Minnesota Department of **Human Services**

April 27, 2011

The Honorable Jim Abeler
Minnesota House of Representatives
479 State Office Buidling
St. Paul, MN 55155

The Honorable David Hann
Minnesota Senate
75 Rev. Dr. Martin Luther King Jr. Blvd., Room 328
St. Paul, MN 55155

Dear Representative Abeler and Senator Hann:

I sincerely appreciate the work you have undertaken over the last few months to put together your proposals for the Health and Human Services (HHS) budget for the coming biennium. I know we share a commitment to protect services for the most vulnerable Minnesotans. I appreciate your efforts to find new and innovative ways to deliver services, and hope we can continue to work together toward system reform.

I am also pleased that many of the proposals from the Governor's HHS budget are included in your bills. While these proposed reductions are challenging, we believe the governor's budget strikes a prudent balance and would encourage you to consider the governor's recommendations as you continue your work in conference committee.

The attached list details my concerns regarding various budget proposals included in the two HHS budget bills now being deliberated by your conference committee.

My greatest concern is that a budget reduction target of $1.6 billion for HHS is simply too large. Budget reductions of this magnitude will put vulnerable people at risk and weaken the infrastructure that supports them. My staff is particularly concerned about increased institutionalization resulting from reductions to home and community based waivered services. It must remain our goal to keep people living in their homes and communities and not force them into nursing homes and other institutional settings.

The cumulative impact of the deep reductions in the HHS bills will weaken the community services that support vulnerable and low-income people. Many of the proposals would directly impact county human services. Counties are the state's primary partner in service delivery; they are particularly crucial to services that protect vulnerable children and vulnerable adults, and for administering the community mental health system. We should not weaken county capacity to deliver services or transfer even greater responsibility to local property taxes. Further, many of the reductions in the legislative proposals would also shift costs to hospital emergency rooms, jails, detox centers and other community-based services that do not have the capacity to absorb services the state neglects.

The attached list details the most significant concerns that the Department of Human Services has with the House and Senate's HHS budget bills. This list is in addition to the technical-level advice provided to your staff earlier last week. I and my staff are happy to meet to discuss these concerns with you in greater detail and to provide

additional technical assistance. However, the Administration cannot negotiate on this bill until you have successfully reached a single legislative position on your budget, with fiscal estimates certified by non-partisan staff at the Department of Management and Budget.

Sincerely,

Lucinda Jesson
Commissioner
Department of Human Services

cc: Governor Mark Dayton
Representative Tom Huntley
Senator Linda Berglin
Representative Steve Gottwalt
Representative Tina Liebling

Department of Human Services concerns
With House and Senate Health and Human Services
Conference Bills (SF 760)

Health Care

1. **Repeal of the expansion of Medical Assistance to adults without children.** The bills propose the complete elimination of Medical Assistance (MA) eligibility for adults without children and reinstatement of General Assistance Medical Care, delivered via the Coordinated Care Delivery Systems (CCDS) effective January 1, 2012. The repeal would eliminate high quality health coverage to 105,000 people, all of whom earn less than $8,000 per year (or $11,000 if married). Replacing early MA in January 2012 with a state-only funded program would mean the loss of $1.3 billion in federal matching funds over three years. In addition, the bill eliminates MinnesotaCare coverage for adults without children with incomes below 75 percent of poverty, which leaves that population with no other option but to seek coverage through a CCDS if one is available where they live.

2. **Health care waivers and reforms that cannot be implemented.** As we have communicated previously, the bills have significant fiscal holes created by proposed health care reforms that cannot be implemented and will not result in the savings being tracked by the legislature. These proposals include: the Global Waiver, Fee for Service Caps, Care Management and Managed Care High Cost Providers and the extension of the defined contribution plan to various Medicaid populations. As we have stated previously, these provisions do not result in savings that can be counted as part of the budget process.

3. **Defined contribution program.** The contribution levels specified in the Defined Contribution Plan proposed by the legislature are insufficient and will force enrollees to purchase plans with significant cost-sharing. Significant cost sharing may limit their access to important primary care and prevention services. For the lowest income populations, it will result in a loss of coverage because they simply cannot afford it. This is of particular concern for a population requiring a higher level of services for chemical and mental health and chronic health conditions than the average utilization in the commercial insurance market. A defined contribution model has the potential to be a workable model for providing health care to a higher-income population with a clear ability to afford to actually pay the deductible. However, it is not appropriate for the lower income households being targeted by the legislative proposals.

4. **Health Care Homes.** DHS shares the goal of improving the value of health care through payment and delivery reform and believes that this is best accomplished through a coordinated and clear strategy that sets consistent expectations of providers. The sections of the bill that address health care homes conflict with current policy and jeopardize the success of Health Care Homes to deliver more efficient services. We have concerns over the proposal to automatically allow federally qualified health centers (FQHCs) to be deemed certified health care homes. DHS shares the goal of partnering with safety net providers to strengthen the vital care coordination role they provide. However, FQHCs vary widely in their adoption of the health care home standards and some will require significant time and effort to adopt the patient-centered medical home model.

5. **Direct contracts with providers.** DHS shares your interest in increasing value and accountability through contracts with providers. The move from pay for volume to pay for value requires testing a variety of models that work for different areas of the state and types of providers. As you are aware, DHS is testing new payment models via the Health Care Delivery System Demonstration Project (256B.0755), authorized by the 2010 Legislature's agreement with Governor Pawlenty. A request for information

(RFI) was recently issued seeking community input on the key operational components of the demonstration, which will result in a competitive request for proposals (RFP) process. The goals of the demonstration include alignment with related payment innovations in the marketplace to ensure that provider organizations experience a "critical mass" of payment reform sufficient to transform care delivery. Sections of the House HHS budget bill would prescriptively define the benefit and payment models considered. This would significantly limit DHS' ability to align with innovative private sector and Medicare reforms, as well as negotiate with CMS regarding the federal authority needed to implement these models.

6. **Proposal to eliminate "optional" services, including therapies, eyeglasses and prosthetics.** Ending coverage for these services creates significant holes in coverage, especially for people with disabilities who often depend on Medical Assistance for much of their lives. If optional services that help people to be more independent are eliminated, some people will substitute more expensive long-term care services such as home care assistance to meet their needs. Additionally, this proposal creates an incentive for people to go into a facility to receive therapy. Nursing homes and intermediate care facilities (that are obligated to meet people's care needs) would have to provide therapies within their current rates.

7. **State-Funded Medical Assistance.** We are concerned with the Senate proposal to eliminate state-funded Medical Assistance coverage for legal non-citizens who would qualify for federally funded MA but for the fact that they have been in the country for less than five years. These individuals include elderly, disabled and families with children. This will result in a loss of health coverage for an average of 1,678 per persons per month in FY 2013.

8. **MinnesotaCare Eligibility Cuts.** Eliminating MinnesotaCare eligibility for adults over 200 percent of poverty, as the House proposes, results the loss of health care coverage for 7,600 people. DHS is also concerned about the House proposal to require the Commissioner verify both earned and unearned income for MinnesotaCare enrollees and verify eligibility for employer-subsidized insurance. MinnesotaCare already verifies income at application and renewal. Adding additional barriers to obtaining MinnesotaCare coverage is burdensome on both the enrollees' and staff resources and runs contrary to the Legislature's suggested policy goal of simplification and administrative reductions.

9. **Compliance with the Affordable Care Act.** There are a number of concerns about provisions in both bills that would direct the state to take actions that are out of compliance with the federal Affordable Care Act (ACA), thus jeopardizing federal Medicaid matching funds to the state. In FY 2012-13, the state is projected to receive $9.7 billion in federal Medicaid matching funds. In particular, the Senate includes language that prohibits the state from implementing the ACA until its constitutionality is affirmed. The language provides no guidance on what to do with regard to provisions of the ACA that have already been implemented. In addition, not implementing the ACA would harm Minnesotans who would benefit from the Act including children receiving hospice care and primary care physicians who would receive a rate increase. Finally, not implementing the ACA would prevent the state from collecting drug rebates from managed care plans and from implementing Medicaid program integrity initiatives that will help stop fraud and abuse.

10. **Medical Education and Research Costs (MERC).** DHS is concerned about the Senate position to completely eliminate funding for Medical Education and Research Costs (MERC). Currently, a portion of managed care rates through the prepaid Medical Assistance program (PMAP) are carved out and distributed to teaching centers throughout the state. Elimination of the state portion of MERC results in a loss of federal reimbursement, for a total loss of $99 million for the teaching centers.

11. **Managed Care for the Disabled.** DHS has concerns about placing persons with disabilities into managed care unless they opt out. This population has traditionally been exempt from managed care.

DHS is focused on providing coordination of care for persons with disabilities while providing them the flexibility of the fee-for-service system.

12. **Lack of Funding for Electronic Health Records (EHR).** Failure to fund this proposal obstructs federal incentive funds available to encourage the adoption of EHR technology by eligible Minnesota providers, hospitals and Critical Access Hospitals. The use of EHR technology will improve patient care and reduce costs by promoting a patient-centric model through the creation of a secure, interoperable nationwide health information network. It is estimated that eligible Minnesota Medicaid providers, hospitals and Critical Access Hospitals could receive $181 million in incentive funds over the next 11 years. The Medicaid EHR incentive program runs through 2021 and Minnesota will receive 90% federal funding to administer this program through its entire duration.

13. **Lack of Funding to Streamline Eligibility System.** Minnesota's two primary health care programs for low-income individuals, Medical Assistance (MA) and MinnesotaCare, are processed using two different systems. The state needs to look at significant changes to the system capacity for health care eligibility to both support current operations and to assist in future reforms. The federal government is supporting such improvements with 90% matching funds for the design, development and installation or enhancement of eligibility determination systems through 2015. Failure to fund this proposal will mean the continued use of multiple systems that are difficult for county and state caseworkers to manage given their already large workload and the overall complexity of the health care programs.

14. **Simplification of Programs.** DHS is striving to simplify health care programs to make them easier for clients to navigate and for county and state staff to administer. The House bill in particular makes a number of eligibility changes that will move in the opposite direction. Under the House proposal, there are three separate programs created for adults without children based on income. This creates the potential for confusion and administrative complications as a change income results in a change in the program for which a person qualifies. In addition, the change from a 12-month to a six-month eligibility period for MinnesotaCare will add more complexity and administrative burden to the program by doubling the amount of renewals that county and state staff must process.

Continuing Care

15. **Waiver caps for people with disabilities.** The House proposal freezes enrollment in three disability waivers, then reduces the number of people served to the level of enrollment in March 2010. The proposal results in close to 5,800 people being unable to access waiver services and 1,250 people forced into nursing homes to receive care. This is an unprecedented level of reduction that affects Minnesota's most vulnerable citizens. Freezing growth will impact individuals moving from institutions to the community, including those seeking to leave institutions such as Anoka or Cambridge State Operated Services, or specialty hospitals, such as Bethesda. It also eliminates a safety net that otherwise diverts people from institutions and other costly deep end services, that will affect aging parents who reach a point where they need assistance for their adult child with a disability, or families coping with a spouse or family member with an acquired disability (e.g.: MS, a spinal cord injury, or a brain injury). The Senate proposal freezes waiver growth at the June 30, 2011 level, but does allow reuse of existing funds. This limit would also significantly impact people's ability to return to or remain in the community. Although both proposals keep the state at the minimum maintenance of effort required to meet federal requirements, either proposal may still be challenged in court as a violation of the American with Disabilities Act, as further clarified in the precedent-setting U.S. Supreme Court's *Olmstead* decision.

16. **Suspend growth in the Elderly Waiver.** Elderly Waiver pays for home and community-based services for people who need long-term care services and are at risk of going into a nursing home. The program

serves people at a much lower cost than a nursing home. Although the proposal to cap the Elderly Waiver saves several million dollars per year, it results in approximately 256 people entering nursing homes over two years. In particular, people who are currently spending down their own assets in an Assisted Living setting will not be able to access Elderly Waiver funding once their assets are depleted. Currently 30% of all people who enter Elderly Waiver already live in an Assisted Living setting. So, on average, 122 people per month will find themselves in this situation. If they are unable to access Elderly Waiver funding, most would have little choice other than to move to a nursing home because they no longer have homes of their own.

17. **Nursing facility rate equalization phase-out.** The House proposes to allow nursing facilities to charge rates to private pay residents higher than the rates determined by MA by up to 8%, subject to actual costs, phased-in over four years. The Senate eliminates the limitation altogether, after a four year phase-out. This will result in more rapid spend-down to MA eligibility and therefore, to higher nursing facility case loads. It will also create an incentive to discriminate in admissions against individuals who are MA eligible. This discrimination results in reluctance by some elderly to use their resources for home and community based services because they will want to preserve resources to be able to access a preferred nursing facility. DHS opposes the repeal of rate equalization.

18. **Lack of funding for federal compliance eligibility changes.** The American Recovery and Reinvestment Act (ARRA) and the Affordable Care Act (ACA), prevent states from implementing more restrictive eligibility standards, methodologies or procedures for Medicaid (as well as for CHIP, the federal Children's Health Insurance Program) than those that were effective on July 1, 2008, and March 23, 2010, respectively. Eligibility changes passed by the 2009 legislature were delayed in 2010 to avoid violating the ARRA requirement. However, the ACA extends the MOE requirement until January 1, 2014 for adult eligibility groups and until September 30, 2019 for eligibility groups containing children. The Governor's budget proposed to delay the eligibility changes to comply with federal law and avoid federal penalties. The Senate bill does not delay these eligibility changes, putting the state in violation of federal law requirements. The House bill includes the policy language to enact the needed delays but does not track the costs in its spreadsheet, putting the MA forecast at risk.

19. **Reduction to Senior Linkage Line.** Aging Prescription Drug Assistance grants provide 50% of the funding for the Senior Linkage line. Eliminating these grants will cut in half Senior Linkage Line's capacity to take calls statewide and to administer a targeted program that helps elderly people return to their own homes following a nursing facility stay. These services provide assistance to elderly people and their families that help people find home and community-based services to meet their needs and to avoid or delay more expensive institutional care. By fiscal year 2013, eliminating this grant will result in a net cost annually to the general fund.

20. **Proposal to eliminate PCA alternative grant**. The House proposal eliminates the appropriation for grants to provide alternatives for those recipients losing access to PCA services due to July 1, 2011, changes in program access criteria. Legislation in 2009 required the development a less expensive alternative, preferably with federal match, to serve people no longer eligible for PCA. Without the grant funding, the proposed plan (included in the Senate bill) to serve children and adults with behavior and mental health needs, and adults who need assistance to live independently, will not be implemented and there will be additional offsets as people use more expensive services.

21. **Eliminate caregiver support grants.** The Senate proposes eliminating all state-funded Caregiver Grants ($456,000 per year). These funds serve as match for the federal Older Americans Act funding. Without this match, the state stands to lose $2.1 million in Older Americans Act federal funding annually. Caregiver grants serve 8,436 people and families annually with service such as in-home respite, caregiver counseling, disease progress education, and supplemental services. All are designed to support the caregiver as they have defined the support needed in order to prolong their care giving career.

22. **Eight-bed provision under the disability waivers:** The House proposal requires DHS to seek waiver amendments to all of the disability waivers to allow up to eight people to live together in existing residential buildings. Minnesota has moved away from using larger congregate settings in favor of smaller settings with four or fewer people. This was a deliberate policy decision that reflects a move towards more cost effective service delivery options, and policy that supports the Americans with Disabilities Act. Because of the increased occupancy in eight-bed buildings, they would no longer meet standards for foster care licensure, and these settings must be licensed as a Supervised Living Facility (SLF) by the Department of Health. As such, these settings would not be subject to the corporate foster care moratorium and would therefore, lead to increased program costs.

23. **Six-month reassessments.** The House proposal requires case managers to visit and reassess individuals' progress toward achieving outcomes at least every six months. Concerns with this proposal include adding administrative requirements for more frequent assessments, which require more frequent billing for services. This is a duplication and expansion of current requirements, where face-to-face visits occur at least twice per year and anytime an individual's condition has changed, a reassessment is required. We suggest that additional training around current statutory requirements may achieve the same outcome, without the requirement of a six-month reassessment.

Children and Family Services

24. **Lack of funding for Adoption Assistance and Relative Custody Assistance.** Governor Dayton's budget request funds the base budget for Adoption Assistance to reflect the current caseload and funds the forecasted growth of children with special needs whose parental rights were terminated, placed in foster care and adopted by new families. Full funding of the base is necessary to fund agreements with thousands of families who are caring for children with special needs and funding for the forecasted growth is necessary to ensure children do not languish in foster care. Funding at the level of the Governor's budget is required to meet federal requirements under Title IV-E necessary to ensure Minnesota can continue to collect federal reimbursement for these services.

25. **Changes to General Assistance.** The General Assistance program provides ongoing assistance of up to $203 per month for people who cannot support themselves due to illness, age or disability. The Senate proposal to cap funding and provide block grants to counties (which also impacts Minnesota Supplemental Aid special needs and emergency programs), is funded at a significantly lower level than the former stand-alone programs. Capping the appropriation under the new, combined program will significantly reduce the number of people who can be served resulting in increased homelessness for those unable to access assistance. Likewise, the House proposal to eliminate certain eligibility categories for GA, such as people with applications pending for federal disability programs, will leave some of Minnesota's poorest citizens without any monthly assistance. The House also adds volunteer or work requirements to the populations served in General Assistance and Group Residential Housing programs which further limits access to housing for vulnerable populations who have limited ability to work. We also note that no funding is provided to pay for any costs associated with developing or supporting work/volunteer opportunities for this population.

26. **MFIP Residency**. The Senate increases the residency requirements for the Minnesota Family Investment Program (MFIP) eligibility from 30 days to 60 days. MFIP provides assistance to low-income families and aims to move parents quickly into jobs and out of poverty. Stabilizing these families and their children increases their odds of being successful contributors to their communities. Residency requirements have been struck down by state courts and the U.S. Supreme Court. This residency policy likely would be challenged and enjoined.

27. **MFIP $150 SSI Recipient.** The Senate proposes to reduce the MFIP grant by $150 per Supplemental Security Income (SSI) recipient who resides in the household. This reduces resources to the very poorest families where a parent often cannot work due to disability. In addition, counting SSI received by children will likely bring a legal challenge and a court injunction that will stop implementation.

28. **MFIP approval of postsecondary education or training**. The House requires MFIP participants to be working in unsubsidized employment at least 20 hours per week in order for postsecondary education or training to be an approved activity. This proposal is inconsistent with state led efforts to ensure low-wage low-skilled adults have access to training and education.

29. **Children and Community Services Act (CCSA).** The Governor proposed reducing Children and Community Services Act (CCSA) grants to counties by $2.5M a year and targets it to support vulnerable children and adults. The Senate has proposed reducing the grants by $10 million in the first year and $12 million in subsequent years without any change in policy, forcing counties to provide a broad range of social services with significantly less state funding.

30. **Child Care Assistance Program rates.** The Senate reduces maximum reimbursement rates by five percent for all child care provider types. Federal Child Care Development Fund regulations set the 75th percentile of rates as a benchmark for achieving access and have noted in letters to DHS that Minnesota's reimbursement rates are far below that level. Based on 2010 data, 38.4% of family childcare homes and 32.5 % of centers in Minnesota have rates within the maximums which were set in 2006. Reducing rates further from the child care market rates may result in federal compliance issues.

31. **Child Care Assistance At-Home Infant Care**. The House reestablishes the At-Home Infant Care Program which makes payments to parents who stay at home with infants under age one. The proposal uses general funds taken from the state's contribution to the Child Care Assistance Program Basic Sliding Fee program and reduces the Basic Sliding Fee allocation that would otherwise serve low income working families. There were over 4,000 families on the statewide waiting list for Basic Sliding Fee as of February 2011.

32. **White Earth Human Services Program**. DHS supports the direction to give the White Earth Tribe more autonomy in the delivery of human services for their people. However, there are several problems with the structure of the current language. We are interested in working with White Earth and the legislature to develop language that would support our common goal.

33. **Tribal Child Welfare Grants**. The Senate eliminates both the American Indian Child Welfare Program and the Indian Child Welfare Act funds. These are both critical to maintaining tribal ability to support American Indian children and if these funds are eliminated, costs will be borne by counties to support these children.

34. **Fraud Prevention Grant Reductions**. The Senate reduces funding for Fraud Prevention Investigation Grants to counties from approximately $1,617,000 per year to $221,000 for FY 2012 and $333,000 for FY13. This reduction would severely limit the scope of the Fraud Prevention Investigation Program in Minnesota, dramatically reducing the public accountability and oversight of public assistance programs in Minnesota. This reduction will likely lead to increases in the number of people committing fraud, increased costs for public assistance programs and decreased collections for overpayments. The proposed action seems inconsistent with legislative proposals this session to reduce fraud and waste.

35. **Electronic Benefit Transfers**. The House limits access to electronic benefits for cash assistance by creating greater barriers on where and how such benefits can be obtained. Such restrictions are unnecessary and place a burden on low-income families' ability to manage very limited resources. Restricting use of the cash card to within the borders of Minnesota means our state can no longer

participate in a joint federal/state/financial consortium that establishes rules governing EBT transactions, taking away all interoperability for cash benefits. Repealing the four free automatic teller machine (ATM) transaction fees will have a direct impact on low-income clients. It will now cost them $1 for each cash withdrawal over and above the ATM network surcharge.

36. **Northstar Care for Children.** The Governor continues to recommend consolidating three existing programs into a single program called Northstar Care for Children to support permanency for children whose parental rights have been terminated due to abuse or neglect by combining the adoption assistance, relative custody assistance and family foster care programs so that incentives do not remain to keep children in foster care any longer than is absolutely necessary.

Chemical and Mental Health Services

37. **Adult Mental Health Grant Reductions.** The Senate's reductions to grants for adults with mental illness will reduce the availability of critically needed community supports, medication monitoring services and treatment. The reductions will eliminate important components in the community mental health system that allowed for the closure of state institutions. Community mental health services were established because they are an effective approach to support and treat individuals who have a mental illness and ultimately save the state money over more expensive and restrictive alternatives. The reduction in community mental health services is likely to result in additional pressure upon law enforcement, emergency rooms, jails, courts, and psychiatric hospitals. In addition, the grant reductions will reduce the availability of services to ethnic and cultural minorities who are already significantly under-served as compared to the general population. Finally, if the grant reductions are adopted, the state will be out of compliance with the Federal Mental Health Block Grant (FMHBG) maintenance of effort requirements. The FMHBG funds American Indian Projects, Adult Mental Health Initiates, the state-wide consumer network, peer specialist training and certification, education and support services of families, and culturally competent services. Loss of the FMHG would also eliminate a substantial amount of the funding for children's crisis services, evidence-based practice training, and other children's services infrastructure.

38. **Children's Mental Health Grant Reductions.** The proposed reductions to children's mental health grants will eliminate local capacity to treat children with severe mental illness. Parents and families will have difficulty finding resources to address their children's needs. It will negatively affect the statewide clinical infrastructure, increase disparities among minority populations, and remove scientific evidence out of treatment decisions and return mental health care to guesswork. In addition, it will take mental health care out of schools, resulting in increased school failure and reduced graduation rates. The grant reductions will shift costs to schools and property taxpayers, as well as impacting hospital emergency rooms and the criminal justice system.

39. **Limitation on Residential Chemical Dependency Treatment.** The proposed language in the House bill limits the number of episodes funded by the chemical dependency treatment fund to no more than three residential chemical dependency treatment episodes for the same person in a four-year period and no more than four residential chemical dependency treatment episodes in a lifetime unless deemed appropriate by the commissioner of human services. DHS is concerned that this language will shift costs to hospitals, detox facilities, jails, and other facilities for persons who no longer qualify for a treatment episode.

Minnesota Sex Offender Program

40. **No funding for Minnesota Sex Offender Program Growth.** The Minnesota Sex Offender Program is projected to grow by 100 clients during the next biennium. The Governor's budget included $7.8 million to support the treatment, security enhancements and operational costs to accommodate this growth. The Office of the Legislative Auditor has documented the efforts MSOP has made to reduce staff and become more efficient and has recommended that MSOP provide additional treatment hours. MSOP cannot absorb the new clients without the additional funds.

Operations

41. **Administrative Reduction.** DHS has experienced a cumulative 15% reduction in funding for central office operations over the last three legislative sessions. Reductions beyond the 3.5% recommended in the Governor's budget will challenge DHS' ability to ensure the proper expenditure of the funds that DHS pays to providers and directly to individuals, and its ability to ensure compliance with the complex state and federal laws that govern human services programs. Although DHS will strive to maintain its highest priority services, the level of reduction proposed by the Senate will impact implementation of new program changes, including possibly slowing the implementation of new program changes and proposals because of its impact on the department's ability to adequately staff the new initiatives.

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