
COMMISSION ON MEDICAID

October 7, 2026

Behavioral health themes, the working session, and the road from here
from here

BEFORE THE NUMBERS

Every rate, every cap, every per-member figure is a person.

A teenager waiting a year for an assessment. A peer specialist in recovery. A parent who left a job to provide care at home. A clinician who still takes Medicaid. Someone who lost coverage because a form was lost.

Four ways people have told us

1,000+

Survey responses



Office hours



Written testimony



Member-hosted
community meetings

Full summaries are in your packet. This morning: the behavioral health themes.

Five things people told us

- 1** **Care keeps people out of costlier places** – the ER, the hospital, jail, out-of-home placement. Said most strongly about peer support and school-based practices.

- 2** **Hard to get into, hard to stay in.** Losing coverage to paperwork was the top problem in the survey; in behavioral health it means treatment interrupted.

- 3** **Administrative burden is a cost.** About 30% of provider time or money goes to administration; about a third have closed or cut a service.

- 4** **Providers asked for targeted fixes, not blanket cuts** – clearer billing rules and the same oversight in every region.

- 5** **People want to see the evidence** – what the dollars produce, and who is accountable for which piece.

Reminder: There is good work taking place.

Of survey respondents who described fraud, waste or abuse they had seen, it pointed to...

~1 in 2

Providers or agencies

~1 in 5

Members or applicants

~1 in 5

The state, counties, or state policy

No one group owns this problem, and no one group should be presumed guilty of it. **Talk about specific about specific practices and how to stop them – not which group to blame.**

Blame looks backward. Accountability keeps going.

1

Someone is **named** to carry it out

2

A **measure** of success, set before it starts

3

Results **reported** where people can see them

4

A point where, if it isn't isn't working, it **changes changes**

For everyone: the Department and the BHA, the regional entities and their contractors, providers – and this Commission and Commission and the legislature that acts on its recommendations.

A first pass, not a vote: one of three marks per line

Explore further

We do our best to come back with projections, numbers, or other data as needed.

More information

It comes back once the question holding it up is answered. SHG records what is wanted.

Set aside

No further discussion.

Every line came from the record. None is SHG's recommendation; none is attributed to anyone. **Nothing is decided today.**

What does this save the general fund?

Not every dollar cut is a dollar saved. For expansion adults, the federal government pays 90¢ of every dollar – cutting a dollar saves the state about a dime. For most others it is closer to half and half; for state-only coverage, the state pays it all.

If the need is still there, where does the cost go?

Cost does not disappear when coverage or a service does. People wait until it is an emergency. Hospitals must screen and stabilize anyone – and recover the cost through private premiums, state hospital payments or local taxes.

Six long-term questions first, then the short-term lines that fit

1

Who administers behavioral health, health, and where its funding sits

2

Whether Medicaid keeps managed care managed care and the ACC in their current form

3

How long-term services and supports are designed and governed

4

What the program’s financing base is, base is, beyond the general fund

5

Who is covered, and for which benefits

6

How the state knows whether a program is working

Long-term lines for question 1

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- 18** Move the Behavioral Health Administration’s payment, contracting and care-coordination functions into HCPF, leaving licensing and crisis outside the payer; consolidate the behavioral health programs scattered across nine to twelve departments that contract with the same providers.
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- 7** Consolidate care coordination – including the care coordination now run through BHA and the BHASOs – into HCPF’s structure on a shared risk-stratification platform, so one entity coordinates for the same member; match intensity to complexity rather than paying across the whole population; stop paying for coordination HCBS providers already carry in their rate; give providers a channel into RAE care coordination; publish cost per engaged member against other states. Alternative proposed (written submission, October 5): complete the 2020 Blueprint’s transfer of individualized care coordination from the BHA to the BHASOs, scaled to need, and return funding not needed for an essential function to the general fund.
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- 73** Consider merging CDHS and HCPF; move BHA block-grant dollars into HCPF. See line 78 for the LTSS-only version.
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- 94** Target behavioral health safety-net and indigent care funding at the highest need: keep the statutory “no refusal” requirement for requirement for comprehensive safety net providers but focus it on the highest-acuity people; redefine “priority populations” in statute; let populations” in statute; let indigent care funding follow the person to any eligible provider – including specialty, essential and substance use and substance use treatment providers – through flexible BHASO funding rather than siloed streams.
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- 96** Re-evaluate the Behavioral Health Ombudsman Office: redirect its resources to proactive accountability by the agencies, BHASOs and RAEs, with consumer protections strengthened so that people can still raise concerns and get help.
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Long-term lines for question 2

- 19** Reduce the number of RAEs and BHASOs – to two, or one with regions – or, in the alternative, standardize them (line 6); a further alternative heard: bar for-profit heard: bar for-profit entities from behavioral health managed care contracts, as Minnesota does.
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- 43** Move behavioral health claims payment onto shared or state-administered infrastructure, keeping RAEs for network and coordination; standardize prior authorization standardize prior authorization statewide and integrate with provider records.
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- 90** End the Accountable Care Collaborative’s primary care case management and care coordination payments, or limit them to adults and fund a pediatric primary care payment model from the children’s share – care coordination, team-based care and preventive care, paid when delivered rather than on outcome metrics, with the AAP PACK report and Commission testimony on pediatric payment as the reference – keeping a per-member payment for pediatric primary care practices. Relates to 7, 15, 19 and 71.
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- 92** End capitated managed care for behavioral health: pay behavioral health services fee-for-service or through an administrative-services contract, keeping network and keeping network and care-coordination functions where they add value; first, have HCPF cost the administrative saving at constant utilization. Relates to 5, 19, 43 and Relates to 5, 19, 43 and 45; line 18 asks the agency question with and without it.
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Long-term lines: questions 3 and 4

Question 3

How long-term services and supports are designed and governed

- 31** Individual budgets for LTSS; fewer waivers
- 48** Area Agencies on Aging serve older adults
- 78** One accountable LTSS office across agencies
- 88** Sunset CFC; return services to the waivers

Short-term lines in this area: 23, 30, 37, 38, 39, 57, 58, 59, 60, 61, 62, 66, 77, 79, 84, 86, 89, 91, 93

Question 4

What the program's financing base is, beyond the general fund

- 11** Who absorbs hospital fee (CHASE) cuts
- 20** An employer contribution to Medicaid
- 21** Cap commercial hospital prices
- 50** Local funds or dedicated taxes as match
- 51** Unclaimed property funds against fee cuts
- 52** Alcohol tax for SUD treatment and Medicaid
- 56** Hospital global budgets or multi-payer model
- 72** A hard growth limit on state Medicaid

Short-term lines in this area: 1, 3, 4, 10, 24, 49, 53, 54, 55

Long-term lines: questions 5 and 6

Question 5

Who is covered, and for which benefits

- 33** CHIP, Cover All and income limits, by name
- 34** Cap optional benefits for expansion adults
- 85** A step-down instead of the eligibility cliff

Short-term lines in this area: 12, 29, 32, 35, 36, 63, 64, 65, 74, 75, 76, 87

Question 6

How the state knows whether a program is working

- 14** Check promised savings against results
- 15** An outcome measure for every program
- 16** Publish forecast assumptions; independent check
- 40** A standing Medicaid oversight body after Dec 11

Short-term lines in this area: 2, 8, 9, 13, 17, 47, 69, 70, 80

THE ROAD FROM HERE

From today's first pass to December 11th



Oct 7th

Last evidence. Begin to review the docket.



Nov 1st

Governor's budget request released.



Nov 10th

Continue to review and discuss the docket.



Nov 18th

Decisions. A recommendation needs seven of ten votes.



Dec 11th

Report to the General Assembly and the Governor.