Dear Mister Chair and Members of the Committee,

Thank you for this opportunity to testify.

The February forecast states that “Growth in HHS, the second largest spending area, is responsible for 87 percent of total spending growth in FY 2018-19.” So, thank you for the decreased spending shown in the spreadsheet.

We also support the exemption to Rule 101 for rural dentists, but would like to also exempt all dentists and all physicians. Likewise, while we support the Benson exemption to the hospital moratorium, we would like the moratorium fully lifted to increase competition and decrease costs. We also support your “I am not a robot” section that withholds 2% of capitation payments until enrollees are verified. And we support the legislative control retained over 1332 and 1115 waivers.

We have a few concerns. We support the repeal of MNsure, the bureaucracy and mandates in the 13 sections in 62V, however the exchange infrastructure is being retained through the federally-facilitated marketplace. For example, on line 254.26, the bill requires incorporation of 62V.055 public program eligibility but does not appear to limit the website to public programs. It also still has the navigators, call center and Website (255.18) as well as a user fee rate that does not exceed the federal platform user fee. So, it appears Minnesotans will still be charged for the system, and that the system is still hooked up to the ACA’s Federal Data Services Hub, which connects Minnesota to data systems in the IRS, DOJ, HHS and SSA. In short, we’ll still be on the Obamacare grid.

We do not support the $4 million on line 315.32 for decreasing racial and ethnic disparities in infant mortality rates. MDH has received $2 million every year since 2005 - $24 million – without any accountability or specific requirements for use of these funds. In 2015, Chair Dean asked for an itemization of spending. The report did not itemize those expenses but instead gave an overview of initiatives such as putting systems in place to ensure that every person has “access to economic, educational and political opportunities.” The report talks about people experiencing disparities due to where roads are constructed, bank are opened and public transit funding is provided. Thus, we view this as unaccountable slush fund for the department. We want accountability required.

We would like to see a definition of Integrated Health Partnerships in the bill. (starting page 31.4) and we’re concerned that the IHP section continues data collection including race, ethnicity, social and economic factors (31.22). Also, we support direct contracting with hospitals and clinics, but have heard that the Health Care Delivery Systems demonstration project (page 35) may include health plans, which is not direct contracting.

Finally, we’re concerned about the line 61.1 mandate that home-visiting programs target mothers and children with pre-natal visits and visits through age three, as this is likely to create pressure on these families to let a government-paid worker into their home for data-collection and reporting. We count at least $17.1 million for these programs. (315.24) (316.4)

Thank you for your time and attention to these matters.