Minnesota Association of County Social Service Administrators

# Position Statement

## For 2022 Session

## State Responsibility as Safety Net Provider

### Proposal

**Issue:**

Throughout Minnesota there are significant gaps and inadequate capacity in the service system/continuum of care, for services needed to support people with complex and/or co-occurring conditions including developmental or intellectual disabilities, mental illnesses, substance use disorders, symptoms that include violent or sexually inappropriate behavior, physical health challenges, sex offender status, being held in local jails without MH treatment awaiting treatment beds, and other involvement in the legal system. These gaps can and do result in people either not receiving the services they need, accessing services outside of Minnesota or receiving a patchwork of services to attempt to meet the needs.

Minnesota's health and social services providers experience barriers to service provision that can be difficult to overcome, including the lack of qualified staff to serve a particular set of needs, the difficulty of hiring qualified staff (especially in rural areas), fear of liability, physical plant challenges, need for upfront investment in site development, and service rates that may not cover the cost of the initial investments or ongoing services. In addition, County or tribal case managers work tirelessly to try to find providers to meet the needs of individuals with complex needs. Much of the time, specialized resources are not available in local communities or even within the State.
To add to these complexities, each major mental health related service decision by the Department of Human Services has changed and impacted any existing State safety net system people in need of services and Counties and Tribes rely upon. Policy changes have come in the way of contracting authority, provider enrollment processes and Licensing regulation changes. Some examples of this are: QRTP, Competency Restoration, Contracting – Chemical Health Services, recent notification by DHS of billing for non-cooperation in treatment at CARE.

The Governor's Task Force on Mental Health (2016 Report) has identified Governance as one of the top issues to be addressed in transforming our mental health system into one that is more effective, comprehensive, understandable and accountable. Responsibility and accountability (in a State directed, County administered system) for services, funding, and quality is blurred, and there is significant variation in service availability across Counties and regions of the State. Integrated, person-centered care is difficult to achieve with many different decision-making bodies and funding sources. When the State delegates the development of services or systems of care, either explicitly or because of the absence of services, the result is a system that is inequitable throughout MN, people who are served differently throughout the State, people who must travel great distances, which doesn't align with person-centered care. For children there can be real damage and harm to their relationships with caregivers, siblings, and family systems that significantly impact their growth and development when they must be served several hours away or even several States away from their home.

In December 2018, then DHS Commissioner, issued a letter to Counties stating: "At a time when mental health services are in such high demand, it is our primary obligation to focus on the mental health treatment needs of our patients — not on their competency to be tried on criminal charges," explaining the agency's decision.
This decision exacerbates the difficulty

People qualifying for safety net services could include people currently unable to leave the Anoka Metro Regional Treatment Center, community hospitals, or the Minnesota Security Hospital because of a lack of community provider capacity as well as those who are in community-based settings, their own home or residing with family or others.

**Implementation Strategy:**

Pursue and support legislation to require the State to provide safety net services for people who are unable to be serviced by community provider capacity, who meet safety net 'criteria'. This could include people currently unable to leave the Anoka Metro Regional Treatment Center (AMRTC), Community Behavioral Health Hospitals (CBHH), Children and Adolescent Behavioral Health Hospital (CABHH), community acute care and/or psychiatric hospitals, or the Minnesota Security Hospital due to lack of community provider capacity or provider ability to provide care to people with complex needs.

Require the State to consider location and cultural needs in the establishment of these services to ensure an adequate system of care throughout the State. People should have options that do not remove them from the very social supports that are often relied upon to help them integrate back into their chosen community.
In considering safety net services, the services and proposals must include an assessment of community based and outpatient service options as well and ensure equal access to these services, including the step-down services to allow people to leave more restrictive settings when they no longer meet medical criteria.

Require an independent team composed of a combination of State/County/Private entities to determine when a someone does not meet medical criteria. This decision is currently made 100% by the State and State employed or contracted providers. Require the determination to include an assessment and recommendation of an appropriate level of care and ensure access to the services.

Request participation, County and Tribal voice, in the work to "assess State-operated direct care and treatment services to the extent to which the services function as safety net services and to make recommendations with a report required to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by October 15, 2023". If DHS does not agree to the request, pursue legislative action to require DHS to include Counties and Tribes as partners in the process.

Codify the definition of Safety Net – One such definition and resource is found in the Transitioning MSOCS Residential to a Safety Net Services Final Report 12.30.2015. Appendix 2: Safety Net Definition, Attached for reference.

## Systemic Priority Alignment (highlight all that apply and explain why)

- **Equity**
- **Integrated Services**
- **Fiscal Framework**

From the GARE Toolkit (See www.racialequityalliance.org): What are the racial equity impacts of this particular decision? Who will benefit from or be burdened by it? Are there strategies to mitigate unintended consequences?

**Comments:**

## Relevant Committee (highlight all that apply and explain why)

- **Adult Services**
- **Behavioral Health**
- **Children's Services**
- **Modernization**
- **Policy**
- **Self-Sufficiency**

**Why:**
Counties are experiencing significant difficulty in finding services for people with complex needs and who typically are difficult to serve. Without an adequate continuum of care or the State serving as a true safety net, Counties must search for services out of State.

Counties typically do not have adequate support in this work from the DHS. This spans across behavioral/mental health services, adult services, and children's services in terms of who it impacts and who we serve.
the concept and idea of a safety net and how Minnesota handles the most vulnerable people in our State is a policy issue. Minnesota has patched together a system without it being policy driven towards a system of care and continuum of care. To change this, policy factors in the various areas need to be addressed.

## Rationale/Background:

In a State directed, County administered system, the State must be the entity that provides for the safety net services for the most vulnerable adults and children residing in Minnesota.
This finding was identified in the 2013 Legislative Auditors Report and the 2015 Transitioning MSOCS Residential to a Safety Net Services Final Report 12.30.2015.

MACSSA
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