Minnesota's Opioid Settlements

The United States is in the **midst of a crisis** on its streets and in its communities as **overdoses, homelessness, and disorder reach record levels**. Yet settlement proceeds secured by the State of Minnesota present an **unprecedented opportunity for generational investment** in treatment capacity for chronic substance abuse (CSA) and severe mental illness (SMI).

Minnesota is set to receive **more than $620 million** (*$627,484,474.13*) in opioid settlement funds. With twenty separate settlements and payments spread out over decades, the funds are **at risk of being squandered** through ad-hoc allocations to **diffuse and disorganized efforts**.

The state must ensure that this opportunity for treatment investment is not underutilized. **Minnesota can make targeted investments in treatment capacity** that will **honor those who suffered** in the opioid crisis and **ensure accessible care** for decades to come.

The Minnesota State-Subdivision Agreement has a conditional clause which modifies the division of opioid funds between the state and subdivisions.[1] It appears as though the clause has not been met, though official documentation on the allocation of funds follows the conditional clause's modification. Therefore, for the purposes of this brief, it will be assumed that the state is reserving 25 percent (*$174,433,567.77*) of funds for the state's use and allocating the remainder to subdivisions.[i] [ii]

It appears that the 20-person Opiate Epidemic Response Advisory Council is tasked with making recommendations to the Commissioner of Human Services, who shall then present the proposal to the legislature.[2] The legislature can preempt the grants and allocate funds elsewhere or allocate the grants as requested. Per the latest grant report, funds have been allocated for a wish list of priorities, including $350,000 for "justice-involved training sessions" for peer recovery specialists, $700,000 for a theatre-based prevention presentation, and $1.5 million for "transcranial magnetic stimulation" for American Indian chronic pain and depression relief efforts.[3] **The legislature must exercise its authority to preempt the Council and the Commissioner and fund decisive statewide treatment infrastructure investments.**

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[i] With the exception of the McKinsey and Publicis settlements, in which the state controls 100 percent of funds.
[ii] If the clause in Section II.G is not invoked by a specific legislative action, the funds are to be allocated 40 percent to the state and 60 percent to subdivisions. If the clause is invoked, the funds are to be allocated 25 percent to the state and 75 percent to subdivisions pursuant to Section II.F. On a plain reading of the Agreement and current law, the legislative action has not taken place, and thus the allocation should be 40/60. *See* Endnote 2; *and* MN. Stat. § 256.043(3)(m). https://www.revisor.mn.gov/statutes/cite/256.043.

The state must rein in the misallocation of these funds and prioritize investments in comprehensive treatment networks. **Three priorities** (Certified Community Behavioral Health Clinics, secure psychiatric beds, and community SMI/CSA response) **will ensure these funds have the largest impact** on Minnesota.

Certified Community Behavioral Health Clinics (CCBHCs)

CCBHCs, designed to ensure access to coordinated comprehensive behavioral health care, have stable funding and are supported by all recent presidential administrations. CCBHCs are a key response to the opioid crisis and can augment other services such as police crisis response teams, homelessness outreach and services, and outpatient psychiatric commitment services.

- **Solution: Fund the development and expansion of CCBHCs.**
    - Expand the CCBHC footprint with an emphasis on a team-based approach to co-occurring disorders.
    - Create a stepped approach to SMI/CSA treatment with services provided by the CCBHCs.
    - Require CCBHCs to offer specific care pathways to meet the needs of individuals with co-occurring disorders.

State Psychiatric Hospitals

Inpatient beds in secure facilities are critical for serving the highest-acuity psychiatric patients. Minnesota currently has only **3.4 state psychiatric beds** per 100,000 people available for civil (i.e., non-criminal) patients.[4] [5] Treatment Advocacy Center recommends a rate of 30-60 beds per 100,000. Even counting non-public secure psychiatric beds, Minnesota still falls short of the minimum.[6] Secure beds are a costly but necessary expenditure to protect patients with severe psychiatric disorders and the public at large.

- **Solution: Fund the expansion of civil psychiatric beds.**
    - Invest in expanding state hospital capacity.
    - Move forensic (criminal) commitments to a jail-based restoration facility.
    - Apply for one of several Section 1115(a) waivers to expand Medicaid reimbursement for institutions for mental diseases (IMDs).

Inpatient Stabilization Centers and Mobile Crisis Teams

Emergency departments (EDs) are supposed to be a last resort for times of true emergencies, but are increasingly used for all types of immediate-need medical care. This is especially true for low- to medium-acuity mental health crises. In order for CCBHCs and state psychiatric bed expansions to have the largest impact, there must be an immediate triage of low-acuity patients from higher-need patients, or else investments in these facilities will be drowned out, overburdened, and underutilized by those that need them most, just like emergency departments.

- **Solution: Fund community-based mental health response resources.**

- Expand community-based recovery centers, including voluntary short-term respite housing, especially for young adults.
- Leverage CCBHC resources to develop comprehensive mobile crisis response teams in conjunction with police crisis intervention teams (CIT).
- Support integration of community resources with crisis networks such as the Lifeline to support those in need or provide guidance for concerned loved ones.

[1] "Amended Minnesota Opioids State-Subdivision Memorandum of Understanding." https://drive.google.com/file/d/1-hSfz4yHqyT6ULjxG-I85Zff0p5gG6Fb/view?usp=sharing.
[2] MN. Stat. § 256.042(4). https://www.revisor.mn.gov/statutes/cite/256.042.
[3] Department of Human Services, "Opioid Epidemic Response Advisory Council grantees for Fiscal Year 2024." https://mn.gov/dhs/assets/2025_%20Opioid%20Epidemic%20Response%20Advisory%20Council%20grantees%20for%20Fiscal%20Year%202024_tcm1053-693907.pdf.
[4] Treatment Advocacy Center, "Minnesota Psychiatric Beds Report." 2023. https://www.tac.org/wp-content/uploads/2023/10/Minnesotabedsinformation.pdf.
[5] United States Census Bureau, "2023 American Community Survey – Total Population." https://data.census.gov/table/ACSDT1Y2023.B01003?q=population&t=Population+Total&g=010XX00US$0400000.
[6] Silver, Shanti, "Estimating Psychiatric Bed Need in the United States," p. 2-4. Treatment Advocacy Center Office of Research and Public Affairs. January 2024. https://www.tac.org/wp-content/uploads/2024/03/TAC_ORPA_ResearchSummary1.24.pdf.