



## **MICA 2010 Legislative Recommendations Health & Human Services**

### **Replace Lost Federal Funding for Child Support Collections**

*The MICA Board of Directors supports permanent state funding to replace federal funding cuts for the child support collection system.*

The federal government requires that states provide child support collection services to all families requesting them. In Minnesota, this responsibility is delegated to counties. Minnesota counties helped over 250,000 families collect child support in 2007. The Federal Deficit Reduction Act of 2006 changed federal matching fund rules, resulting in an annual loss of \$24 million. In 2007, the Minnesota Legislature appropriated \$7.3 million in one-time funding to offset the loss of federal incentive matching funds. This delayed the impact of the federal cuts by one year, but did not address the ongoing cost to counties or the impact on families using collection services.

Without the addition of ongoing state funding, counties will be pressured to decrease staff and increase worker caseloads, making it more difficult to meet performance standards, resulting in the loss of additional federal funds. Even more disturbing is the impact on low income families. Statewide, over 60% of families who got help from their counties in collecting child support are former welfare recipients. Another 18% are currently receiving MFIP (2005). A high proportion of these mostly low-income families depend on their child support to move from welfare to self-sufficiency. The loss of regular monthly child support would push a significant number of these families back on welfare. An increase in the state's welfare rolls would not only demand more state funds, it would make it more difficult for the state to meet its federal welfare work participation targets, thus jeopardizing another federal bonus (about \$24 million per year).

### **Assist Counties with Targeted Case Management Costs and Provide Adequate Funding for Child Protection Services**

*The MICA Board of Directors urges the 2010 Legislature to make a permanent financial commitment to counties for targeted case management and to provide stable state funding for basic child protection services.*

Targeted case management (TCM) provides for the effective coordination of health and social services allowing Minnesota counties to minimize health care costs for at risk-children and the mentally ill. Vulnerable adults and the developmentally disabled also benefit from TCM services.

Child protection services have already been battered by previous base cuts to the Children and Community Services block grant (CCSA), and federal cuts in Medicaid, the Social Services Block Grant and Title IV-E foster care reimbursements.

Currently, counties fund nearly half of the costs of child protection, foster care, adoption and related services. The federal government provides 36%, and the state only 14%. Minnesota's state funding of child protection is among the lowest in the nation. The 2010 Legislature needs to step up and provide permanent adequate funding to better support child protection and to hold the counties harmless from any future loss of federal TCM funding.

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### **The State Should Pay Its Share of the Hold Costs for the Civil Commitment of Sex Offenders**

*The MICA Board of Directors urges the 2010 Legislature to pay the state's statutory share of 50% of the "hold" costs for sex offenders being petitioned for civil commitment.*

Since 1999, MS 253B.185 has required the state to pay for 50% of the costs of "holds" (temporary confinement) of sex offenders being petitioned for civil commitment. The state's obligation is limited to the amount appropriated. Only once since 1999 has the Legislature appropriated any money for this purpose. As a result, counties have ended up paying the full costs of holds, costs that have risen dramatically - nearly 10-fold from FY 2003 to 2006. The cost to counties for civil commitment hold orders for FY 2008 was \$5,089,163.

Changes in the state's policy for referring imprisoned sex offenders for civil commitment have largely precipitated the increase. While the law requires that the Department of Corrections make their referrals one year before a sex offender's release from prison, many referrals are not made within this deadline. Dakota County received timely referrals in only 40% of the cases referred between 2003 and the middle of 2007. Furthermore, the recently-enacted requirement that county attorneys file commitment petitions within 120 days of the referral did not have the effect of reducing the counties' costs for sex offender civil commitment holds. The filing of the petition only formally initiates the civil commitment process. A preliminary hearing, as well as at least one, if not two, psychiatric exams have to occur before the commitment hearing occurs and the commitment order is issued. This process can take months.

### **Sensible Maintenance of Effort (MOE) Policy**

*The MICA Board of Directors urges the 2010 Legislature to modify or eliminate maintenance of effort (MOE) requirements that are counter-productive to budgetary prudence.*

Over the years, the Legislature has enacted numerous MOE requirements dictating county spending and spending increases in various mandated programs. While these requirements may have been intended to protect an important public endeavor, they are all too often intransigent. MOE requirements are almost always rigid and inflexible, while the obstacles to be surmounted in the pursuit of the related public policy objectives constantly change relative to form and extent. Specifically mandating a level of spending on a public policy that has been attained or has dissipated, or can be better attained through an alternative, less expensive technique is wasteful. Examples of this are the set of mental health mandates first enacted in 2006. These MOE requirements were based on historic spending. In cases where unusually high but temporary spending was required, such spending increases became permanent, even while the need decreased. It would be much wiser and more cost-effective if the Legislature would identify desired objectives without attaching MOE requirements.

### **Improve Background Studies for Licensing by Allowing Access to Corrections Data**

*The MICA Board of Directors supports county social services department access to the Department of Corrections Statewide Supervision system to improve background studies done by counties as part of foster care, child care and adoption licensing activities.*

On behalf of the state, counties conduct licensing of foster care and some child care providers and assess prospective adoptive families for children who are wards of the state. A major part of the

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licensing activity is focused on background studies, which include criminal records checks. The current protocol checks fingerprints obtained by the counties against the state's BCA and the federal government's FBI databases. The BCA system does not include many older prints. Additionally, it takes 4-6 weeks before counties get results from the state. Under this system, vulnerable children could be exposed to care involving people not eligible under licensing exclusions. To minimize this risk, the Statewide Supervision System (S3) maintained by the Department of Corrections could be made available to county social services departments. The S3 system contains lists of every individual on probation in the state and includes criminal histories and the names and contact information of assigned probation officers. Access to S3 would provide more timely, accurate and complete information, ensuring safer care for our most vulnerable children and adults.

### Fully Fund Family Stabilization Services Program

*The MICA Board of Directors supports the Family Stabilization Services (FSS) Program if fully funded by the State of Minnesota.*

Under the new federal welfare work participation rate requirements that states must achieve in order to earn TANF incentives, it was apparent that almost all states would miss the mark - including Minnesota. To improve Minnesota's rates, in 2007, the Legislature created a separate program for families facing multiple barriers to employment, funded without federal dollars. Now these families will not be counted by the federal government in assessing our participation rate.

Unfortunately, the Legislature only provided one-time funding for the service-intensive FSS program. The Department of Finance estimated that counties statewide would have to spend \$16.6 million each biennium to assist the estimated 6,200 eligible families. Therefore, the FSS program should be continued only if funded by the state.

### Reform Consolidated Chemical Dependency Treatment Fund

*The MICA Board of Directors supports reforms to the Consolidated Chemical Dependency and Treatment Fund (CCDTF) that provides sufficient and flexible state funding for the proactive treatment of chemical dependency.*

Since its creation in 1986, the Chemical Dependency Treatment Fund has provided funding for treating chemical dependency. Unfortunately, funding cuts, restricted use of funds and structural problems in the funding formula have created barriers to effective treatment for many who depend on the fund for access to treatment. The maintenance of effort (MOE) requirements included in the original legislation have compounded funding inequities across Minnesota counties. The following changes would improve access to treatment and the rate of successful outcomes:

- **Increase funding to enhance access to treatment:** The elimination in 2003 of sliding fee funding for individuals with moderate incomes, and those without insurance coverage, limited access to treatment for a significant number of people. Currently, CCDTF funding is only available for low-income individuals who qualify for MA, GAMC or MinnesotaCare. For all others without insurance who are placed in treatment by the counties or the courts, the counties pay 100% of the treatment costs.
  - **Allow reimbursement for services related to positive treatment outcomes:** If counties could use the CCDTF for services that support treatment - like detox, intensive case management, transportation services, rent deposits and other one-time services - treatment outcomes would improve. Additionally, services related to mental health needs of those with chemical dependency issues need to be considered. A large segment of the treatment population has a dual diagnosis requiring chemical dependency treatment geared toward treating other behavioral health problems as well.
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- **Eliminate or reduce county maintenance of effort requirements:** Under the current parameters of the CCDTF, each county must spend a set amount of county taxpayer dollars each year relative to the state dollars they receive. The requirements from county to county vary widely - from 4% to more than 60%. MOEs should be equalized across counties. A graduated equalization that does not raise the current rates of any counties (holds harmless) should be instituted to provide for uniform access to treatment across the state.

## Simplification

*The MICA Board of Directors supports the streamlining and simplification of the delivery of human services.*

Historically, Minnesota's system of administering human services has been complicated and inefficient. Statutory and administrative requirements have become increasingly complex, inconsistent and lacking in uniformity. This has created significant burdens for counties throughout the state. For example, there are numerous different application forms and procedures used for the process of determining health care eligibility and enrolling people in various human services programs. When transfer of this information is required, a duplicate entry or a complex manual transfer of information is the norm.

By requiring uniformity, and by centralizing and automating certain functions, administrative cost-effectiveness, customer service and program integrity could be dramatically enhanced. With an increasing number of people seeking human services, it is critical that the workload of those who directly serve clients become more manageable, and that unnecessary duplication be eliminated.

The MICA Board supports:

- That enrollment in Minnesota human services programs and renewal procedures be automated, simplified and made uniform in order to promote efficient verification and registration.
  - That the State Medical Review Team (SMRT) process be reformed in an effort to simplify applications, reduce paperwork, streamline eligibility determinations and prevent lengthy processing of appeals.
  - That statutes that mandate waste and inefficiency be repealed. For example, counties are required to send complicated health plan booklets to all PMAP enrollees to inform them of their available plan options. In some counties, there are up to five options. The cost for these mandated mailings is significant. MICA supports an alternative that would allow counties to mail health plan summaries to enrollees, followed by full program brochures upon client request.
  - Minnesota's automated MAXIS computer system, which is utilized by county financial workers when reviewing public assistance applications, is not consistently reprogrammed when the Legislature makes changes to Minnesota statutes. Additionally, the large number of program determinations for which MAXIS is used, without adequate flexible computer programming, causes county financial workers to make manual changes and work-arounds, which are extremely time consuming and inefficient. The State of Minnesota should provide adequate funding to update the MAXIS computer system to address the ever-increasing number of statutory changes and the differences between programs.
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### **Clarity in the Law Regarding Representation in Child Protection Cases**

*The MICA Board of Directors urges the Legislature to clearly identify the Board of Public Defense as responsible for providing representation of custodial and non-custodial parents in TPR and CHIPS cases and to provide necessary funding for the Board to meet this responsibility.*

In January 1990, the State took over the public defender costs in the Eighth Judicial District. By January 1995, all judicial districts were included within the State program overseen by the State's Board of Public Defense. As a result of this takeover, the State reduced aid payments to counties on a dollar-for-dollar basis to reflect the cost of this takeover and increased funding to the Board of Public Defense. The Board of Public Defense continued to provide representation to adults in child protection cases without question when appointed by the court until July 7, 2008. On that date, public defenders began refusing to provide representation for either custodial or non-custodial parents in Termination of Parental Rights (TPR) cases and Child in Need of Protective Services (CHIPS) cases.

In order to preserve the integrity of the child protection process, most counties provide contingency funds to support representation of parents in TPR and CHIPS cases. Unfortunately, the State statute is not clear on whether counties are obligated to fund representation of parents in these cases, and without legislative action, the system will be bogged down in litigation for a number of years. If this issue is left unattended by the 2010 Legislature, it will jeopardize child placement and parental rights.

### **General Assistance Medical Care (GAMC)**

*The MICA Board of Directors supports continued funding of General Assistance Medical Care, the state health care program that serves Minnesota's poorest and least healthy population.*

Via a veto in May 2009, funding for General Assistance Medical Care (GAMC) was eliminated, effective July 1, 2010. Through unallotment, the date was moved up to March 1, 2010.

GAMC is a state program that pays for the medical care for persons with limited income who are not able to access private medical insurance and who do not qualify for Medical Assistance (MA). Counties are responsible for administering the program. Eligible persons include:

- Any adult without children whose income is below 75% of the federal poverty guideline (\$8,123 annual income).
- Disabled people who are waiting for the federal government to approve their application for Social Security Retirement, Survivors and Disability Insurance (RSDI) or Supplemental Security Income (SSI), which can take as long as six months to a year to process.
- People with mental health or chemical dependency issues who have difficulties meeting requirements of other programs, such as MA.

While some GAMC enrollees may be eligible for MinnesotaCare, numerous barriers render MinnesotaCare inadequate in a large number of cases. These barriers include:

- MinnesotaCare requires premium payments that many enrollees cannot afford.
  - MinnesotaCare requires a 10% copayment for hospitalization (up to \$1,000 per year).
  - MinnesotaCare caps hospitalization at \$10,000 per year, per enrollee.
  - MinnesotaCare has no current month or retroactive eligibility. Under GAMC, many people become eligible when first hospitalized with a catastrophic physical or mental health condition.
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A high percentage of GAMC enrollees suffer from chronic mental health and chemical dependency issues. Eliminating GAMC will disrupt their health care coverage, including important psychotropic drug coverage. It is anticipated that these individuals will turn to the emergency room for their health care needs. It is also anticipated that these individuals will add further stress on the public safety system as law enforcement turns to county jails to care for them. Simply put, these individuals will continue to get sick and require care; the loss of state funding will shift costs to counties and local property taxpayers.

### **Access Transportation Services (ATS)**

*The MICA Board of Directors supports state funding for the administration of a statewide ATS transportation management system.*

Effective July 1, 2009, the Legislature eliminated state funding for the administration of the transportation management system for Access Transportation Services (ATS) for public health care program enrollees in 11 counties in the metropolitan area. This shifted costs in excess of \$2 million per year to the property taxpayers of these counties. In addition, in counties outside the metropolitan area, reduction in mileage reimbursement for volunteers has created a serious lack of transportation assistance and greatly increased costs for counties. The state should fund the administrative costs of a statewide ATS transportation management system to ensure consistent access to the least-costly option for transportation that is appropriate for the individual and effective oversight of provider quality.

Access transportation services are required for all MA recipients who need to obtain medical services. The federal government's Center for Medicare and Medicaid Services (CMS), recommend that states use a centralized broker to manage this service. Prior to the legislative implementation of a management system for ATS in the 11-county metropolitan area in 2005, costs had been increasing rapidly. In 2006, after the implementation of the new management system, costs had been reduced by \$4 million. The county-administered system relies on bus tokens, taxi contracts, volunteers and a paper trail to document valid rides and reimbursement to the client. It is a service that is too easily abused by recipients and transportation providers absent consistent oversight.

If a state-funded transportation management system is not implemented, counties will bear increased costs for administration at a time when they are reducing staff and resources for human services and property tax levies cannot be increased. Overall costs to the MA program for ATS will increase due to decreased oversight and increased abuse.

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