CHIP agency in Connecticut. Medicaid and CHIP are collectively described as the HUSKY Health program. By contrast to most other state Medicaid programs, Connecticut Medicaid does not contract with capitated Managed Care Organizations (MCOs). Instead, like most large employers, the program is self-insured and uses a managed fee-for-service approach. Since there are no MCOs, Connecticut Medicaid assumes the financial risk, and has sovereign control of the coverage, utilization management, and provider payments. In addition, data is held in one singular statewide claims dataset.

To administer this system, DSS manages a contract with Administrative Services Organizations (ASOs) to assist with managing Medicaid-covered dental, medical, and behavioral health services. Each ASO operates as the single vendor to pay all claims for their service area. They operate using a performance-based contract with DSS that requires achievement of identified benchmarks on health outcomes, health quality, and both member and provider satisfaction measures. All savings that are achieved through coordination of care and administrative efficiencies go back into the program, instead of contributing to the profit of an MCO. [lxxviii]

Connecticut reports efficiencies gained through their unique self-insured Medicaid funding model, including low administrative costs and stable, low state costs.[lxxix] In addition, the use of the singular ASO per service area, and therefore a unified statewide claims system, streamlines additional insights and analytics to predict cost trends and proactively address needs.

North Carolina

As noted previously in the Organizational Structure Benchmarking section, the Division of Health Benefits within North Carolina's Department of Health and Human Services (DHHS) is responsible for overseeing the state's Medicaid Transformation. On July 1, 2021, NC Medicaid began its transformation to managed care for most Medicaid beneficiaries by changing the delivery of services to five health plans and the Eastern Band of Cherokee Indians Tribal Option, which is the first of its kind in the country. NC Medicaid planned to launch a behavioral health plan with specialized services for individuals with significant mental health and substance use disorders, intellectual and developmental disabilities, traumatic brain injuries, and people using state-funded and waiver services on October 1, 2023. The Tailored Plans are based on a Tailored Care Management model that aims to provide whole person care and drive better health outcomes. However, DHHS delayed the implementation date due to uncertainty with the state budget, which will support transformation costs and raves for the Medicaid program. This delay aims to ensure seamless care for beneficiaries, and a new implementation date has yet to be announced.[lxxx]

North Carolina currently contracts with six Local Management Entities (LMEs) and MCOs that manage the care of NC Medicaid beneficiaries who receive mental health, developmental disabilities, or substance use disorder services. The LME/MCOs currently only manage behavioral health services; however, they will manage all

Medicaid services for their enrollees, including physical health services once Tailored Plans launch. Unless NC DHHS is specific about how to spend state, block grant, and settlement funds, the LME/MCOs have flexibility in the type of providers they cultivate and the types of services they pay for. Therefore, it is crucial to have a shared vision around flexible use.

Furthermore, North Carolina DHHS is operationalizing its dedication to buying health is through the Healthy Opportunities Pilots. This innovative program works in conjunction with the state's transition to NC Medicaid Managed Care to examine and evaluate the use of Medicaid to specific evidence-based interventions designed to address non-medical factors that improve health outcomes and costs. This is the nation's first comprehensive program with this focus, and DHHS was authorized up to $650M in Medicaid funding from the federal government.[lxxxi]

In December of 2022, North Carolina Medicaid initiated a noteworthy change by increasing payments to primary care practices employing the collaborative care model to 120 percent of the Medicare rate. This stands out as a significant shift, as Medicaid traditionally compensates at rates considerably lower than those of Medicare for the majority of reimbursement codes. It serves as a strong indicator of the state's dedication to embracing collaborative care as a means of addressing behavioral health needs.[lxxxii]

Behavioral health funding by source

Colorado

In FY22–FY23, $2.1B was allocated to behavioral health programs by the Colorado General Assembly, about twice what Minnesota spent on a comparably sized population. Much of this funding was allotted to HCPF (59.6%) and CDHS (30.4%). The remaining funds were distributed to the Judicial Branch, Department of Agriculture, Department of Corrections, Department of Early Childhood, Department of Education, Department of Higher Education, Department of Law, Department of Public Health and Environment, Department of Public Safety, and Department of Regulatory Agencies.[lxxxiii] Colorado has a similar sized population to Minnesota and spent about $600M more on behavioral health during the same period.

In addition to these state funds, Colorado receives a number of SAMHSA grants equating to tens of millions of dollars annually. Recent grant awards include the Mental Health Block Grant and supplement, the FY22 Cooperative Agreements for States and Territories to Build Local 988 Capacity, Projects for Assistance in Transition from Homelessness, the Substance Abuse Block Grant, Healthy Transitions: Improving Life Trajectories for Youth and Young Adults with Serious Mental Disorders Program, the Children's Mental Health Initiative, and the SOR Grant.

In FY22, Health First Colorado spent $1B (88.7% of overall Medicaid spending) on behavioral health capitation.[lxxxiv] Colorado's federal match in FY22 was 56 percent, higher than normal due to funding available through the FFCRA.[lxxxv] Health First Colorado is the largest payer for behavioral health in the state, further emphasizing the importance of the BHA, who spends roughly $250M on behavioral health services annually, working closely with them.

It is worth noting that in the past, much of the funding allocated for underinsured and uninsured individuals across Colorado was to support specific populations or legislative priorities. Funds have been appropriated for these specific programs or purposes, limiting flexibility in how the funds could be repurposed by the BHA and limiting the development of a full continuum of behavioral health services for these populations.

Connecticut

Connecticut's behavioral health services are financed by a blend of private and public funds. Private funds include insurance, out-of-pocket co-payments by people with insurance, and direct payments by self-insured people. Public funding comes from state General Fund appropriations to state departments, federal grant awards, Medicare, and Medicaid.

Connecticut's FY24–FY25 biennium budget shows significant investments in behavioral health services across state departments including DMHAS, DCF and DSS. Alone, DMHAS' annual budget appropriations from the General Fund for FY24 are roughly $730M. Connecticut's population is approximately two-thirds that of Minnesota, and its expenditure on behavioral health is roughly half of Minnesota's.

DMHAS' annual budget appropriations combined with behavioral health initiatives in other state departments totals to be more than $1B statewide. In addition, the state utilized large buckets of ARPA funds to dedicate toward behavioral health initiatives, specifically targeting system improvements for children. The most recent budget includes recommendations to continue such funding into FY25.[lxxxvi]

Medicaid and CHIP represent cost sharing partnerships under which the federal government and state government; a report in 2019 indicated the federal government covered 59 percent of Medicaid costs and 88 percent of CHIP costs.[lxxxvii] The most recent biennium budget shows that $8B are appropriated for the HUSKY Health program.

North Carolina

The North Carolina Governor's Recommended Budget FY23–FY25 includes more than $1.5B total investment in mental health (roughly equal to Minnesota's expenditure for a population twice the size). Approximately $1B is dedicated to the Improving Health Outcomes for People Everywhere (IHOPE) Fund which includes ensuring Medicaid reimbursement rates for behavioral health services match cost of care, expanding access to mental health and substance use disorder treatment, and integrating behavioral health treatment in primary care and schools, among others. Overall, the plan focuses on three areas: making mental health services more available when and where people need them; building stronger systems to support people in crisis and people with complex behavioral needs; and enabling better health access and outcomes with data and technology.[lxxxviii]

In addition to the state funds, North Carolina actively applies for, competes for, and manages various grants and initiatives that align with the overarching mission of the Chief Deputy Secretary for Health and DMH/DD/SUS. North Carolina received behavioral health funding from various grants including the Community Mental Health Services Block Grant, the Substance Abuse Prevention and Treatment Block Grant, the SOR Grant, and the Certified Community Behavioral Health Clinics Planning Grant. Additionally, the state received ARPA funding to strengthen current health and human services-related programs, and to invest in new programs. On April 25, 2023, House Bill 855, Strengthening Care for Families and Children, was introduced which would appropriate $1B in nonrecurring, non-reverting funds for the 2023–25 fiscal biennium from the ARPA Temporary Savings Fund. These funds would be used transform child welfare and family well-being, strengthen the state Behavioral Crisis System, fund community and school-based behavioral health, fund justice-related behavioral health matters, improve the capacity of state psychiatric facilities, improve behavioral health data technology, and increase Medicaid rates.[lxxxix]

Furthermore, North Carolina entered into a settlement agreement with the U.S. Department of Justice in 2012. The aim of this agreement was to ensure that individuals with mental illness can live in their communities in the least restrictive settings of their preference. DHHS is implementing the agreement through the Transition to Community Living Initiative (TCLI). The TCLI promotes recovery through community-based supported housing, community-based mental health services, supported employment (individual placement supports), discharge and transition process, pre-admission screening and diversion, and quality assurance and performance improvement.[xc]

Like Minnesota, the largest funder of behavioral health services in North Carolina is the state Medicaid program. North Carolina's Medicaid program is also jointly funded by the state and federal governments. In the state FY22, the combined expenditures for Medicaid and NC Health Choice programs[xci] were $21.3B, with $3.9B paid by the State, $14.8B paid by the federal government, and $2.5B in other revenue sources.

Financial benchmarking among peer states

Table 24 outlines each state's top strengths and weaknesses relative to the financial analysis described in the previous sections.

Table 24. Top Benchmarking Financial Strengths and Weaknesses

State	Strengths	Weaknesses
MN	• Minnesota has an established system to compensate service providers for rendering services to individuals without insurance, utilizing the Behavioral Health Fund. • The Walz-Flanagan Administration's budget includes behavioral health initiatives that aim to improve access to mental health care, support Minnesotans with substance use disorders, and increase housing stability.[xcii] • Additionally, the Walz-Flanagan's $3.3B Infrastructure Plan dedicated 14 percent to housing and homelessness and 16 percent to community and equity, spending categories aimed at positively affecting social determinants of health associated with behavioral health outcomes.	• The behavioral health system is not achieving intended impacts on key performance indicators explored in **Table 17**. • Insufficient behavioral health reimbursement rates and inefficient grant allocations are a barrier to providers offering necessary services.

State	Strengths	Weaknesses
CO	• State leadership has made significant investments to improve the behavioral health system. Notably, $550M was allocated to behavioral health from ARPA funds alone to transform the system. • BHA data is being worked into HCPF's MMIS system to review system capacity and ensure those who can be covered by Medicaid are.	• In the past, much of the funding allocated for underinsured and uninsured individuals across Colorado was to support specific populations or legislative priorities. Funds have been appropriated for these specific programs or purposes, limiting flexibility in how the funds could be repurposed by the BHA and limiting the development of a full continuum of behavioral health services for these populations. • Reimbursement rates are a challenge. If they're not high enough, providers report not wanting to provide care to the BHAs or Medicaid demographic of individuals.
CT	• ARPA funds allocated to children's behavioral health initiatives; now being built into the state budget. • The contracted ASO model has improved financial efficiencies and maximization as they are tied to the contract performance	• There is no formal process for monitoring, and therefore responding to, service access. • Many departments hold funds related to behavioral health that aren't connected or coordinated. • Low reimbursement rates and massive workforce shortages are impacting behavioral health providers.

State	Strengths	Weaknesses
NC	• DHHS plans to implement Behavioral Health and IDD Tailored Plans through Tailored Care Management to provide integrated care management. • The state pays primary care practices that use the Collaborative Care Model 120 percent of the Medicare rate to increase model uptake. • DHHS is launching the Health Opportunities Pilot to evaluate the impact of evidence-based, non-medical interventions for high-needs Medicaid enrollees. • House Bill 855 could allocate $1B of ARPA funding to support behavioral health in North Carolina.	• DHHS delayed the implementation of Tailored Plans due to uncertainty with the state budget. • Through Medicaid transformation, providers have experienced administrative burden around enrollment with managed care plans.

Financial challenges and opportunities

Throughout the research and data collected for this effort, a number of themes related to financial challenges arose. The financial challenges listed below are aggregated from all data sources, including perceptions of challenges recounted by behavioral health partners during interviews. **Table 25** outlines the challenges and their data source(s).

Table 25. Financial Challenges

No.	Financial Challenge	Data Source
1	There was concern expressed during interviews that some providers are advising individuals to disenroll from Medicaid to attain reimbursement through the Behavioral Health Fund, which is perceived by some providers to be more efficient.	Interviews
2	Interviewees shared that there is no centralized data system for individuals receiving services. For instance, the Behavioral Health Fund data is not integrated into Minnesota's Medicaid Management Information System (MMIS).	Interviews
3	DHS financial data is dispersed across various sources, lacking standardization and a centralized data system posing challenges for compliance and reporting tasks. Access to crucial information such as program ownership, fiscal year, and grant initiation details is not easily attainable.	Interviews, Document Review
4	Value-based payment models utilized by payers to encourage improved health outcomes and more efficient care are not yet widely understood and resulted in the perception shared during interviews that publicly funded payments for care are still predominately paid on a fee-for-service basis.	Interviews

No.	Financial Challenge	Data Source
5	Care quality policies regarding equitable, clinically appropriate care are inconsistent across Medicaid, the Behavioral Health Fund, Managed Care, and grant-funded programs.	Interviews, Document Review
6	Adult Mental Health Initiatives are allocating financial resources primarily for routine service care and delivery instead of the funding's intended purpose to pilot innovative services and enhance collaboration of mental health services within their respective regions.	Interviews, Document Review
7	Grant administration initially meant for promoting innovation in behavioral health services is primarily being utilized for long-term service delivery rather than fostering innovation as intended. Prolonged reliance on these grants disrupts the creation of a sustainable system. Additionally, the administrative workload placed on DHS staff for grant administration is disproportionately high.	Interviews, Document Review
8	Interviewees shared that DHS' recently conducted rate study found that publicly funded behavioral health rates are too low, and it will take time to adjust them upward across multiple service categories to help providers supply quality care.	Interviews
9	Interviewees shared their perspective that DHS' current methodologies for making funding distribution decisions do not consistently incorporate the input or involvement of individuals receiving services, including providers and other partners.	Interviews
10	Both audit findings and interviewees noted that DHS behavioral health grant administration policies lack transparency, consistency, and standardization on how funding decisions are made.	Interviews, Document Review
11	Interviewees expressed concern that DHS is not able to capitalize on all federal grant dollars available since DHS' grant initiation process is ineffective and inefficient.	Interviews
12	Without clear guidance, the usage of various state funding streams for behavioral health can create confusion, operational inefficiencies, and challenges for individuals using services, staff, advocates, and providers due to multiple nuances and complexities resulting in waste and misuse of funding.	Interviews, Document Review
13	Interviewees reported that limited availability of behavioral health services in some areas causes individuals to extend their stays in emergency departments and inpatient care unnecessarily, which ultimately results in higher costs covered by state resources.	Interviews
14	Insufficient funding for prevention services leads to increased downstream costs for state resources.	Interviews, Document Review
15	Interviewees reported that administratively burdensome policies, particularly related to grants administration, licensing, and provider reimbursement, place a time strain on providers and restrict funds that could be more effectively utilized for service delivery.	Interviews

No.	Financial Challenge	Data Source
16	Interviewees noted that DHS behavioral health staff often lack the fiscal knowledge and resources to effectively create, orchestrate, and manage financial and grant programs.	Interviews
17	Across the 87 counties that each act as a local mental health authority, there is notable variation in available financial resources and approaches employed to address behavioral health issues.	Interviews, Document Review

Table 26 and **Table 27** summarize actionable organizational opportunities for DHS. They include references to the data sources for each opportunity and align them with the corresponding goals outlined in DHS's 2023-2027 Strategic Plan. The tables arrange these opportunities according to their alignment with the sequence in the DHS Strategic Plan.

Table 26. Financial Opportunities for DHS Agency Strategic Plan Outcome A: People in Minnesota Thrive

No.	Financial Opportunity	Data Source	DHS Strategic Plan Goals
1	Develop a best practice model to provide guidance on how to expand access to and delivery of prevention and early intervention services to reduce downstream spending.	Interviews	A.2 *Promote adult and children's safety and wellbeing with easy access to behavioral health supports and optimal living situations.*
2	Evaluate waiver opportunities to maximize federal match dollar funds for service provision, thereby developing more sustainable financing mechanisms.	Interviews	A.3 *Champion a service continuum that centers justice, equity and choice, supporting people with disabilities and older adults to lead meaningful lives in the community.*

Table 27. Financial Opportunities for DHS Agency Strategic Plan Outcome B: People Experience High-Quality Human Services

No.	Financial Opportunity	Data Source	DHS Strategic Plan Goals
1	Increase investment in financial data infrastructure system to optimize DHS financial operations and contract management for services provided under the Behavioral Health Fund, Medicaid, and behavioral health grants.	Interviews	B.2 *Administer programs effectively and efficiently through streamlined processes and reduction of errors, fraud and waste.*
2	Work with partners to continue to expand coverage of ASAM-approved treatment options under all payment mechanisms at a minimum annually. Examine billing and coding practices that support this effort.	Interviews, Document Review	B.2.

No.	Financial Opportunity	Data Source	DHS Strategic Plan Goals
	Continue to expand alternative payment methodologies.		
3	Enhance the Behavioral Health Fund appropriations, policy legislation, and enrollment methodology to ensure eligible Medicaid individuals are enrolled in Medicaid and the BHF is optimized. • Develop a BHF centralized data infrastructure, incorporating the MMIS system, to better track individuals, service utilization, and funding and ensure eligible Minnesotans are being enrolled in Medicaid. • Develop incentive payments for providers and counties who identify Medicaid-eligible members who are currently enrolled in the BHF and help them (re)enroll in Medicaid.	Interviews	B.2.
4	Provide incentive payments to providers who enroll consumers into Medicaid programs, provide quality care and patient satisfaction.	Interviews, Document Review	B.2.
5	Expand opportunities for innovation within Adult Mental Health Initiatives to test research informed practices to be scaled and implemented across the state.	Document Review, Interviews	B.2.
6	Create mechanisms for partner inclusion in funding distribution methodologies and/or decisions. • Prioritize diversity and equity in grant awards and disbursement • Prioritize diverse representation in the grant selection committee • Create training and capacity development opportunities for diverse businesses to apply for grants and to attain necessary licenses	Interviews	B.4 *Build capacity to engage with community and amplify voices in decision-making processes.*

Conclusion

Opportunities

The eighteen opportunities identified through this effort support a broad vision for a path forward that may or may not be actionable or realistic for the Department. These opportunities were identified through the document review, partner interviews, and benchmarking exercises. Data sources for each opportunity are noted, as well as the associated goal of that opportunity mapped from DHS's 2023–2027 Strategic Plan. **Table 28, Table 29**, and **Table 30** below combine all organizational opportunities described in **Table 20**, **Table 21**, and **Table 22**, as well as financial opportunities identified above in **Table 26** and **Table 27**, for each of the Outcomes.

Table 28. Organizational and Financial Opportunities Relative to DHS Agency Strategic Plan Outcome A: People in Minnesota Thrive

No.	Opportunity	Opportunity Type	Data Source(s)	DHS Strategic Plan Goal
1	Develop a best practice model to provide guidance on how to expand access to and delivery of prevention and early intervention services to reduce downstream spending.	Financial	Interviews	A.2 *Promote adult and children's safety and wellbeing with easy access to behavioral health supports and optimal living situations.*
2	Evaluate waiver opportunities to maximize federal match dollar funds for service provision, thereby developing more sustainable financing mechanisms.	Financial	Interviews	A.3 *Champion a service continuum that centers justice, equity and choice, supporting people with disabilities and older adults to lead meaningful lives in the community.*
3	Deepen behavioral health expertise, including clinical knowledge, in DHS/BHD leadership to strengthen guidance to staff and partners to improve services across both mental health and substance use.	Organizational	Interviews, Benchmarking (NC)	A.3

No.	Opportunity	Opportunity Type	Data Source(s)	DHS Strategic Plan Goal
4	Address workforce shortages by eliminating barriers to accessing behavioral health workforce employment opportunities. This could involve initiatives such as forming strategic partnerships to create or support behavioral health career pipelines, broadening scholarship offerings that either fully cover or reduce examination fees, eliminating the master's degree requirement where feasible, and further examining opportunities for background studies reform.	Organizational	Interviews	A.4 *Invest in home, community, and facility-based care workforce and strengthen Minnesota's network of caregiving.*

Table 29. Organizational and Financial Opportunities Relative to DHS Agency Strategic Plan Outcome B: People Experience High-Quality Human Services

No.	Opportunity	Opportunity Type	Data Source(s)	DHS Strategic Plan Goal
1	Increase investment in financial data infrastructure system to optimize DHS financial operations and contract management for services provided under the Behavioral Health Fund, Medicaid, and behavioral health grants.	Financial	Interviews	B.2 *Administer programs effectively and efficiently through streamlined processes and reduction of errors, fraud and waste.*
2	Work with partners to continue to expand coverage of ASAM-approved treatment options under all payment mechanisms at a minimum annually. Examine billing and coding practices that support this effort. Continue to expand alternative payment methodologies.	Financial	Interviews, Literature Review	B.2

No.	Opportunity	Opportunity Type	Data Source(s)	DHS Strategic Plan Goal
3	Enhance the Behavioral Health Fund appropriations, policy legislation, and enrollment methodology to ensure eligible Medicaid individuals are enrolled in Medicaid and the BHF is optimized. • Develop a BHF centralized data infrastructure, incorporating the MMIS system, to better track individuals, service utilization, and funding and ensure eligible Minnesotans are being enrolled in Medicaid. • Develop incentive payments for providers and counties who identify Medicaid-eligible members who are currently enrolled in the BHF and help them (re)enroll in Medicaid.	Financial	Interviews	B.2
4	Provide incentive payments to providers who enroll consumers into Medicaid programs, provide quality care and patient satisfaction.	Financial	Interviews, Literature Review	B.2
5	Expand opportunities for innovation within Adult Mental Health Initiatives to test research informed practices to be scaled and implemented across the state.	Financial	Document Review, Interviews	B.2
6	Continue to improve the grant management and grant initiation process with the objective of optimizing efficiency. This review should include an assessment of the feasibility of implementing umbrella contracts to foster workload reduction of grants administration and oversight.	Organizational	Interviews	B.2
7	Standardize and streamline data collection and reporting for behavioral health services funded through the Behavioral Health Fund, Medicaid, and behavioral health grants to one central statewide system for comprehensive claims and administrative data to inform decision-making and quality improvement initiatives.	Organizational	Benchmarking (CT)	B.2

No.	Opportunity	Opportunity Type	Data Source(s)	DHS Strategic Plan Goal
8	Empower Mental Health and Substance Use Disorder Licensing staff in the Licensing Division to expand oversight and management of administration and delivery of services to improve programmatic fidelity and monitoring for continuous quality improvement.	Organizational	Interviews, Document Review	B.2
9	Create mechanisms for partner inclusion in funding distribution methodologies and/or decisions. • Prioritize diversity and equity in grant awards and disbursement • Prioritize diverse representation in the grant selection committee • Create training and capacity development opportunities for diverse businesses to apply for grants and to attain necessary licenses	Financial	Interviews	B.4 *Build capacity to engage with community and amplify voices in decision-making processes.*
10	Review DHS's behavioral health communication strategy to ensure it: • includes sufficient opportunity for partner engagement • fosters a two-way feedback loop for continuous improvement • includes an educational element highlighting DHS' ongoing initiatives • includes a strategy to enhance participation in external events and conferences	Organizational	Interviews, Benchmarking (CO)	B.4
11	Review existing processes for developing a process to ensure BHD evaluates proposed policies for operational feasibility before they are presented to legislators. Ensure people with lived experience, external partners, and BHD subject matter experts are included throughout the process.	Organizational	Interviews	B.4

Table 30. Organizational and Financial Opportunities Relative to DHS Agency Strategic Plan Outcome C: People at DHS Thrive in an Inclusive Environment

No.	Opportunity	Opportunity Type	Data Source(s)	DHS Strategic Plan Goal
1	Revise the organizational structure within DHS to require Directors to be formally involved, actively engaged, and accountable to multiple administrations within the agency, facilitating knowledge sharing and bridging gaps between divisions.	Organizational	Benchmarking (CT, NC)	C.2 *Create an organizational culture where employees experience inclusion, psychological safety, respect, wellbeing and joy.*
2	Review job functions and expertise needed by role to match skills and resources to organizational needs. For example: • Identify grant management skill set and capacity gaps. • Work with the legislature and Human Resources to prioritize hiring for behavioral health grant management resource needs, employing an agile hiring process to accelerate staff acquisition.	Organizational	Interviews	C.3 *Build career pathways and create ways for staff to grow in their job.*
3	Improve collaboration and coordination of behavioral health efforts being implemented by various state and local entities by assigning roles, responsibilities, and action items to drive progress. This can be achieved by OAR continuing to act as an organizing body.	Organizational	Interviews, Benchmarking (CO and CT)	C.4 *Be a collaborative partner in the creation of separate state agencies while supporting employees and continuity of operations.*

Options

Three overarching pathways surfaced from this review for the future of how administrative responsibility for behavioral health could be organized and financed in Minnesota. These courses of action were gleaned from interviews and best practice review and research, including benchmark states Colorado, Connecticut, and North Carolina. Each option is accompanied by the associated benefits and challenges and supporting evidence from the review (detailed in **Table 31**, **Table 32**, and **Table 33**). These three options can be pursued independently or in concert with each other.

Option 1: Retain Behavioral Health within DHS and Continue Innovations

Keep behavioral health within DHS while continuing to innovate, improving collaboration and coordination among existing and new collaborative partners.

Table 31. Benefits and Challenges of Option 1

Benefits (Pros)	Challenges (Cons)
• Maintains strong connection between behavioral health and Minnesota's Medicaid program. • Leverages current momentum and appetite for advancing parity in behavioral health services. • Allows time to "let the dust settle" on the changes that have already been made within DHS and assess for improvement. • Continuing to house behavioral health and Medicaid within the same agency allows for centralized data and shared administrative functions (*e.g.,* Budget and Finance, Compliance, Human Resources, IT). • Allows time to implement opportunities outlined in this report to see if it shores up the system before making a disruptive and costly change. • Provides an opportunity for DHS to review their job descriptions and staffing plans, allowing for the precise determination of the appropriate staffing composition and skillsets. • Least disruptive and lowest-cost option.	• Oversight of operations and funding within such a large agency will continue to be a challenge. • Requires continued and expanded investment of significant time and resources for coordination and collaboration to gain alignment across DHS administrations and collaborative partners. • Behavioral health priorities and operational needs will require ongoing advocacy among DHS strategic goals. • Reduced ability to respond quickly to growing or changing behavioral health needs that require significant collaboration among administrations due to ongoing competing priorities within DHS.

Key findings

The retainment of behavioral health within the purview of DHS was overwhelmingly supported. Reasons included:

- Promote parity among behavioral health services and other healthcare services.
- Retain BHD, Mental Health Licensing, and Substance Use Disorder Licensing within DHS, under the same administrative leadership and strategic vision.
- Sustain a well-defined, transparent, and easy to understand decision hierarchy.
- Preserve a single authority figure with one strategic vision.
- Reduce challenges for data sharing and reporting.
- Focus on improved internal communication and collaboration.
- Prevent confusion to an already complex system.
- Empower the BHD with more autonomy to foster nimbleness and innovation.
- Lead an all-encompassing, interdisciplinary effort to formulate a unified vision and strategy, mirroring the approach employed during the COVID-19 pandemic, to tackle Minnesota's behavioral health needs.
- Bridge gaps within DHS and among partners.
- Understand past efforts, current situations, and forecast future behavioral health system needs.
- Observe the outcomes of separating DCT and Children, Youth, and Families and utilizing lessons learned to form prudent approach for continued coordination and collaboration among remaining DHS administrations.
- Capitalize on this opportune moment of DHS’ reorganization to initiate internal restructuring within DHS to effectively address any identified gaps.

Option 2: Develop a Blueprint for a Cohesive Behavioral Health System

Led by DHS, along with its partners, develop a formalized strategic plan and/or blueprint for behavioral health that charts a path towards a cohesive system, incorporating broader and deeper partner engagement and generating large-scale buy-in for action.

Table 32. Benefits and Challenges of Option 2

Benefits (Pros)	Challenges (Cons)
• Allows for more widespread buy-in and builds a "mandate" for action on how to build a more cohesive organizational and financing system for behavioral health. • Can include evaluating Options 1 and 3 as potential paths forward, creating tests of change for viability. • Formalizes system-wide change to synchronize efforts among counties, regional initiatives, Tribal Nations, DHS, Medicaid, and other public and private partners. • Provides assessment of infrastructure and resources to establish a systematic, efficient, and sustainable system of care. • Gives Minnesota time to continue to study outcomes from other states' reorganization of behavioral health staff and policies.	• Consumes additional resources and delays implementation when the system is under strain now. • Data saturation may have already been reached and new information may not emerge. • Innovation can be sacrificed when searching for thoroughly validated alternatives.

Key findings

In Colorado and North Carolina, there have been recent investments in behavioral health system reform and infrastructure modifications. Colorado recently split behavioral health from DHS, investing in a strategic process to develop a blueprint for behavioral health reform which resulted in the Behavioral Health Administration as a new entity. Both states acknowledged it is still premature to ascertain the benefits or unforeseen consequences of these structural changes, underscoring the potential need for a formalized behavioral health strategic plan to help maximize the benefits of coordinated efforts and minimize unintended consequences. Minnesota's DHS has already created a clear strategic plan for 2023–2027 referenced throughout this report and could benefit from undergoing this same visioning process for the future of behavioral health.

Rather than advocating for the separation of behavioral health from DHS, partners proposed further strategic investigation, which should encompass:

- A five-year strategy that outlines attainable goals and aspirational outcomes of efforts to create a more cohesive behavioral health system.
- Assessing practices and ensuring the workforce is representative of populations that are served.
- Perceptions that there has not been a behavioral health system infrastructure created post deinstitutionalization; rather, there has just been a patchwork created to provide services and address needs. Further partner engagement and creation of a blueprint for reform will allow the opportunity to take a step back and build a comprehensive, efficient and sustainable system that elevates what is working and transforms what has not worked.
- Watching Colorado to see if their Behavioral Health Administration restructure results improves outcomes before Minnesota makes substantive decisions.

Option 3: Remove the Behavioral Health Division from DHS and Create a Separate Behavioral Health Agency

Create a dedicated behavioral health agency to be responsible for overseeing coordination and collaboration across all collaborative partners, centralizing the majority of administrative tasks to address behavioral health needs of Minnesotans. Oversight for all Medicaid funded services would remain with DHS.

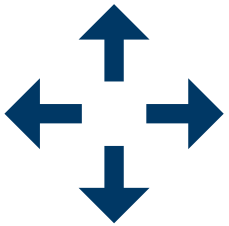


Table 33. Benefits and Challenges of Option 3

Benefits (Pros)	Challenges (Cons)
• Serves as the safety net administrator for uninsured and underinsured. • Provides organizational and financial structures that inherently prioritize behavioral health. • Clarifies ownership of behavioral health strategy and oversight. • Behavioral health leadership has more autonomy and agility to make decisions in collaboration with Medicaid. • Manages and provides oversight of the Behavioral Health Fund and behavioral health grants for increased accountability. • Legislative, finance, legal and compliance team would specialize and understand the nuances of behavioral health. • Can serve as the statewide coordinator for all state, local, and sovereign Minnesota Tribes, providers and organizations to ensure high quality of care, coordination and innovation of behavioral health services. • Opportunity to rebuild collaborative partner trust through redesigning behavioral health delivery to include partner input. • Natural opportunity for staff to change roles and elevate strong performers when hiring for positions in the new organization.	• Infuses more change into a system that is already in flux. • Requires formalized strategies for coordination and alignment across behavioral health services. • Creates opportunities for misalignment in priorities, data and health care coverage between the new behavioral health "agency" and Medical Assistance (Medicaid) when Medicaid funded behavioral health program and services stay within DHS. • Risk of eroding the parity among behavioral health, physical health conditions, and reduced coordination of care across other healthcare services. • Potential for unclear authoritative structure for matters that extend across different agencies. • Multiple agency decision makers could result in less clear accountability, slower decisions, and lack of understanding of roles and responsibilities. • Multiple agencies may cause confusion for providers needing support, individuals receiving services, the general public and other partners.

Key findings

If Minnesota chooses to separate behavioral health into a distinct organization, effective communication and coordination between the behavioral health organization, DHS (Medicaid and other administrations), counties, Tribal Nations, and other partners and associations is paramount. Planning, policies and procedures, staffing, funding and administration need to be clearly outlined leaning into collaboration and coordination to reduce duplication and improve efficiency. Having a change management process and plan in place is also critical to guide the separation to foster buy-in and continuity.

Beyond standing up the Behavioral Health Administration, which serves almost exclusively as a coordinator and contractor, Colorado is actively working towards fostering a provider-friendly state, a collaborative culture, and eliminating unnecessary administrative and financial barriers for providers. Their provider engagement model, characterized by continuous bidirectional communication, a commitment to addressing provider feedback as a priority, dedicated mailing lists, scheduled email correspondence, standing forums, a clear and advertised grievance process, transparent and easily accessible rate information, and proactive provider education on regulations and payment methodologies, has proven highly effective. This model ensures that providers are involved in every step of the policy-making process, contributing to the success of the transition.

There was both support for and apprehension about having behavioral health operate as its own organization. Reasons included:

- Opportunity to create a fresh start and rebuild trust with individuals receiving services, agencies, and community partners.
- Allows for specialization and keeps behavioral health a priority since it has a dedicated team and focus.
- Concerns stemming from lingering unanswered questions (e.g., What happens with appeals? Do they want to build their own appeals division, or should DHS keep appeals? What about contracts? How would you restructure teams; how do you split one supervisor?).
- Absence of a strategic plan for executing this transformation.
- Apprehensions that the parity of behavioral health with other medical diagnoses may diminish if Behavioral Health is no longer integrated with other Medicaid medical services.
- Concerns regarding the division of positions that currently support both Behavioral Health and other administrations and teams that would remain within DHS.
- Apprehension that the separation between DHS and Behavioral Health into two different agencies would result in additional administrative burdens.

Appendix A: Interview protocol

Consultation Services to Review Minnesota's Behavioral Health System Assessment

Interview Protocols

Interview Date	[date]	**PCG Interviewer**	[name]
Interviewee Name	[name]	**Title**	[title]
Organization / Department	[organization name]	/	[department name]

Introduction

Thank you for agreeing to speak to me today. Public Consulting Group LLC (PCG) has been contracted by the Department of Human Services and the Office of Addiction and Recovery to conduct a review of Minnesota's Behavioral Health system. The review will focus on three high-level components: 1) a review of the structure of DHS; 2) a review of the way Minnesota finances behavioral health; 3) a review of Minnesota's behavioral health continuum of care with a particular focus on substance use disorder.

There are no right or wrong answers, and everything that we learn from you today will be kept confidential and reported in aggregate form only. Please let me know if you need me to clarify any questions at any time. The interview is expected to take about 45–60 minutes.

Background

First, we would like to start by learning more about your background and role.

1. How long have you worked at [org/department name]?
2. What is your current role and how long have you been in it?
3. Do you participate in any behavioral health –
    a. Committee(s)?
    b. Workgroup(s)?
    c. Taskforce(s)?

Current State – Gaps and opportunities

Next, I want to understand the current state and how you (and your team) fit into the Behavioral Health system from an organizational and financial perspective.

1. Please describe [*insert organization/departments*]'s role in Minnesota's behavioral health system, including your interactions with key behavioral health partners.
2. Please describe the current organizational structure of behavioral health programs and services as it relates to your [*insert organization/department*]?
3. What are the top two greatest gaps/challenges and the top two areas of opportunity?
4. Please describe how the behavioral health services and programs you work with are funded?
5. What are the top two greatest gaps/challenges and the top two areas of opportunity?
6. Describe the challenges and opportunities for referral to and access of treatment services and transition of care through the behavioral health system.

7. What work or initiatives has [insert organization/department] undertaken to promote health equity for behavioral health services and programs?
8. Who are your priority populations and how are they engaged?
9. What are the top two greatest challenges and the top two areas of opportunity?
10. Are there other communities with organizational and financing models that you consider exemplary?

Future state

Imagine that it is 2028—five years from now. Minnesota has created a highly efficient, accessible, equitable and sustainable behavioral health service delivery system.

1. What were the most critical action steps taken by the state and more specifically your [*insert organization/department*] to achieve this vision for behavioral health service delivery?
2. What connection points between services and organizations have the most viability? [*e.g., housing and Medicaid; public safety and transition to community treatment*]
3. What organizational structure or functions [*e.g., services, funding streams, reporting/data*] might be aligned and leveraged or disaggregated to meet the vision?
4. How can sustainability be achieved both in behavioral health structure/services and financing?
5. Which partners would you like to better engage to bolster equity and sustainability?

Closing

1. Do you have any documents you can share to bolster our understanding of the current behavioral health system from an organizational and financial perspective and with a particular focus on substance use disorder?
2. Is there anything you would like to add to bolster our understanding of or to improve Minnesota's Behavioral Health System?

   Thank you so much for your time today, I really enjoyed speaking with you. If you have any questions or follow-up information, or if you remember something which might be helpful, please feel free to contact me.

Appendix B: Partner visioning

The **Partner Visioning Funding/Financing, DHS, Policy, and System Design Matrix** (**Table 1**) consolidates partner interview insights concerning the future vision for financing behavioral health service delivery. Responding to the prompt, *"Imagine it's 2028 – five years from now. Minnesota has established a remarkably efficient system for financing BH service delivery. What does this system entail? How was it achieved?"* The matrix aligns stakeholders' viewpoints with essential objectives or criteria, and responses are ranked in descending order of priority within the matrix.

Table 1. Partner Visioning Funding/Financing, DHS, Policy, and System Design Matrix

Funding/Financing	DHS	Policy	System Design
Funding for critical ongoing services transitioned from grants to a sustainable long-term funding mechanism	DHS, Office of Addiction and Recovery & Licensing all housed together and under the same chain of command	State supervised county administered model reviewed	Shared understanding, clearly defined role, scope and authority of the state, MCOs and counties
Behavioral Health waiver in place that draws on federal funds	Shared decision-making structure in place that includes DHS, partners and people of MN	County of financial responsibility policy reformed or eliminated	Legislatures have a global understanding of how the Behavioral Health System works, who is in charge, and how the money flows
Criminal Justice Waiver that draws on federal funds	MN is compliant and fully integrated in latest version of ASAM	Reduced complexity of funding streams and requirements	Coordinated and consistent approach across DHS, Medicaid HCA, the counties, and Tribal Nations
Value-based payment system in place	Interconnected culture (siloes removed)	The BHF & Bundled Services reviewed and reformed	Parity among Behavioral Health and all other medical conditions
More dollars allocated for operating expenses	DHS leadership team takes the time to understand past initiatives and shadow front line staff providing care	Medicaid enrollment incentives in place so the BHF is not being used for Medicaid eligible individuals	Parity between Medicaid and commercial insurance benefits

Funding/Financing	DHS	Policy	System Design
Funding pass-throughs in place with simplified contracting vetting process for Tribal Nations and other providers (similar to how counties are contracted and funded now)	DHS staffing aligned with current volume of grants and other initiatives	Commercial insurance mandated Behavioral Health coverage	More focus on the user experience & full spectrum of care
N/A	DHS staff skills set aligns with their function (*e.g.*, more staff hired with a financial management skills)	All services and licensing meet ASAM standards	Expanded periods of continuous Medicaid eligibility to support transitions in care
N/A	Shift from looking through a DHS lens to a participant lens that also meets the needs of providers	Accurate data collection mechanism in place, policy driven by data	Incentives to counties and providers to enroll everyone who is eligible for Medicaid in Medicaid
N/A	Public engagement to determine how grants will be distributed, followed by transparent public awareness on where grants dollars are distributed	Standards for recovery community organizations and sober homes in MN established	N/A
N/A	Streamlined and efficient contracting process in place across DHS	Administrative overreached corrected. Redundant paperwork and processes that added no value eliminated.	N/A
N/A	More people Tribal Nations and minority racial and ethnic groups at DHS executive level making decisions	Engaged, interagency licensing board that includes Dept of Health, Universities etc., that meets with DHS regularly to ensure licensing addresses quality of care	N/A

Funding/Financing	DHS	Policy	System Design
N/A	Better relationships with legislatures, DHS subject matter experts able to speak directly with legislatures	Simplified claims systems and process	N/A
N/A	Counties are true partners (hard now due to how funding and contracting working)	Simplified SUD statues, rules and policies	N/A
N/A	People who are receiving BH services currently part of the decision-making process	Support for providers on billing, licensing and regulation	N/A

The **Partner Visioning Technology Improvements, Key DHS Partnerships, Workforce, and Services/Care Matrix** (**Table 2**) reflects partner interview insights concerning the future vision for financing behavioral health service delivery. Responding to the prompt, *"Imagine it's 2028 – five years from now. Minnesota has established a remarkably efficient system for financing BH service delivery. What does this system entail? How was it achieved?"* The matrix aligns stakeholders' viewpoints with essential objectives or criteria, and responses are ranked in descending order of priority within the matrix.

Table 2. Partner Visioning Technology Improvements, Key DHS Partnerships, Workforce and Services/Care Matrix

Technology Improvements	Key DHS Partnerships	Workforce	Services/Care
Centralized grants management system that incorporates a dashboard, consistent reporting capabilities, document storage, and integrated contracting established	Individuals who are currently using BH services and with lived experience	Rates are adequate to meet providers expenses and reflect the true cost of care. Rates include automatic inflation adjustments	Behavioral Health services integrated with physical Medicaid services

Technology Improvements	Key DHS Partnerships	Workforce	Services/Care
CMS-approved IT system implementation, which facilitates the sharing of participant records across various programs, identifies additional services, and broadens access points for other services, extended to encompass all DHS programs	Tribal Nations	Adequate, and culturally competent, provider base across the state that includes providers from all communities of the population served	Culturally appr services, including traditional healing & innovations like empath units, in place in all communities and regions of the state
DHS data collection mechanism established to ensure uniform data collection and analysis throughout the entire Human Services system. Data then used to inform policymaking efforts and to detect Behavioral Health service deserts.	Members from MN's ethnic communities	Sustainable career pipelines in place for careers that pay a living wage	Harm reduction model services in place. Recognizing that there's more than one path to recovery and meeting people where they are at in that continuum.
Expand the current MNMH Access website (mechanism that shows in patient mental health bed availability) to include all Behavioral Health services and providers	Associations	Quality care incentivized	More prevention programs, reintegration programs, recovery programs & employment programs, and long-term recovery programs
Implement a system that uses analytics and business intelligence to drive more proactive engagement with individuals	Managed Care Organizations	N/A	Certified Community Behavior Health Clinics in place to meet whole families' needs with primary care and behavioral health all under one model
N/A	Justice System	N/A	Mobile crisis units (diversions from jail and ERs)
N/A	Education	N/A	More community-based services in place
N/A	Housing	N/A	More after care services in plan to support people in recovery

Technology Improvements	Key DHS Partnerships	Workforce	Services/Care
N/A	SAMHSA	N/A	More preventative services in place, especially in schools
N/A	N/A	N/A	Adequate affordable housing
N/A	N/A	N/A	Adequate affordable transportation
N/A	N/A	N/A	More transitions of care/warm hand offs

The **Partner Visioning Equity, Priority Populations, and Connection Points Matrix** (**Table 3**) consolidates partner interview insights concerning the future vision for financing behavioral health service delivery. Responding to the prompt, *"Imagine it's 2028 – five years from now. Minnesota has established a remarkably efficient system for financing BH service delivery. What does this system entail? How was it achieved?"* The matrix aligns stakeholders' viewpoints with essential objectives or criteria and responses are ranked in descending order of priority within the matrix.

Table 3. Partner Visioning Equity, Priority populations and Connection Points Matrix

Equity	Priority Populations	Connection Points
Cultural and linguistic standards in place	Adolescents & Kids	State and Tribal Nations
Grants have a build in equity mechanism to ensure grant makers are getting feedback from communities served & support in the grant making process to ensure a level playing field with big players	Tribal Nations	State and individuals receiving services
Services and funding are nimble enough to meet MN's diverse populations needs and adjust as demographics change	Participants receiving services through the BHF who Medicaid are eligible	Law enforcement and crisis services/community-based responses

Equity	Priority Populations	Connection Points
DHS provides consistent outreach to continuously understand MN's every changing diverse population needs	Immigrant communities, in particular the Somali and Hmong communities	Licensing and provider advocacy groups
Licensing's reformed to meet the needs of different population groups	Family Units	Counties and managed care organizations
Integrated, whole person, person-centered view in place	People of Color	Counties and Tribal Nations
Greater representation of individuals from diverse backgrounds in leadership roles	Rural communities	State and criminal justice system
Policy encompasses members of all tribal communities, irrespective of their enrollment in Minnesota Tribal Nations	Veterans	Federal and state
N/A	People Experiencing Homelessness	Housing and services providers
N/A	LGBTQ+	Mental health providers and substance use disorder providers
N/A	Low-Income	State and associations
N/A	Children with IDD	State and counties
N/A	N/A	State and managed care organizations
N/A	N/A	State and provider agencies

Appendix C: Summary of DHS audit findings

Table 4. Summary of DHS Audit Findings

Year	Audit	Key Findings	Substantiated
2019	**DHS: Behavioral Health Grants Management – Internal Controls and Compliance Audit**	OLA found that internal controls over the areas in our audit scope were not adequate to ensure that DHS, through BHD, safeguarded assets and ensured compliance with legal requirements and state policies related to grant oversight.	Y
2020	**Behavioral Health Division Special Review Final Report**	IAO was able to substantiate allegations related to five of their nine objectives, leaving allegations related to four of our objectives unsubstantiated. Also, their scope included limited work on two personnel-related issues. They found evidence that certain staff had a possible conflict of interest and referred what was found to Human Resources. They found no corroborating evidence that a specific staff member requested gifts from grantees, and, accordingly, did not refer that matter to Human Resources.	Y
2020	**Managed Care Organizations: Reporting of Dental and Mental Health Encounter Data**	OLA found that the MCOs complied with the legal and DHS contract requirements with oversight of their third-party administrators for dental or mental health benefits. Additionally, OLA found that all eight MCOs complied with selected legal and DHS reporting requirements for mental health encounter records, and payment information was accurate, complete, and timely. However, OLA found that four of the eight MCOs had a small number of exceptions in their reporting of dental encounter claim data.	N
2021	**Certified Community Behavioral Health Clinics (CCBHC) Payment Review**	While reviewing the contract payments, IAO did not discover any payments beyond what was authorized. As of October 2020, DHS has paid Mercer Health & Benefits approximately $1.3M out of $1.5M for the entire contract, including amendments. However, IAO noted concerns with the duties required by Mercer under the contract as discussed in Findings Section.	N

Year	Audit	Key Findings	Substantiated
2021	**Mini Grant Application and Official Grant Award Notification (OGAN) Audit**	IAO found weaknesses in controls over the mini-grant award process related to carrying out and documenting the grant award decisions. They recommended that BHD verifies that sufficient documentation exists in their system to justify the evaluation of the grant award. Additionally, they recommended that BHD ensures that the final documents demonstrate adherence to contractual and conflict of interest requirements.	Y
2021	**State Opioid Response (SOR) Eligible Expenses/ Award Report Audit**	Ultimately, the IAO did not find evidence that the BHD mismanaged SOR grant contracts related to underspending of SOR grants, improper use of 1115 demonstration project funds, or discrepancies among governing documents such as the application, Request for Proposal, and contracts. However, they did identify delays related to the awarding of funds and challenges related to the COVID-19 pandemic that led to no cost extensions and unexpended funds. The assessment also revealed that there are potential risks associated with unstructured decision-making processes and poor processes that may lead to a loss of funds. The IAO recommended that BHD ensures that ongoing monitoring occurs during the no cost extensions, as well as consistent reporting to senior management regarding the risks associated with potential fund loss related to underspending of SOR grants.	Y
2022	**Mental Health Rate Enhancements**	OLA found that all three of the providers flagged by CSA as suspect of being ineligible for rate enhancements were eligible due to their inclusion on the Essential Community Providers list through the Health Department.	Y
2022	**DHS Homelessness and Housing Support Grants Performance Audit**	OLA found that DHS generally did not have adequate internal controls to ensure compliance with applicable legal requirements over homelessness and housing support grants. The department had significant control deficiencies related to the management of homelessness and housing support grants. Further, the department	Y

Year	Audit	Key Findings	Substantiated
		did not always comply with the significant legal requirements related to grants management.	
2022	**MCOs: Personal Care Assistance Services Encounter Data and Oversight Performance Audit**	Although the MCOs generally complied with the selected legal and DHS contract requirements, OLA identified several instances of noncompliance. The more significant instances of noncompliance were in the areas of reporting of encounter data, and provider and service oversight. OLA found instances of DHS noncompliance in provider oversight.	Y

Behavioral Health Division Special Review Final Report, 2020

The BHD was created as a result of a merger in late 2018 between the ADAD and the Children's and Adult Mental Health divisions. Previously, both ADAD and the Mental Health divisions were managed by two deputy directors. The BHD merger resulted in one vacant deputy director position, as both previous deputies left the division. The new BHD deputy position was filled in March 2019. The director position, to whom the previous deputy directors reported, has been occupied since September 2017.

The IAO received several complaints and allegations made against the BHD and BHD management. Allegations included violations that were not properly documented, policies not being followed, staff receiving gifts from grantees in exchange for providing grantees with funding, etc.. The objective of this report was to determine if the allegations could be substantiated.

This report shows IAO was able to substantiate allegations related to five of their nine objectives, leaving allegations related to four of our objectives unsubstantiated. Also, their scope included limited work on two personnel-related issues. They found evidence that certain staff had a possible conflict of interest and referred what was found to Human Resources. They found no corroborating evidence that a specific staff member requested gifts from grantees, and, accordingly, did not refer that matter to Human Resources.

State Opioid Response (SOR) Eligible Expenses/Award Report Audit, 2021

In April 2021, the IAO initiated a review to address concerns related to spending of the State Opioid Response (SOR) grant funds. The review focused on assessing the appropriate management and timeliness of the SOR grant, the eligibility of awarded grants for the 1115 demonstration project, and the consistency between the governing documents. In October 2018, DHS received a federal SOR grant of $8,870,906 each year for two years, and DHS was awarded an additional supplemental grant of $4.26 million in July 2019. Over $11.2 million in grants were awarded to 27 counties, tribes, health care providers and community agencies with the aim to expand services, address disparities, and increase the availability of Naloxone, a life-saving medication that reverses an opioid overdose.

The IAO reviewed various federal regulations related to the SOR funds and grant monitoring functions, conducted interviews with those responsible for awarding and monitoring the awards, and reviewed and analyzed relevant documents. Ultimately, the IAO did not find evidence that the Behavioral Health Division (BHD) mismanaged SOR grant contracts related to underspending of SOR grants, improper use of 1115

demonstration project funds, or discrepancies among governing documents such as the application, Request for Proposal, and contracts. However, they did identify delays related to the awarding of funds and challenges related to the COVID-19 pandemic that led to no cost extensions and unexpended funds. The assessment also revealed that there are potential risks associated with unstructured decision-making processes and poor processes that may lead to a loss of funds. ***The IAO recommended that BHD ensures that ongoing monitoring occurs during the no cost extensions, as well as consistent reporting to senior management regarding the risks associated with potential fund loss related to underspending of SOR grants.***

Mini Grant Application and Official Grant Award Notification (OGAN) Audit, 2021

In March 2021, the IAO conducted a review of the mini-grants application and Official Grant Award Notification (OGAN) to determine if the process used in early 2018 to expedite grants was fair and equitable. The Office of Grants Management (OGM) within the Minnesota Department of Administration creates grant policies to provide direction to agencies, and a state must adhere to the same policies and procedures when procuring services under a federal award as it would when seeking services from its non-federal funds. The mini-grants application and OGAN is a process that was approved by OGM as a best practice and is used together to streamline grant award and execution processes. The process was replaced by a new mini-grant application process, and neither BHD nor any other division within DHS has employed the mini-grant application and OGAN since spring 2018.

The IAO focused their review on the procurement process for all BHD OGANs awarded during State Fiscal Years 2017-2019. They reviewed federal regulations, state statute and policy related to pre-award functions and the mini-grant process, conducted interviews with BHD management and staff, and performed sample testing and reviewed the mini-grant documentation for two projects and 30 mini-grants. Ultimately, the IAO found weaknesses in controls over the mini-grant award process related to carrying out and documenting the grant award decisions. ***They recommended that BHD verifies that sufficient documentation exists in their system to justify the evaluation of the grant award. Additionally, they recommended that BHD ensures that the final documents demonstrate adherence to contractual and conflict of interest requirements.***

Mental Health Rate Enhancements, 2022

In May 2022, The IAO reviewed mental health rate enhancements, following concerns from the Community Supports Administration (CSA) of the possibility of ineligible providers receiving enhanced payment rates for psychotherapy and related services. CSA believed that there were insufficient checks to ensure that only eligible providers were enrolled for the enhancement.

OLA reviewed federal regulations, state statutes and the state plan amendment related to mental health rate enhancements, interviewed with CSA, Healthcare Administration and Licensing staff, and analyzed Medicaid Management Information System payment codes. ***OLA found that all three of the providers flagged by CSA as suspect of being ineligible for rate enhancements were eligible due to their inclusion on the Essential Community Providers list through the Health Department.***

DHS Homelessness and Housing Support Grants Performance Audit, 2022

This audit conducted in 2022 examined homelessness and housing support grants managed by the Office of Economic Opportunity and the Housing and Support Services Division within the Department of Human Services for the period July 2019 through December 2021.

The OLA found that DHS generally did not have adequate internal controls to ensure compliance with applicable legal requirements over homelessness and housing support grants. The department had significant control deficiencies related to the management of homelessness and housing support grants. Further, the department did not always comply with the significant legal requirements related to grants management.

DHS: Behavioral Health Grants Management – Internal Controls and Compliance Audit, 2019

In 2019, OLA found significant management problems in the Behavioral Health Division. Those management problems resulted in DHS overpaying some health care providers approximately $29 million for take-home, self-administered opioid treatment medications. Given the seriousness of the management problems OLA found, they decided to conduct a follow-up audit to assess DHS's internal controls over certain grants awarded by BHD and its compliance with certain legal requirements from July 2017 through March 2020. The audit focused on contract grants to counties, tribes, and providers; these grants totaled $58 million in FY19.

OLA found that internal controls over the areas in our audit scope were not adequate to ensure that DHS, through BHD, safeguarded assets and ensured compliance with legal requirements and state policies related to grant oversight.

MCOs: Personal Care Assistance Services Encounter Data and Oversight Performance Audit, 2022

As specified in federal law and state statutes, DHS contracts with MCOs to provide certain administrative functions and services to enrollees under public health care programs. For the Personal Care Assistance (PCA) program, DHS contracted with seven MCOs to provide services in the Minnesota Senior Health Options and Minnesota Senior Care Plus programs in 2020 and 2021. These MCOs included four entities licensed as health maintenance organizations (Blue Plus, HealthPartners, Medica Health Plans, and UCare Minnesota) and three "county-based purchasing organizations" (Itasca Medical Care, PrimeWest Health, and South Country Health Alliance). Minnesota's MA program covers PCA services for recipients. PCA services help recipients with disabilities, chronic diseases, or mental illness live independently in their homes by providing assistance with essential tasks.

The OLA audited the seven MCOs that managed the delivery of PCA services to determine their compliance with key legal and contract requirements regarding (1) reporting of PCA services encounter claims data, (2) oversight of PCA providers and services, and (3) program integrity. Our audit scope focused on DHS contracts and payments to provider agencies reported to DHS by the MCOs from April 1, 2020, through March 31, 2021.

Although the MCOs generally complied with the selected legal and DHS contract requirements OLA tested, they identified several instances of noncompliance. The more significant instances of noncompliance were in the areas of reporting of encounter data, and provider and service oversight. Additionally, ***OLA found instances of DHS noncompliance in provider oversight.***

MCOs: Reporting of Dental and Mental Health Encounter Data, 2020

DHS is responsible for overseeing Minnesota Health Care Programs, which includes Medical Assistance (Minnesota's version of the federal Medicaid program) and MinnesotaCare (a federally approved Basic Health Program for individuals who do not qualify for regular Medical Assistance). Medical Assistance consists of the following programs: Prepaid Medical Assistance Program (PMAP), Minnesota Senior Care Plus (MSC+), Minnesota Senior Health Options (MSHO), and Special Needs Basic Care (SNBC). As specified in federal law and state statutes, DHS contracts with MCOs to provide certain administrative functions and services to enrollees

under public health care programs. DHS contracted with eight MCOs to each provide services for one or more of these programs in 2017 and 2018. These MCOs included five entities licensed as health maintenance organizations (Blue Plus, HealthPartners, Hennepin Health, Medica Health Plans, and UCare Minnesota) and three "county-based purchasing organizations" (Itasca Medical Care, PrimeWest Health, and South Country Health Alliance). For calendar year 2018, these eight MCOs reported nearly $5.2 billion in expenses for hospital, medical, and other professional services (including dental). Dental services represented about 3.1 percent of these expenses.

OLA audited these eight MCOs to determine their compliance with key legal and DHS contract requirements regarding MCO oversight of third-party administrators for dental and mental health services and reporting of dental and mental health encounter claims data to DHS. OLA audit scope focused on DHS contracts and samples of payments to providers reported to DHS by the MCOs during calendar years 2017 and 2018. ***OLA found that the MCOs complied with the legal and DHS contract requirements with oversight of their third-party administrators for dental or mental health benefits. Additionally, OLA found that all eight MCOs complied with selected legal and DHS reporting requirements for mental health encounter records, and payment information was accurate, complete, and timely. However, OLA found that four of the eight MCOs had a small number of exceptions in their reporting of dental encounter claim data.***

Certified Community Behavioral Health Clinics (CCBHC) Payment Review, 2021

CCBHCs provide outpatient services which utilize a cost-based methodology known as PPS (prospective payment system). The rates are based on cost report totals that include estimated changes in costs and are divided by projected encounter claims to arrive at a daily rate per CCBHC facility. According to a DHS website, all cost reports submitted by CCBHCs are reviewed by DHS.

IAO conducted a review of risks related to the CCBHCs, which were identified by the Community Supports Administration (CSA). The purpose of this report is to address the risks of improper payments for services provided by the CCBHC providers. CCBHCs provide outpatient services which utilize a cost-based methodology known as PPS (prospective payment system).

While reviewing the contract payments, ***IAO did not discover any payments beyond what was authorized.*** As of October 2020, DHS has paid Mercer approximately $1.3 million out of $1.5 million for the entire contract, including amendments. However, IAO noted concerns with the duties required by Mercer under the contract as discussed in Findings Section.

Appendix D: Relevant statutes and regulations

The governance of the behavioral health system in Minnesota involves a complex network of state and local agencies, as well as nonprofit organizations and community providers, described below.

Governance of the Behavioral Health System – Role of State and County

Minnesota Comprehensive Adult Mental Health Act

First enacted in 1987, governed by Chapter 245, Section 245.461 – 245.4863

The Adult Mental Health Act of 2022 was enacted to establish a unified and comprehensive adult mental health service system in accordance with specific principles that reflect the right of adults with mental illness to control their own lives as fully as possible and receive the highest quality services possible. Within this Act, the Commissioner is required to integrate housing services into the mental health service system that allows all persons with a mental illness to live in stable, affordable housing in settings that maximize community integration and opportunities for acceptance. These services will be developed and coordinated by the county boards with support from the Commissioner. Locally available behavioral health services are coordinated with services available from regional treatment centers, including any state-operated services offered at sites outside of the regional treatment center. The county board in each county is responsible for using all available resources to develop and coordinate a system of locally available and affordable adult mental health services.[xciii]

Minnesota Comprehensive Children's Mental Health Act

First enacted in 1989, governed by Chapter 245, Sections 245.487 – 245.4888

The legislature identified that there was a need for further development of existing clinical services for emotionally disturbed children and their families and the creation of new services for this population. The Children's Mental Health Act of 2022 emphasizes the need for a child- and family-oriented approach of therapeutic programming and the need for continuity of care across community agencies. This act emphasizes the importance of developing special mental health expertise in children's mental health services because of the unique needs for this population. Coordination of delivery of these services happen at both the state and local levels to assure the availability of these services to meet the needs of children.[xciv]

Alcohol and Other Drug Abuse Section within DHS

First enacted in 1973, governed by Chapter 254A

In the 2017 update of this statute, Minnesota declares that scientific evidence shows that addiction to alcohol or other drugs is a chronic brain disorder with potential for recurrence, and people with SUD can be effectively treated and can enter recovery. Minnesota identifies that the best interests of society are best served by reducing the stigma of SUD and providing persons who are dependent upon alcohol or other drugs with a comprehensive range of rehabilitative and social services that span intensity levels and are not restricted to a particular point in time. Treatment under these services is voluntary when possible and treatment shall not be denied based on prior treatment but will be based on an individual treatment plan for each person undergoing

treatment. Treatment includes a continuum of services available for a person leaving a program of treatment, which includes all family members at the earliest possible phase of treatment.

To achieve this, DHS created an Alcohol and Other Drug Abuse section which:

1. Conducts and promotes research on the causes, prevention, diagnosis, treatment, and recovery of individuals with substance misuse and substance use disorder.
2. Coordinates and reviews activities and programs across various state agencies related to substance misuse and substance use disorder.
3. Develops, demonstrates, and disseminates new methods and techniques for prevention, early intervention, treatment, and recovery support.
4. Gathers information on substance misuse and substance use disorder, as well as the effectiveness of prevention, treatment, and recovery services from various programs. The authority can request information from these programs and share relevant data with agencies, local governments, and the courts.
5. Educates the public about substance misuse and substance use disorder.
6. Serves as the state authority responsible for monitoring diagnosis and referral services, research, and comprehensive programs. Provide biennial reports to the governor and legislature, including recommendations for improving coordination, quality, and cost-effectiveness of services.
7. Establishes a state plan outlining goals and priorities for a comprehensive continuum of care for substance misuse and substance use disorder in Minnesota. Ensure that state agencies align their program goals and budgets with the state plan.
8. Makes contracts and grants with public and private agencies, organizations, and individuals to support state administration, evaluation, programs, research, and projects related to substance misuse and substance use disorder.
9. Administers funds available for substance misuse and substance use disorder programs, including those from the alcohol, drug abuse, and mental health services block grant.
10. Accepts gifts, grants, and donations from various sources for the purposes of addressing substance misuse and substance use disorder.
11. Establishes guidelines for hiring personnel with practical experience in substance misuse and substance use disorder, as well as an understanding of social and cultural issues, particularly concerning the American Indian community, for programs serving this community.[xcv]

Regulation of behavioral health services

DHS Services Licensure

First enacted in 1987, governed by Chapter 245A

The Department, in cooperation with counties, licenses approximately 20,000 service providers and monitors and investigates compliance with Minnesota laws and rules, including those related to behavioral health. In 2023, the legislature made several changes that impact DHS licensed and certified programs and services. The Division of Licensing enforces standards adopted to protect the health, safety, rights, and well-being of children and vulnerable adults in programs required to be licensed under Minnesota Statues, Chapter 245A and Minnesota Statues Chapter 245B. Certain licensing functions have been delegated to counties and private agencies. County social service agencies process license applications and monitor family childcare, child foster

care, and adult foster care programs. Some private agencies have been authorized to perform licensing functions related to child placing and child foster care.[xcvi] Each program has license requirements unique to the type of program licensed. The 2023 Legislature made several changes that impact DHS licensed and certified programs and services.

1. Coordinates and reviews activities and programs across various state agencies related to substance misuse and substance use disorder.
2. Develops, demonstrates, and disseminates new methods and techniques for prevention, early intervention, treatment, and recovery support.
3. Gathers information on substance misuse and substance use disorder, as well as the effectiveness of prevention, treatment, and recovery services from various programs. The authority can request information from these programs and share relevant data with agencies, local governments, and the courts.
4. Educates the public about substance misuse and substance use disorder.
5. Serves as the state authority responsible for monitoring diagnosis and referral services, research, and comprehensive programs. Provide biennial reports to the governor and legislature, including recommendations for improving coordination, quality, and cost-effectiveness of services.
6. Establishes a state plan outlining goals and priorities for a comprehensive continuum of care for substance misuse and substance use disorder in Minnesota. Ensure that state agencies align their program goals and budgets with the state plan.
7. Makes contracts and grants with public and private agencies, organizations, and individuals to support state administration, evaluation, programs, research, and projects related to substance misuse and substance use disorder.
8. Administers funds available for substance misuse and substance use disorder programs, including those from the alcohol, drug abuse, and mental health services block grant.
9. Accepts gifts, grants, and donations from various sources for the purposes of addressing substance misuse and substance use disorder.
10. Establishes guidelines for hiring personnel with practical experience in substance misuse and substance use disorder, as well as an understanding of social and cultural issues, particularly concerning the American Indian community, for programs serving this community.[xcvii]

Mental Health Uniform Service Standards Act

First enacted in 2021, governed by Chapter 245I

The purpose of this act is to create a system of mental health care that is unified, accountable, and comprehensive, and to promote the recovery and resiliency of citizens who have mental illnesses. The state's public policy is to support all citizens access to quality outpatient and residential MHS, as well as protect the health and safety, rights, and well-being of citizens that receive MHS.[xcviii]

Substance Use Disorder Licensed Treatment Facilities

First enacted in 2017, governed by Chapter 245G

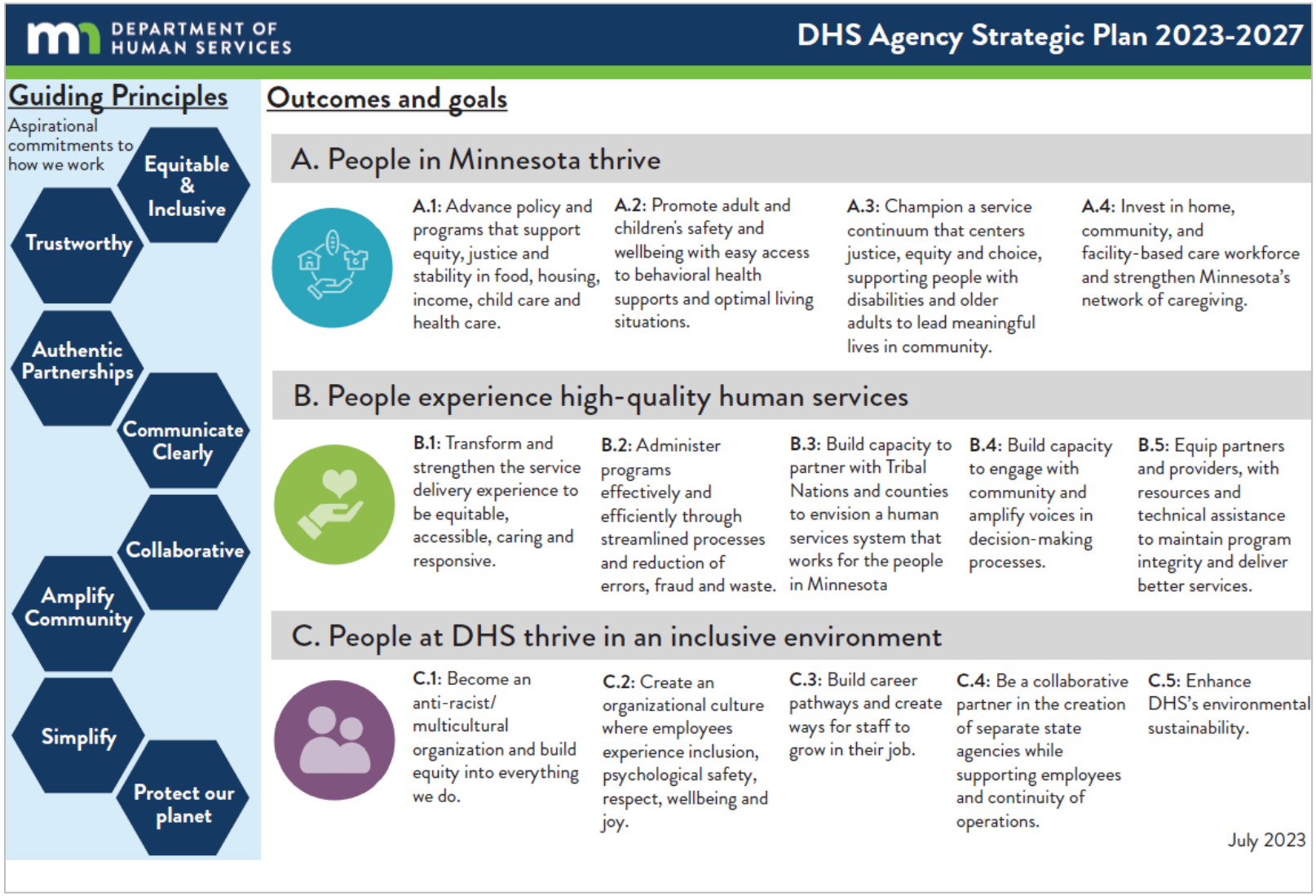
This statute outlines the licensing and funding requirements for SUD licensed treatment facilities, including opioid treatment programs. The applicant for a license to provide substance use disorder treatment must comply with the general requirements in section 626.557; chapters 245A, 245C, and 260E; and Minnesota Rules, chapter 9544. This section details guidance on service initiation, how to conduct a comprehensive assessment, form an individual treatment plan, the types of treatment services that must be offered, maintenance of client records, staff requirements and qualifications, rights of the clients, and behavioral emergency procedures.

Withdrawal Management

First enacted in 2015, governed by Chapter 245F

This statute establishes minimum standards for withdrawal management programs licensed by the commissioner that serve one or more persons. Licensing these facilities allows them to provide efficient and effective withdrawal management services to persons in need of appropriate detoxification, assessment, intervention, and referral services. An applicant for licensure as a clinically managed withdrawal management program or medically monitored withdrawal management program must meet the following requirements, except where otherwise noted. All programs must comply with federal requirements and the general requirements in sections 626.557 and 626.5572 and Chapters 245A, 245C, and 260E. A withdrawal management program must be located in a hospital licensed under Sections 144.50 to 144.581 or must be a supervised living facility with a class B license from the Department of Health under Minnesota Rules, parts 4665.0100 to 4665.9900.[xcix]

Appendix E: DHS Agency Strategic Plan 2023–2027

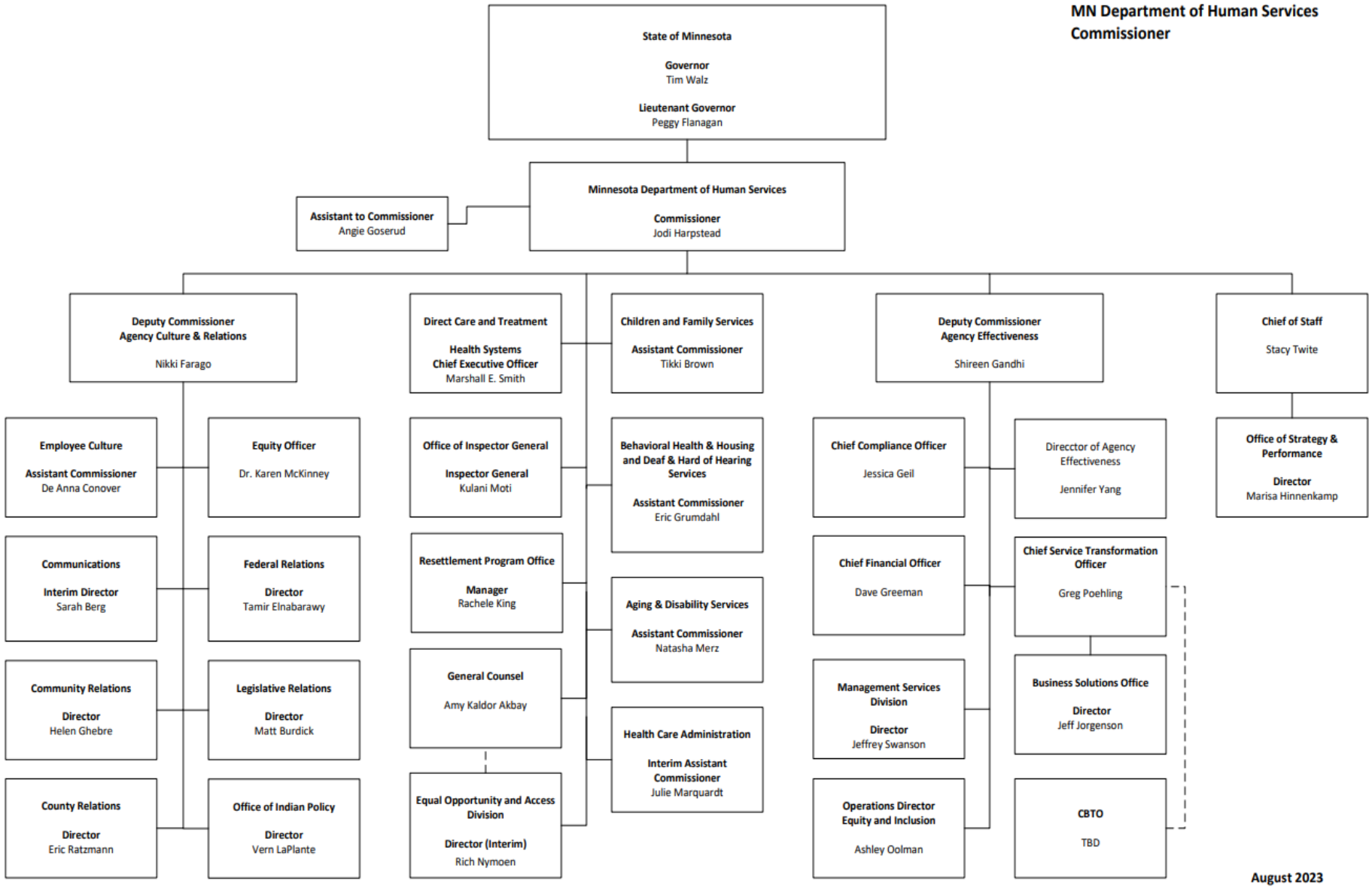


Full text version: [DHS Agency Strategic Plan 2023 - 2027]

Appendix F: Minnesota DHS human service administrations

At a state level, DHS involves a collaborative effort among diverse government agencies, programs, and initiatives, with a shared mission of providing a continuum of mental health and substance use services to residents. Their dedication to addressing behavioral health needs underscores the critical role played by DHS in nurturing a healthier and more resilient community. Each administration within DHS contributes uniquely to this effort. The administration organizational chart is in **Figure 8** below.

Figure 7. Minnesota DHS Administration Organizational Chart



Information about the organizational structure of Minnesota's DHS may be accessed at [Minnesota DHS Agency Organizational Information].

The role of each DHS administration is detailed below:

Commissioner

The Commissioner of DHS leads one of the state's largest agencies. This part of the organization includes Aging and Disability Services; Behavioral Health, Housing and Deaf and Hard of Hearing Services; Children and Family Services; DCT; General Counsel's Office; Health Care Administration; Office of the Inspector General; and the Office of Strategy and Performance.[c] These administrations all collectively influence service delivery and accessibility to Minnesotans by shaping policies within their respective domains.

Aging and Disability Services

Aging and Disability Services, led by an Assistant Commissioner, consists of Aging and Adult Services, Disability Services, Moving Home MN, Equity and Inclusion, Operations and Central Functions, Nursing Facility Rates and Policy, and a Deputy Assistant Commissioner. This agency also has an Age-Friendly Council which aims to make the state's systems and communities more inclusive of and responsive to older adults.[ci]

Behavioral Health, Housing and Deaf and Hard of Hearing Services

The Behavioral Health, Housing and Deaf and Hard of Hearing Services is led by an Assistant Commissioner and consists of the BHD, Housing and Support Services, Deaf and Hard of Hearing Services, a BHDH Equity Director. This administration also hosts and provides administrative support to the Minnesota Commission of the Deaf, Deafblind and Hard of Hearing, which operates largely as a stand-alone entity led by a Governor-appointed Board of Directors.

The BHD encompasses services for adult mental health, children's mental health, and alcohol and drug use services and employs about 134 employees as of 2023 with 20 vacant FTEs in process of being filled. The division aims to integrate mental health and substance use disorder with physical health care, to enhance the effectiveness of treatments and provide support to families and communities.[cii]

Children and Family Services

Children and Family Services, led by an Assistant Commissioner, includes Child Safety and Permanency, Child Care Services, Economic Assistance and Employment Supports Division, Child Support Division, Business Integration, and Management Operations.

Based on input from state agency leaders, local service providers, and extensive feedback received regarding needed investments and priorities for the physical and mental wellbeing of children and families in Minnesota, the Walz-Flanagan Administration recently proposed the establishment of a new Department of Children, Youth, and Families (DCYF). On May 24, 2023, Governor Walz signed a bill into law that will create the new DCYF. The goals of this new state agency are to:[ciii]

1. align outcomes and policy for children youth, and families across state government;
2. elevate the priorities and funding needs of children, youth, and families;
3. focus local partners on improving the front door for services, with a goal to ease access and navigation for families and improve service; and
4. to sharpen the focus of state agencies to best address issues central to the people they serve.

The new department will include Management Operations and Business Integration, Child Care Services, Child Safety and Permanency, Child Support, and Economic Assistance and Employment Supports Division (except housing programs). Planning and transition efforts began in July 2023, including the establishment of the Implementation Office which is responsible for coordination and planning for the creation of the new agency.

Governor Walz is responsible for appointing a commissioner for DCYF by July 1, 2024, and all programs from state agencies are expected to transfer to the new agency by July 1, 2025.

Direct Care and Treatment

The DCT division currently serves as a specialized behavioral health care system that includes psychiatric hospitals and other facilities for inpatient mental health treatment, facilities for inpatient substance use treatment, group homes catering to individuals with disabilities, vocational sites, and treatment facilities for sex offenders. There are approximately 200 service sites statewide, and most referrals for inpatient services are created by county social services, the courts, or other health care providers.[civ]

One of the Governor's Biennial Budget recommendations for FY2023-25 was to separate DCT from DHS by establishing DCT as its own agency. This recommendation was proposed due to DHS' capacity to manage this specialized health system and because of the difference in DHS's and DCT's goals, leadership, requirements, environments, budget priorities and subject matter expertise. It is expected that both entities would experience advantages through their separation, allowing them to focus on their different missions. Additionally, the separation would enable DHS to focus on its primary role of leading and managing the state-supervised, county-administered human services system, and it would allow DCT to operate similarly to other healthcare systems.[cv]

As a result of legislative action, on January 1, 2025, the DCT Division will become its own agency and take its approximately 5,000 employees with it. Similar to DCYF, state lawmakers and providers have discussed the separation for years to ultimately improve outcomes for individuals who receive services in Minnesota. The current CEO of the division is expected to stay on to lead the department after separation.[cvi]

General Counsel's Office

The general counsel serves as the principal in-house attorney, tasked with offering legal guidance, counsel, and direction for all of DHS. The General Counsel's Office oversees and coordinates all legal functions within DHS, taking charge of providing legal advice on

complex issues, such as litigation. Furthermore, it serves as the department counsel in settlements and negotiations.

Health Care Administration

The Health Care Administration, led by an Assistant Commissioner, consists of a State Medicaid Director, Medicaid Medical Director, Chief Administrative Officer, Health Care Budget and Finance, Health Care Legislative Budget, a PHE Project Director, Health Care Integrity and Accountability Division, an Equity Director, Federal Relations, Health Care eligibility and Access, Medicaid Payments and Provider Services, Health Care Eligibility Operations, an Executive Project Leader for the Unwind/Renewals, Operations, and a Deputy Assistant Commissioner and Assistant Medicaid Director. The Health Care Administration oversees Minnesota's Health Care Programs including eligibility, benefit and payment policies, program development, member and provider relations and outreach, oversight of county and tribal administration of health care programs, among other duties.

Office of Inspector General

The licensing office, in cooperation with counties, licenses approximately 20,000 service providers and monitors and investigates compliance with Minnesota laws and rules. The 2023 Legislature made several changes that impact DHS licensed and certified programs and services. The division of Licensing enforces standards adopted to protect the health, safety, rights, and well-being of children and vulnerable adults in programs required to be

licensed under Minnesota Statues, Chapter 245A and Minnesota Statues Chapter 245B. Certain licensing functions have been delegated to counties and private agencies. County social service agencies process license applications and monitor family childcare, child foster care, and adult foster care programs. Some private agencies have been authorized to perform licensing functions related to child placing and child foster care.[cvii] Each program has license requirements unique to the type of program licensed.

Office of Strategy and Performance

The Office of Strategy and performance, led by a director, is responsible for conducting data analysis, research and assessment of performance measures to evaluate health care programs. It also oversees quality assurance and improvement of managed care.

Agency Culture and Relations

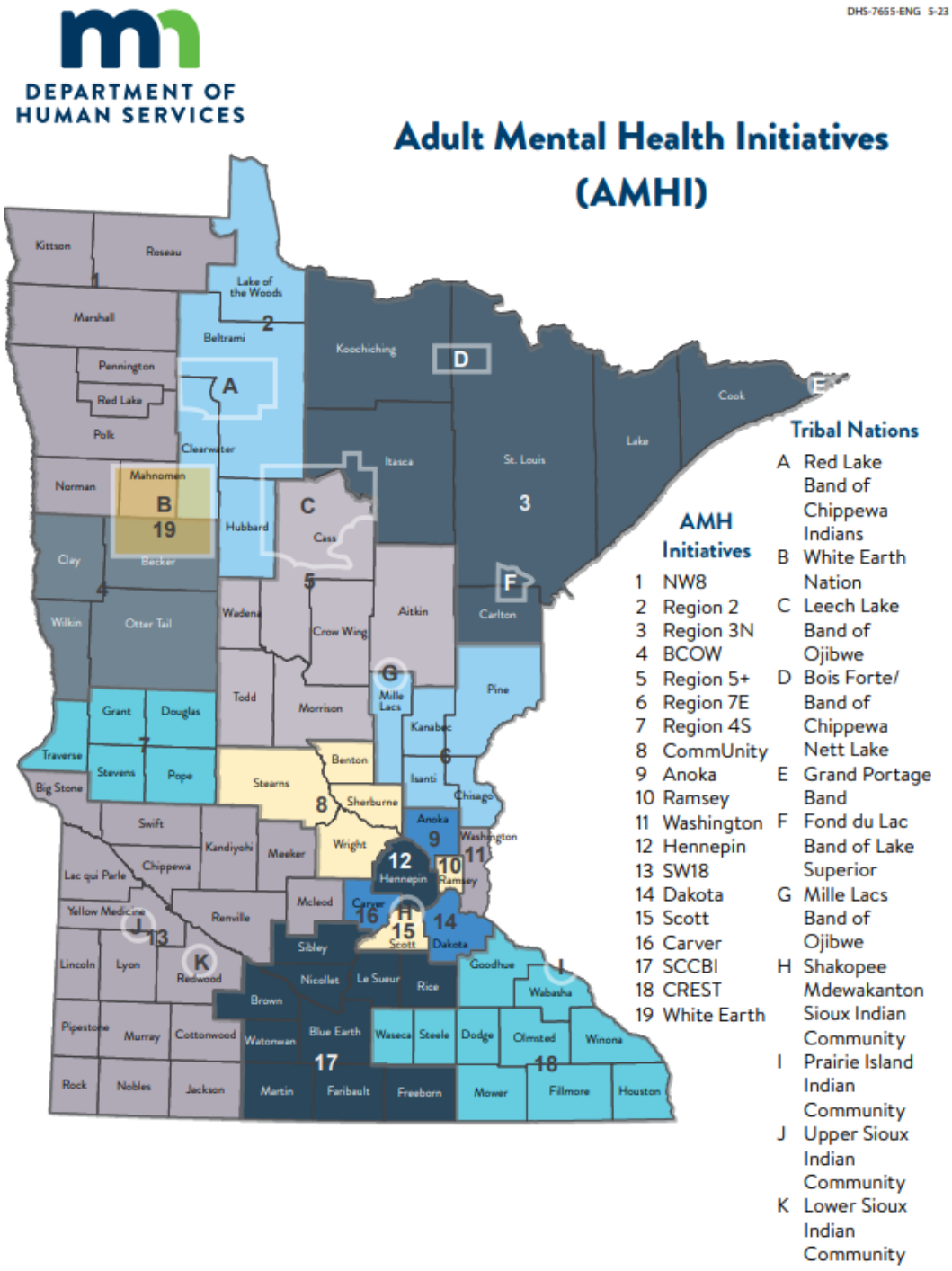
Agency Culture and Relations, led by a Deputy Commissioner, includes the Communications Office, Community Relations, County Relations, Employee Culture, Equity and Inclusion, Federal Relations, Legislative Relations, and the Office of Indian Policy.[cviii] The Agency Culture and Relations Division plays a pivotal ***role in facilitating communication, community engagement, federal cooperation, equity and inclusivity, legislative liaison, and the Office of Indian Policy to enhance access and the provision of behavioral health services in Minnesota***.

Agency Effectiveness

Agency Effectiveness, led by a Deputy Commissioner, consists of the Compliance Office, the Financial Office, the Management Services Division, the Business Solutions Office, a Chief Service Transformation Officer, an Operations Director of Equity and Inclusion, and MNIT Services.[cix] The Compliance Office and Financial Office play a pivotal role in the delivery and access of behavioral health services by ensuring regulatory adherence, fiscal responsibility, and effective resource allocation, thus supporting the overall quality and sustainability of these vital services.

Appendix G: Adult Mental Health Initiatives map

Figure 8. Map of Adult Mental Health Initiatives (AMHI)



A fully accessible version of this map, detailing Minnesota DHS's Adult Mental Health Initiatives (AMHI), as well as a printable information page is available at [Adult Mental Health Initiatives / Minnesota Department of Human Services (mn.gov)]

Appendix H: Minnesota and benchmark Medicaid covered behavioral health services

Table 5. Covered Behavioral Health Services: *Institutional Care and Provider Services*

Service Type	MN	CO	CT	NC
Medicaid Behavioral Health Services: Inpatient Psychiatric Hospital	Yes	Yes	Yes	Yes
Medicaid Behavioral Health Services: 23-hour Observation	No	Yes	Yes	Yes
Medicaid Behavioral Health Services: Psychiatric Residential Treatment	Yes	Yes	No	No
Medicaid Behavioral Health Services: Adult Group Homes	Yes	No	Yes	No

Table 6. Covered Behavioral Health Services: *Outpatient Facility Services and/or Provider Services*

Service Type	MN	CO	CT	NC
Medicaid Behavioral Health Services: Case Management	Yes	No	No	Yes
Medicaid Behavioral Health Services: Day Treatment	Yes	Yes	Yes	No
Medicaid Behavioral Health Services: Partial Hospitalization	Yes	Yes	Yes	Yes
Medicaid Behavioral Health Services: Psychosocial Rehabilitation (*e.g.*, "Clubhouse model")	No	Yes	No	Yes
Medicaid Behavioral Health Services: Intensive Outpatient Treatment	Yes	Yes	Yes	No
Medicaid Behavioral Health Services: Mental Health Rehabilitation	Yes	Yes	No	Yes
Medicaid Behavioral Health Services: ADL/Skills Training	Yes	Yes	No	No
Medicaid Behavioral Health Services: Assertive Community Treatment	Yes	Yes	Yes	Yes
Medicaid Behavioral Health Services: Psychiatric Services – Evaluation	Yes	Yes	Yes	Yes
Medicaid Behavioral Health Services: Psychiatric Services – Testing	Yes	Yes	Yes	Yes
Medicaid Behavioral Health Services: Psychological Testing	Yes	Yes	Yes	Yes
Medicaid Behavioral Health Services: Individual Therapy	Yes	Yes	Yes	Yes
Medicaid Behavioral Health Services: Group Therapy	Yes	Yes	Yes	Yes
Medicaid Behavioral Health Services: Family Therapy	Yes	Yes	Yes	Yes

Table 7. Covered Behavioral Health Services: *Substance Use Disorder (SUD) Services*

Service Type	MN	CO	CT	NC
Medicaid Behavioral Health Services: ASAM Level 0.5 – Early Intervention	Yes	Yes	Yes	Yes
Medicaid Behavioral Health Services: ASAM Level 1 – Outpatient Treatment	Yes	Yes	Yes	Yes
Medicaid Behavioral Health Services: ASAM Level 2.1 – Intensive Outpatient Treatment (IOT)	Yes	Yes	Yes	Yes
Medicaid Behavioral Health Services: ASAM Level 2.5 – Partial Hospitalization Services	No	No	Yes	Yes
Medicaid Behavioral Health Services: ASAM Level 3.1 Clinically Managed Low-Intensity Residential Services	Yes	Yes	Yes	No
Medicaid Behavioral Health Services: ASAM Level 3.3 – Clinically Managed Population-Specific High Intensity Residential Services	Yes	Yes	Yes	No
Medicaid Behavioral Health Services: ASAM Level 3.5 – Clinically Managed Medium-/High-Intensity Residential Services	Yes	Yes	Yes	Yes
Medicaid Behavioral Health Services: ASAM Level 3.7: Medically Monitored Intensive Inpatient Services	No	Yes	Yes	Yes
Medicaid Behavioral Health Services: ASAM Level 4 – Medically Managed Intensive Inpatient Treatment	No	No	Yes	No
Medicaid Behavioral Health Services: Outpatient Detoxification	Yes	Yes	Yes	Yes
Medicaid Behavioral Health Services: Oral Naltrexone for Medication Assisted Treatment (MAT)	Yes	Yes	Yes	Yes
Medicaid Behavioral Health Services: Injectable Naltrexone for Medication Assisted Treatment (MAT)	No	Yes	Yes	Yes
Medicaid Behavioral Health Services: Methadone for Medication Assisted Treatment (MAT)	Yes	Yes	Yes	Yes
Medicaid Behavioral Health Services: Oral Buprenorphine for Medication Assisted Treatment (MAT)	Yes	Yes	Yes	Yes
Medicaid Behavioral Health Services: Injectable Buprenorphine for Medication Assisted Treatment (MAT)	Yes	Yes	Yes	Yes
Medicaid Behavioral Health Services: Suboxone Treatment	Yes	Yes	Yes	Yes
Medicaid Behavioral Health Services: Smoking and Tobacco Use Cessation Counseling (Excluding Mandatory Coverage for Pregnant Women)	Yes	Yes	Yes	Yes

Table 8. Covered Behavioral Health Services: *Naloxone (Without Prior Authorization)*

Service Type	MN	CO	CT	NC
Medicaid Behavioral Health Services: Naloxone Available in at Least One Formulation Without Prior Authorization	Yes	Yes	Yes	Yes
Medicaid Behavioral Health Services: Naloxone Nasal Spray Covered Without Prior Authorization	Yes	Yes	Yes	Yes
Medicaid Behavioral Health Services: Naloxone Nasal Spray Atomizer Covered Without Prior Authorization	N/A	No	Yes	Yes
Medicaid Behavioral Health Services: Naloxone Coverage Provided for Family Members or Friends Obtaining a Naloxone Prescription on Enrollee's Behalf	No	Yes	Yes	Yes

Table 9. Covered Behavioral Health Services: *Crisis Services*

Service Type	MN	CO	CT	NC
Medicaid Behavioral Health Services: Crisis Hotline	Yes	No	Yes	No
Medicaid Behavioral Health Services: Mobile Crisis	Yes	Yes	Yes	Yes
Medicaid Behavioral Health Services: Crisis Residential	Yes	No	No	No
Medicaid Behavioral Health Services: Crisis Stabilization Unit	Yes	Yes	No	Yes
Medicaid Behavioral Health Services: Crisis Respite	Yes	Yes	No	No

Table 10. Covered Behavioral Health Services: *Integrated Care*

Service Type	MN	CO	CT	NC
Medicaid Behavioral Health Services: Collaborative Care Model Services	No	No	No	Yes
Medicaid Behavioral Health Services: Health Behavior Assessment and Intervention (HBAI) Services	Yes	No	No	No
Medicaid Behavioral Health Services: Health Home Services	Yes	No	Yes	Yes
Medicaid Behavioral Health Services: Medicaid Individual Counseling or Family Counseling Services	Yes	Yes	Yes	Yes
Medicaid Behavioral Health Services: Medicaid Psychiatric Evaluation With Medical Services	Yes	Yes	No	Yes
Medicaid Behavioral Health Services: Medicaid Psychiatric Evaluation Without Medical Services (Non-Face to Face)	Yes	Yes	No	No

Service Type	MN	CO	CT	NC
Medicaid Behavioral Health Services: Mental Health Screening in Primary Care	Yes	Yes	Yes	Yes
Medicaid Behavioral Health Services: Screening, Brief Intervention, and Referral to Treatment (SBIRT)	Yes	Yes	Yes	Yes

Table 11. Covered Behavioral Health Services: *Other Behavioral Health Services*

Service Type	MN	CO	CT	NC
Medicaid Behavioral Health Services: Mental Health Clinic Services	Yes	Yes	Yes	Yes
Medicaid Behavioral Health Services: Targeted Case Management for Chronic Mental Illness	Yes	Yes	Yes	Yes
Medicaid Behavioral Health Services: Peer Support Services	Yes	Yes	No	Yes

Appendix I: Minnesota DHS FY22 behavioral health grant programs

Table 12 below outlines the 57 grant programs that DHS reported actively funding during FY22, ordered from the largest dollar value to the lowest dollar value. Note that DHS purposely included the ARPA MHBG as $0 in this spending report to PCG, and PCG has retained this last row in the table.

Table 12. Behavioral Health Grant Programs Funded During FY22

Grant Name	Summary/Description of Grant	General Fund	Opioid Account	Other State Funds	Federal	Total
Adult Mental Health Integrated Fund	Grants to counties for Adult Mental Health Initiatives including crisis response and case management services. For most counties, this includes integrated administration of Adult MH Community Support Grants and Residential Treatment Grants.	34,597,916	0	0	0	**34,597,916**
Rule 78 Adult Mental Health Grant	Grants to counties for community support services to adults with serious and persistent mental illness.	19,539,689	0	0	0	**19,539,689**
Mobile Crisis Services Grants	Grants to counties in regional partnerships to build psychiatric crisis response capacity, including mobile crisis intervention and follow-up stabilization services.	17,866,046	0	0	0	**17,866,046**
Children's Mental Health (CMH) – Capacity School Based Services	Grants to provider agencies to integrate mental health service capacity into the non-stigmatized natural setting of children's schools and to cover direct	15,053,262	0	0	0	**15,053,262**

Grant Name	Summary/Description of Grant	General Fund	Opioid Account	Other State Funds	Federal	Total
	clinical and ancillary services for uninsured and under-insured children.					
2020 SOR Grants 93.788	The purpose of this program is to address the opioid overdose crisis by providing resources to states and territories for increasing access to FDA-approved medications for the treatment of opioid use disorder (MOUD), and for supporting the continuum of prevention, harm reduction, treatment, and recovery support services for opioid use disorder (OUD) and other concurrent substance use disorders.	0	0	0	11,393,121	**11,393,121**
Federal CD Block Grant – CFDA 93.959	The Substance Abuse Prevention and Treatment Block Grant (SABG) Program was authorized by Congress to provide funds to States, Territories and tribes for the purpose of planning, implementing and evaluating activities dedicated to preventing and treat substance abuse within Minnesota.	0	0	0	10,280,824	**10,280,824**
Federal MH Block Grant CFDA 93.958	Block Grants for Community Mental Health Services: Grants to counties and non-profit agencies for innovative projects based on best practices. Projects include children's mental health collaborative,	0	0	0	7,379,907	**7,379,907**

Grant Name	Summary/Description of Grant	General Fund	Opioid Account	Other State Funds	Federal	Total
	crisis services for children and adults, adult mental health initiatives and self-help projects for consumers. As required by state law, 25% of the Federal MH Block Grant is used for grants to American Indian Tribes and non-profit agencies to provide mental health services, particularly community support services, to American Indians.					
Children's Mental Health (CMH) Screening Grant	Grants to county child welfare and juvenile justice agencies to pay for mental health screenings and follow-up diagnostic assessment and treatment; covers children already deeply involved in child-serving systems.	4,388,125	0	0	0	**4,388,125**
State Fiscal Recovery Fund-School Link MH-Grant – U.S. Department of the Treasury 21.027	School Mental Health: Grants to fund innovative projects to improve mental health outcomes for youth attending an Intermediate School District organized under Minnesota Statutes 136D.01 that provides instruction to students in a setting of federal instructional level 4 or higher	0	0	0	4,133,315	**4,133,315**
Housing Support Grants	Grants to establish recipients in stable housing and provide a foundation for accessing healthcare and other needed resources. Housing with supports grants fund activities that are designed to assist	3,938,479	0	0	0	**3,938,479**

Grant Name	Summary/Description of Grant	General Fund	Opioid Account	Other State Funds	Federal	Total
	tenants with significant or complex barriers to housing.					
Opiate Epidemic Response- Advisory Council Grants	Grants appropriated in the Opioid Epidemic response funding which are awarded through the Opiate Epidemic Advisory Council. The appropriations vary per year depending on revenue generated in the fund. Grants are awarded based on the outcomes noted under M.S. 256.042 subd. 3.	0	3,605,075	0	0	**3,605,075**
System of Care-Grant – CFDA 93.104	Systems of Care Grant: Community MH Services for Children with Serious Emotional Disturbances: Develop children's mental health system of care to improve behavioral health outcomes for Minnesota children and youth with (birth to 21) with serious emotional disturbance. 18,000 children and youth served by year 4. This grant ended September 29, 2022	0	0	0	2,094,185	**2,094,185**
Transition Initiative Populations	Disability Services and Adult Mental Health divisions are working together to develop contracts to pay for the costs of individuals moving from Anoka, St. Peter including wrap around services to support people in the community.	1,704,852	0	0	0	**1,704,852**

Grant Name	Summary/Description of Grant	General Fund	Opioid Account	Other State Funds	Federal	Total
COVID-19 Emergency Response Grant – CFDA93.665	Emergency Response to COVID-19, Substance Abuse and Mental Health Services Administration (SAMHSA): The Department of Human Services, partnering with our existing Certified Community Behavioral Health Clinics (CCBHCs), will provide mental health, substance use disorder and cooccurring treatment services to people who have been impacted by COVID-19. Grant funds will help Minnesota serve people with serious mental illness (SMI), substance use disorders (SUD) and co-occurring disorders, including healthcare practitioners, other first responders and individuals and families experiencing mental health concerns less severe than SMI. The state estimates 6,600 people will be served through this funding; 70% of which will be SMI/SUD, 20% healthcare practitioners and first responders, and 10% people with mental health concerns less than SMI. This grant is now expired.	0	0	0	1,649,037	**1,649,037**
Opiate Epidemic Response – Adult Mental Health (CEMIG)	This funding s appropriated from the opiate epidemic response fund to the commissioner of human services to award grants to Tribal Nations and five urban Indian communities for traditional healing practices to American Indians and to	0	0	1,489,595	0	**1,489,595**

Grant Name	Summary/Description of Grant	General Fund	Opioid Account	Other State Funds	Federal	Total
	increase the capacity of culturally specific providers in the behavioral health workforce. The grant expires after FY 2024.					
Children's Mental Health (CMH) – Capacity Respite Grants	Grants to counties to build service capacity for planned and emergency respite to relieve family stress that can result in out-of-home placement, violence, and ER visits.	1,363,959	0	0	0	**1,363,959**
Text Message	Grant to a nonprofit organization to establish and implement a statewide text message suicide prevention program. In 2016-2017, Text-4-Life responded to a total of 22,162 text message conversations in 54 counties throughout Minnesota. In 2018-2019, Crisis Text Line (which replaced TXT4Life) had 6,208 text message conversations in 68 counties through MN. This service started in April 2018.	1,125,000	0	0	0	**1,125,000**
Mental Health Innovations Grants	These grant funds are dedicated to finding innovative approaches for improving access to and the quality of community-based, outpatient mental health services. Programs are focused on helping people with mental illness receive effective and culturally specific services in their	0	0	1,087,994	0	**1,087,994**

Grant Name	Summary/Description of Grant	General Fund	Opioid Account	Other State Funds	Federal	Total
	community. These were new funds in 2018.					
CMH – Capacity Early Intervention Grants	Grants to provider agencies to build evidenced-based MH intervention capacity for children birth to age 5 whose social, emotional, and behavioral health is at risk due to biologically based difficulty in establishing loving, stable relationships with adults; having cognitive or sensory impairments; or living in chaotic or unpredictable environments.	1,014,976	0	0	0	**1,014,976**
CD Native American Program	Provides funds to American Indian tribes, organizations, and communities to provide culturally appropriate alcohol and drug abuse primary prevention and treatment support services. Federal funds also partially support this activity (approx. 30%).	972,916	0	0	0	**972,916**
Adult Mental Health Int Fund: Non-County Allocation	Grant to providers to develop a resource and training center in evidence-based practices for the treatment of co-occurring mental illness and substance use as well as support training of therapists in an evidence-based treatment for high need individuals (Dialectical Behavior Therapy).	964,316	0	0	0	**964,316**

Grant Name	Summary/Description of Grant	General Fund	Opioid Account	Other State Funds	Federal	Total
MH McKinney Grant – Project for Assistance in Transitions from Homelessness (PATH) CFDA- 93.150	SAMHSA's PATH Program is a formula grant authorized by the Stewart B. McKinney Homeless Assistance Amendments Act of 1990 and was reauthorized by Section 9004 of the 21st Century Cures Act (P.L. 114-255). PATH, part of the first major federal legislative response to homelessness, is administered by the SAMHSA Center for Mental Health Services (CMHS).	0	0	0	786,880	**786,880**
Fetal Alcohol Syndrome	Grant to the Minnesota Organization on Fetal Alcohol Syndrome (MOFAS) to support non-profit Fetal Alcohol Spectrum Disorders (FASD) outreach prevention programs in Olmsted County. This grant is both treatment and prevention focused. This grant will be appropriated to the Department of Health starting in FY 2024.	740,160	0	0	0	**740,160**
Gambling Receipts Grants	These funds support the MN Problem Gambling Helpline, a statewide phone and text service that offers crisis assessment, and treatment referral for persons struggling with problem gambling and families of someone dealing with problem gambling issue. Additional funding is appropriated through a grant contract to increase public awareness of problem	700,892	0	0	0	**700,892**

Grant Name	Summary/Description of Grant	General Fund	Opioid Account	Other State Funds	Federal	Total
	gambling and to conduct research on problem gambling.					
Gambling Grants Lottery Transfer	Funds transferred from the Minnesota State Lottery to DHS -- provides funding for problem gambling assessments, non-residential and residential treatment of problem gambling and gambling disorder; training for gambling treatment providers and other behavioral health services providers; and research projects which evaluate awareness, prevention, education, treatment service and recovery supports related to problem gambling and gambling disorder. About 700 to 800 individuals receive non-residential or residential treatment per year. The total served represents a combined number of individuals that received treatment.	0	0	657,590	0	**657,590**
2020 Disaster Response Grant CFDA 93.982	Disaster response grant in response to COVID. Grant has expired.	0	0	0	630,164	**630,164**
South Central Crisis Program	This grant funds Psychiatric Urgent Care for people in crisis. It also funds Residential Crisis Stabilization services for those people who are uninsured or underinsured.	575,327	0	0	0	**575,327**

Grant Name	Summary/Description of Grant	General Fund	Opioid Account	Other State Funds	Federal	Total
Preschool Development Grant	Interagency agreement between the Department of Human Services and Department of Education for preschool development funding including family well-being and mental health.	0	0	381,516	0	**381,516**
State Opioid Response Grant – CFDA 93.788	State Opioid Response (SOR): Expedite opioid treatment and recovery resources and support integration of services at each point in the substance use disorder service continuum through a comprehensive effort to provide targeted response for the following populations: American Indian; African American; and populations with justice involvement. This grant expired September 30, 2021	0	0	0	378,871	**378,871**
CD Peer Specialists Grants	Grants to recovery community organizations to train, hire, and supervise peer specialists to work with underserved populations as part of the continuum of care for substance use disorders. Recovery community organizations located in Rochester, Moorhead, and the Twin Cities metropolitan area are eligible to receive grant funds.	362,000	0	0	0	**362,000**
Crisis Counseling RSP Grants – CFDA 97.032	Crisis Counseling Regular Services Program (RSP). This fund is a continuation of the Immediate Services Program fund received	0	0	0	332,380	**332,380**

Grant Name	Summary/Description of Grant	General Fund	Opioid Account	Other State Funds	Federal	Total
	to provide crisis counseling services to those affected by COVID-19. These funds will be used to contract with 11 community-based organizations for outreach, crisis counseling and referral services, and short-term intervention counseling for mental health problems caused or aggravated by the COVID-19 disaster. This grant has expired.					
CAA-Substance Abuse Block Grant (SABG) CFDA 93.959	Substance Abuse Prevention and Treatment Block Grant (Consolidated Appropriations Act): To provide financial assistance to states and territories to support projects for the development and implementation of prevention, treatment and rehabilitation activities directed to the diseases of alcohol and drug abuse.	0	0	0	327,054	**327,054**
ACT Quality Improvement & Expansion Grants	Enhances and expands Assertive Community Treatment (ACT) services. Provides start-up funding to establish new ACT teams, including a specialized Forensic ACT team to support people with serious mental illnesses who are exiting the correctional system. Clarifies services standards for ACT and provides for enhanced training and oversight to ensure quality and consistency in ACT services across the state.	325,827	0	0	0	**325,827**

Grant Name	Summary/Description of Grant	General Fund	Opioid Account	Other State Funds	Federal	Total
Adverse Childhood Experiences Grants	Grants to provide training for parents, collaborative partners, and mental health providers on the impact of Adverse Childhood Experiences (ACEs), resilience and trauma toward creating community action plans and resilience initiatives to increase protective factors for children and families.	319,709	0	0	0	**319,709**
Mental Health Block Grant (MHBG) ARPA Covid Mitigation Grants – CFDA 93.958	Community Mental Health Services Block Grant- American Rescue Plan ACT COVID Mitigation plan: Funds can be used to expand dedicated testing and mitigation resources for people with mental health and substance use disorders.	0	0	0	313,303	**313,303**
First Episode Psychosis Grants	Grants to provide evidence-based practice interventions for youth and adults ages 15-40 who are experiencing a first episode of psychosis.	301,000	0	0	0	**301,000**
CMH – Cultural Competence Provider Capacity Grants	Grants to provider agencies to support cultural minority individuals to become qualified mental health professionals and practitioners; to increase access of mental health services to children from cultural minority families; and to enhance the capacity of providers to serve these populations.	300,000	0	0	0	**300,000**

Grant Name	Summary/Description of Grant	General Fund	Opioid Account	Other State Funds	Federal	Total
Adult Mental Health Culturally Specific Services	Grants to support increased availability of culturally responsive mental health services for racial and ethnic minorities through providing internship placements and clinical supervision to emerging mental health professionals.	292,365	0	0	0	**292,365**
MHBG-COVID – CFDA 93.958	Mental Health Block Grant Coronavirus Response and Relief Supplement Appropriations Act, 2021 [P.L. 116-260] (CAA): SAMHSA released funding to states through the Community Mental Health Services Block Grant (MHBG) program to assist in response to the COVID-19 pandemic. MHBG is designed to provide comprehensive community mental health services to adults with serious mental illness (SMI) or children with serious emotional disturbance (SED).	0	0	0	286,516	**286,516**
Pregnant Postpartum-Grant CFDA – 93.243	Pregnant and Postpartum Women (PPW): Expand and enhance women's pregnant and postpartum substance use disorder (SUD) services across our continuum of care (prevention, treatment and recovery) for women, children and families who receive treatment for SUDs. The program will serve 100 women and 200 children per grant year	0	0	0	230,489	**230,489**

Grant Name	Summary/Description of Grant	General Fund	Opioid Account	Other State Funds	Federal	Total
SABG – American Rescue Plan CFDA-93.959	Substance Abuse Block Grant American Rescue Plan (ARPA) - Public Law 117-2, the American Rescue Plan Act of 2021 (ARPA) directed SAMHSA to provide additional funds to support states through Block Grants to address the effects of the COVID -19 pandemic for Americans with mental illness and substance use disorders. The grant includes funding for primary prevention, pregnant women services, substance use treatment services, substance use treatment services and gaps which includes school linked health grants and the Pathfinder Companion finder pilot	0	0	0	230,171	**230,171**
Problem Gambling Rider	Funds transferred from the Minnesota State Lottery to grant to the state affiliate recognized by the National Council on Problem Gambling to increase public awareness of problem gambling, education and training for individuals and organizations providing effective treatment services to problem gamblers and their families, and research related to problem gambling.	0	0	225,000	0	**225,000**
Opiate Epidemic Response – ECHO Grant	This funding is appropriated from the opiate epidemic response fund to the commissioner of human services to Hennepin Health for the opioid-focused	0	200,000	0	0	**200,000**

Grant Name	Summary/Description of Grant	General Fund	Opioid Account	Other State Funds	Federal	Total
	Project ECHO program ($200,000 per year) and another $200,000 per year for a competitive ECHO project. The funding is available from FY 2022 through FY 2024.					
Transition Init Waivered Services	Grants to counties and/or providers to transition individuals from Anoka Metro Regional Treatment Center and the Minnesota Security Hospital to the community when clients no longer need hospital level of care.	192,000	0	0	0	**192,000**
Compulsive Gambling Indian Game	Funds combined with the Gambling Grants from the lottery to provide funding for problem gambling assessments, non-residential and residential treatment of problem gambling and gambling disorder; training for gambling treatment providers and other behavioral health services providers; and research projects which evaluate awareness, prevention, education, treatment service and recovery supports related to problem gambling and gambling disorder. Approximately 700 to 800 individuals receive non-residential or residential treatment per year. The total served represents a combined number of individuals that received treatment.	0	0	170,623	0	**170,623**

Grant Name	Summary/Description of Grant	General Fund	Opioid Account	Other State Funds	Federal	Total
Childrens Intensive Service Reform	Grant funding for start-up grants to prospective psychiatric residential treatment facility sites for administrative expenses, consulting services, Health Insurance Portability and Accountability Act of 1996 compliance, therapeutic resources including evidence-based, culturally appropriate curriculums, and training programs for staff and clients as well as allowable physical renovations to the property.	125,000	0	0	0	**125,000**
CD Treatment Grants	Grant to nonprofit organization to treat methamphetamine abuse and the abuse of other substances. The focus audience is women with dependent children identified as substance abusers, especially those whose primary drug of choice is methamphetamine.	125,000	0	0	0	**125,000**
Arnold LifeSkills Substance Use Prevention Grant	These grant funds support middle school substance use prevention programming. Programs are designed to reduce the likelihood of youth smoking and drinking	0	0	117,754	0	**117,754**
Mental Illness (MI) – Crisis Housing	Grant to nonprofit agency (sole source contract) for the provision of financial assistance to hospitalized clients needing help to pay for their housing. These funds	117,163	0	0	0	**117,163**

Grant Name	Summary/Description of Grant	General Fund	Opioid Account	Other State Funds	Federal	Total
	are used only when other funds, such as SSI, are not available.					
Opiate Epidemic Response – Chemical Dependency Treatment Support Grants	This grant funding is to a nonprofit organization that has provided overdose prevention programs to the public in at least 60 counties within the state, for at least three years, has received federal funding before January 1, 2019, and is dedicated to addressing the opioid epidemic. The grant must be used for opioid overdose prevention, community asset mapping, education, and overdose antagonist distribution. The annual appropriation amount is $100,000 and expires after FY 2024.	0	100,000	0	0	**100,000**
Supplemental State Opioid Resp CFDA 93.788	State Opioid Response (SOR) Supplemental – Supplemental funds through SAMHSA State Opioid Response (SOR) grant to expand Medication Assisted Treatment, improving recovery resources for Medication Assisted treatment, increasing opioid use disorder workforce and expanding opioid use disorder training and response with Naloxone. Target populations include rural and disparate populations specifically including African	0	0	0	69,832	**69,832**

Grant Name	Summary/Description of Grant	General Fund	Opioid Account	Other State Funds	Federal	Total
	Americans, American Indians. This grant expired September 30, 2021.					
MAT Opioid Exp-Grants – CFDA 93.243	Medication-Assisted Treatment (MAT): Build on the comprehensive Minnesota State Targeted Response to the Opioid Crisis (MN Opioid STR) through this Minnesota Targeted Capacity Expansion of Medication Assisted Treatment Services to target under-served African American and American Indian high-need communities not reached through MN Opioid State Targeted Response grants. This grant has expired as of September 2021.	0	0	0	65,837	**65,837**
CMH – Evidence Based Practices	Grants to individual mental health clinicians to train them in the use of scientific evidence to support clinical decision-making and to implement evidence-based interventions across the state.	47,255	0	0	0	**47,255**
State Fiscal Recovery Fund- fund-Children in Crisis Grant- U.S. Department of the Treasury 21.027	Children in Crisis: Transition children with behavioral health crisis from emergency departments across Minnesota.	0	0	0	45,887	**45,887**
University of Rochester – MN FACT Grant	Grant with University of Rochester	0	0	24,666	0	**24,666**

Grant Name	Summary/Description of Grant	General Fund	Opioid Account	Other State Funds	Federal	Total
Indian Elders benefit grant – Coronavirus Relief Fund	One time funding for COVID-19 relief for Indian Elders.	0	0	0	22,674	**22,674**
SPF for Prescription Drugs-Grant – 93.243	Strategic Prevention Framework for Prescription Drugs (SPF-Rx): The SPF Rx grant program provided an opportunity to target the priority issue of prescription drug misuse. The program was designed to raise awareness about the dangers of sharing medications and work with pharmaceutical and medical communities on the risks of overprescribing to young adults. SPF Rx also raised community awareness and bring prescription drug abuse prevention activities and educations to schools, communities, parents, prescribers, and their patients. This grant has now expired	0	0	0	6,676	**6,676**
Mental Health Block Grant (MHBG) ARPA – CFDA 93.958	MHBG-ARPA – This funding provides COVID emergency relief funding for the Community Mental Health Services (MHBG) Block Grant Program, in accordance with the Coronavirus Response and Relief Supplement Appropriations Act, 2021 [P.L. 116-260]. The awarded funds must be used for activities consistent with the MHBG program requirements. The grant includes the following: Enhancing	0	0	0	0	**0**

Grant Name	Summary/Description of Grant	General Fund	Opioid Account	Other State Funds	Federal	Total
	and expanding Mental Health Crisis services; Expanding First Episode Psychosis services and programs; Increasing Mental Health services and programs for the American Indian communities; Expanding Culturally Specific and relevant Mental Health Services; Increasing Mental Health Recovery Supports and Services; Workforce Development and Trainings for Providers of Mental Health Services; Addressing Gaps in Equity.					
	Grand total	**107,053,233**	**3,905,075**	**4,154,739**	**40,657,123**	**155,770,169**

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