



To: Chair Hoffman; Senate Human Services Committee
From: Brian Zirbes, MARRCH Executive Director
Subject: Public Testimony on [SF4710](#)
Date: April 7, 2026

MARRCH, the statewide trade association for Substance Use Disorder (SUD) programs and professionals, represents thousands of dedicated individuals and organizations committed to providing life-saving care to Minnesotans. Through education, training, advocacy, and public policy engagement, we support the critical work of our members and the countless lives they touch each year.

We would like to thank Chair Hoffman and Senator Abeler for authoring this funding bill.

Withdrawal Management (245F)

At the end of 2025, there were Withdrawal Management (WM) program closures in Ramsey and Stearns County. Both programs noted financial strain as a factor in their decision to close. In [245F.01](#), WM programs are prohibited from denying admission due to inability to pay. This is a *good* public policy. These programs admit, stabilize, treat, and refer patients to appropriate services. They then attempt to get paid for their services from the client's insurance plan or the Behavioral Health Fund. There are instances where a person either has income too high for the BHF, or it is found out that they have coverage from Tricare or Medicare, neither of which will pay for 245F WM services. Programs should not be left on the hook for providing uncompensated care.

Sections 1, 6, and 7 seek to expand the definition of in the BHF to add language to include uncompensated WM claims. In an informal survey with WM programs, they consistently report that they see these cases 1-2 times per program per month. Section 17 of this bill seeks to re-purpose WM capacity building grants previously appropriated by the Legislature, to offset the costs of covering these services. In the last legislative session, \$500,000 in unspent funds from this pool of money went back to the Legislature.

BHF transition from counties to DHS

In the 2025 Special Session, a proposal was passed that seeks to transition BHF eligibility from the counties to DHS by July 2026. We have concerns about the viability of this project being completed in a few months as well as the potential consequences of people not getting covered by the BHF in a timely manner. The intent of this proposal is to continue with the timeline for Tribal programs but delay implementation for counties to avoid system disruptions until there is a seamless handoff between the counties and DHS (Sections 8-14). Sections 3 and 4 seek to increase the eligibility window from 60 days to 180 days. This extension of eligibility is intended to avoid cumbersome appeals process which will add administrative burden and threaten continuous coverage for clients.

Pilot alternative licensing inspections (section 15)

This proposal seeks to build upon previous legislation that expanded Alternative Licensing Inspections in 245G for programs with Joint Commission Accreditation. It seeks to develop a pilot program to add additional national bodies that include the Commission on Accreditation of Rehabilitation Facilities (CARF) and the American Society of Addiction Medicine (ASAM) Levels of Care.

Adolescent SUD rates

The recent [Outpatient Rate study](#) that came before this body in 2024, did a thorough job of analyzing and putting forth recommendations for many SUD rates. The study unfortunately did not include an analysis of adolescent rates. The current reimbursement for [adolescent residential services is \\$216/day](#). This low rate has resulted in many programs closing over the past few years with limited options for families in need. A report from the [National Institute on Drug Abuse](#) noted the average daily cost for adolescent for-profit facilities is \$1,211 vs. \$395 for nonprofit adolescent facilities.

Section 5 seeks to increase the current adolescent rate to be 130% of base rate for high-intense adult residential, resulting in a new rate of \$381.07 (section 5). That adult rate was increased last session to \$294.67, but it only represents 80% of the modeled rate (\$355.02) from the Outpatient Rate Study. The higher cost in this proposal accounts for added staffing costs to treat adolescents. Lastly, Section 16 seeks to update the Outpatient Rate Study report for benchmark payment rates for adolescent residential and non-residential treatment.

Thank you for your time and consideration. We stand ready to assist and provide any further information to support these critical changes.