Minnesota Department of Human Services
2016 Governor's Supplemental Budget Recommendations

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Change Item Title: Increase Inpatient Psychiatric Beds within Direct Care & Treatment

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	0	32,268	40,171	39,604
Revenues	0	4,141	7,560	7,560
Net Fiscal Impact = (Expenditures – Revenues)	0	28,127	32,611	32,044
FTEs	0	370.82	370.82	370.82

Request:

Effective July 1, 2016, the Governor recommends increased funding to expand the capacity of state-operated mental health hospital services and to more appropriately and effectively utilize these services. This will be accomplished in the following ways: (1) developing a stand-alone Competency Restoration Program (CRP) to free up beds at Anoka Metro Regional Treatment Center (AMRTC) that are currently occupied by people who need competency restoration but not a hospital level of care; (2) provide funding to increase staff at state-operated hospitals in order to utilize currently licensed but unfunded beds; (3) provide a county cost of care share for individuals in the Community Behavioral Health Hospitals (CBHHs) that do not meet hospital level of care criteria; (4) provide funding to increase clinical oversight at AMRTC, create a nursing float pool and implement the Systems Improvement Agreement (SIA) in response to Centers of Medicare and Medicaid Services (CMS) citations at AMRTC, and (5) provide funding to increase Direct Care and Treatment (DCT) Operations Support Services to ensure compliance with quality standards as well as licensing and accreditation.

Proposal:

Minnesota continues to have waiting lists for psychiatric beds across the state. This is even more significant at state-operated facilities, which are the primary provider responsible for mental health safety net services. The elements of this proposal are based upon an examination of the current direct care services provided by the Department of Human Services (DHS) and stakeholder feedback about key points in the continuum of care where Minnesotans "get stuck." The Governor proposes several, inter-dependent changes, to maximize effective use of scarce state-operated psychiatric hospital beds.

Anoka Metro Regional Treatment Center (AMRTC) has been significantly affected by the 48-hour rule. This statute, passed in 2013, requires that anyone in a jail who meets the criteria for civil commitment must be transferred to a psychiatric facility within 48 hours. The pressure for hospital beds also increased as Minnesota (and many other states) has experienced a significant rise in requests for evaluations to determine if defendants are competent to stand trial (referred to as "Rule 20"). These additional evaluations place an even heavier burden on Minnesota's system because of our state Court Rules of Criminal Procedure. In Minnesota, for any defendant ruled incompetent, civil commitment proceedings must be initiated. This has resulted in a significant demand for admission to the Competency Restoration Program (CRP). CRP serves adults who have been charged with a crime, but whose mental illnesses or cognitive limitations prevents them from participating effectively in their legal proceedings. CRP was transferred from AMRTC to the Minnesota Security Hospital (MSH) in 2008. But even after expanding the CRP in MSH in 2010, the demand was so high, that additional referrals for competency restoration have been admitted to AMRTC. AMRTC averages about 25-30 people in CRP at any given time.

To address this latter pressure, the Governor seeks to restructure CRP into a model which serves people at the level of care they need, rather than what is available. To accomplish this, a third level of state-operated CRP care will be created for individuals needing to be restored to competency. The three levels will include hospital level of care when clinically indicated (located at AMRTC), a secure setting for restoration (located at MSH) and a third level, which does not currently exist, in a locked community residential setting. This third level of care is where the greatest need exists and would greatly reduce the reliance on AMRTC and would free-up much needed hospital beds. Currently, having only two options (AMRTC and MSH) often places the state in conflict with Olmstead principles and unnecessarily spends state funds on more expensive services than people may need, while others in need of these hospital services remain on lengthy waiting lists.

With regard to other state-operated hospital beds, the Community Behavioral Health Hospitals (CBHH) have had to limit the number of people they serve so the facilities operate within the level of appropriated funds. This lack of funding has limited the hours that active treatment is available. Engaging individuals with the appropriate active treatment helps them to move through the treatment process and on to the next level of care. In order to fully use the capacity of the CBHHs, while providing more active treatment, the Governor

recommends increased funding that would allow six of the current seven CBHHs to operate at full bed capacity (16 beds), allowing the programs to increase active treatment hours and improve the safety of patients and staff.

This proposal includes closing the seventh CBHH program in St. Peter and moving the St. Peter Community Additions Recover Enterprise (C.A.R.E) program into this leased facility. Then the former St. Peter C.A.R.E. site will be repurposed as a new stand-alone community residential locked CRP site. CRP patients from AMRTC and MSH will transfer to the new CRP program in St. Peter. This will free up approximately 20 hospital beds at Anoka and 10 secure beds at MSH.

As the CRP capacity at MSH is lowered, current CRP staff (FTEs) will be redirected to serve a small number of individuals with developmental disabilities, autism-spectrum disorders, and other significant cognitive limitations admitted to MSH. The needs and treatment modalities are different for individuals with cognitive impairments, so placement on traditional secure treatment units, designed for individuals experiencing primary mental health disorders, may not only be counter-therapeutic, the environment may exacerbate aggressive or destructive behaviors. Specifically, the size, activity, and climate of a traditional unit may lead to overstimulation and decrease behavioral controls. As a result, a significant proportion of the aggressive incidents at MSH that have occurred, involved some of these individuals and were likely related to the unavailability of more appropriate therapeutic living spaces and staff specialized in assessment and interventions with this population. In an attempt to provide a safe environment, in lieu of having the needed environment, staff, and programming for clients and staff, some of these individuals have been placed on constant 1:1 or even 2:1 supervision.

In addition to providing treatment for people in the most therapeutic but least restrictive setting, this proposal also results in a financial incentive for transitioning individuals out of levels of care they no longer need. Currently, the county share of the cost of care is 100% for individuals who do not need a hospital bed but who are participating in restoration services at AMRTC. If these same individuals receive services at the new residential locked CRP facility, the county share for the cost of care will be 20% while the person is in need of restoration services. This share increases to 50% and 100% for continued admission when the person is no longer in need of restoration services (e.g. evaluation has been submitted to the court), or the charges have been resolved or dropped, respectively.

While these steps increase the “potential” for increased capacity, full capacity is still unattainable if DHS cannot recruit and retain professional clinical staff. This is particularly true in the case of prescribing and nursing staff. To lessen attrition of these essential staff, new funding is being requested to provide tuition reimbursement requiring some level of commitment for continued employment in a direct service capacity.

All of the above recommendations focus on front-end access to state-operate hospital beds. However, there are also significant challenges on the “back end” of the process. Specifically, there continues to be an increase in the number of individuals who complete treatment at the CBHHs and no longer need hospital level of care but remain in a CBHH, due to lack of discharge placement options. When an individual no longer meets criteria for a hospital level of care, the stay is no longer covered by insurance and becomes billable only to the individual client. In most cases the person is committed to the Commissioner but as the CBHHs do not fall under the current county liability statute there is no cost to the county for the stay. This proposal recommends increasing the county share of the cost of care at the CBHHs to 100%, starting on the day the client no longer meets hospital level of care criteria. This change creates consistency in the county share across state-operated adult psychiatric hospital beds whether they are at CBHHs or AMRTC, which already uses this statutory model for cost of care.

Furthermore, this proposal also requires the state to partner with the counties to help remove barriers and identify options for clients that can leave hospitals and move to more integrated, community based placements. For example, patients civilly committed only to the Commissioner of Human Services have to be placed on a provisional discharge by a state-operated program clinician. This means the patient either has to be admitted into a state-operated program for treatment until they meet the criteria for a provisional discharge or be assessed and placed on provisional discharge remotely by state-operated clinical staff. Due to the decreased capacity in state-operated programs, more patients committed only to the Commissioner are receiving care and treatment in non-state-operated programs (e.g. community and county hospitals). These patients, however, remain under commitment to the Commissioner of Human Services. Therefore when a bed becomes available in a state-operated program, frequently the patient may be transferred to a facility for the primary purpose of developing a discharge plan. This is despite the fact the person may no longer need the level of care provided in the state-operated program and in some cases there is even a less restrictive option available. However, current statute does not allow the treating facility or the designated agency to provisionally discharge a client under civil commitment to the commissioner. To remove this barrier, the Governor is recommending a change in statute authorizing the designated agency to develop the aftercare plan and notify the court of the provisional discharge when the patient does not require the level of care provided in a state-operated program. This proposed change would allow the designated agency and the treating facility the ability to create and implement a person’s aftercare plan without the involvement of state-operated program staff. The patient would remain under civil

commitment to the Commissioner but would be placed on a provisional discharge so he or she can continue to receive services in the community in a less restrictive setting.

DHS held a series of regional stakeholder listening sessions in 2015. The primary goal of these listening sessions was to understand stakeholders' perspectives on "what is working, what is working but needs adjustment, and what is not working" with regard to DHS as a direct care provider. A frequent topic was the Centralized Pre-Admission Process (CPA) which is the admission entry point to access state-operated services, except in the case of MSOP. Many people said the model "works" but that the wait time for this process was too long which adversely impacted the effectiveness of this resource. CPA is gradually being implemented for all state-operated programs. In the coming year, CPA will begin to manage referrals and admissions for Community-Based Services programs (e.g., MSOCS, MN Life Bridge). This will place even greater demands on this critical entry-point into safety net services. This proposal recommends funding two FTEs to work in CPA, serving as direct resources for county and private providers.

This proposal also adds staff necessary to increase and support the delivery of quality clinical care. Specifically, staff resources are requested to enhance measurement and monitoring in quality assurance, strengthening clinical oversite and direction, and creating a direct care float pool to assure sufficient staff availability without using overtime. Funding is also requested to comply with the recent System's Improvement Agreement (SIA) with CMS.

Rationale/Background:

There continues to be waiting lists and lack of psychiatric beds throughout the state especially for individuals with acute mental health needs who engage in aggressive, and sometimes violent, behavior. People experiencing this level of clinical complexity are primarily served in state operated facilities. However, these facilities have had to reduce available bed capacity due to insufficient resources needed to maintain staffing levels for safe and quality care. AMRTC and the CBHHs are now primarily admitting individuals that have been civilly committed, and none of these state facilities has capacity to accept individuals on hold orders or voluntary admissions. This has resulted in backups of individuals waiting in emergency rooms and other locations not designed to provide the level of care needed. Some stakeholders have reported the current statewide bed crisis has created an unintended consequence. Specifically, in desperation to obtain safety net services for people in acute need, some providers are seeking civil commitment as a way to access services.

Based on feedback obtained during the regional stakeholder listening sessions, there are questions as to whether private providers would be interested in operating the current hospital capacity provided by the CBHHs. To determine the interest of the private providers, the Commissioner will issue a Request for Information (RFI). Specific requirements for who is served by the facilities would need to be included to assure that individuals committed to the Commissioner continue to be admitted to the facilities within the current legal requirements. In alignment with this proposal, DHS will seek direction from the Legislature regarding the long range plan for CBHHs and whether they should remain as state operated facilities or if they should be operated and managed by private or local government agencies and if so how they would be funded for non-covered services provided by these entities.

Fiscal Impact:

The net cost to create the CRP program and increase accessibility of 20 psychiatric beds at AMRTC is $6.3 million in FY17 and $7.5 million annually in FY18 and FY19. The net cost includes: operating cost for the new residential CRP, one-time physical plant upgrades to both the C.A.R.E. and CRP site, net operating savings from closing the St. Peter CBHH, revenue from the new CRP, and lost revenue at AMRTC due to no longer being able to bill 100% for the 20 or so CRP clients that do not need hospital level of care.

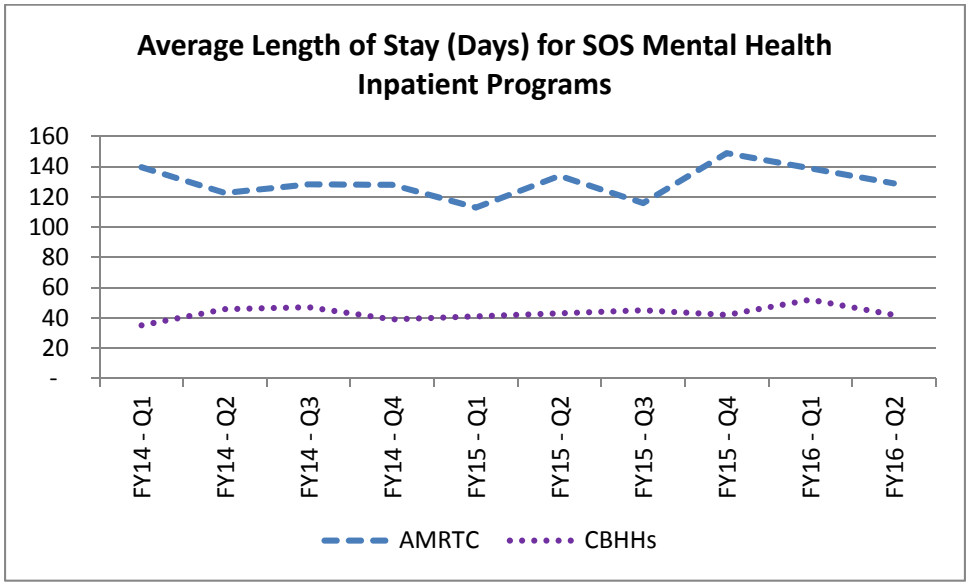
The net cost to increase accessibility of psychiatric beds within the CBHHs is $13.7 million in FY17 and $16.5 million annually in FY18 and FY19. The net cost includes: salary and benefit costs for 239.97 FTEs, non-salary costs (food, drugs, medical supplies, etc.) associated with serving additional clients, security and technology system upgrades at each CBHH site, a tuition reimbursement pool and an increase in revenue collected due to an increase in the per diem rate billed (result of increased operating expense) as well as an increase in revenue from billing for the new 100% county share for clients no longer meeting hospital level of care criteria.

The net cost to enhance clinical oversight and create a float pool at AMRTC is $4.7 million in FY17, $5.1 million in FY18 and $4.5 million in FY19. The net cost includes: salary and benefit costs for 33.0 FTEs, one-time and on-going contract cost associated with the Anoka Systems Improvement Agreement, and an increase in revenue collected due to an increase in the per diem rate billed (result of increased operating expense).

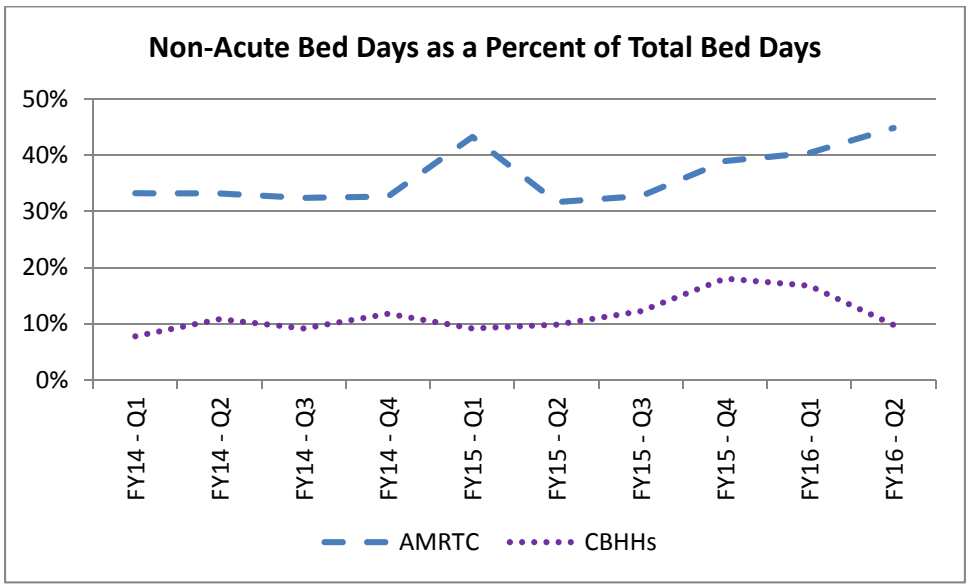
The net cost to increase DCT Operations Support Services is $3.4 million in FY17 and $3.6 million on-going. The net costs includes: salary and benefit costs for 38.0 FTEs.

Results:

We measure success by the reduction in the length of stay in our inpatient programs. Shorter lengths of stays give clients a greater chance to retain their community support services and living arrangements. The increase in length of stay is related to challenges in finding a community placement when a client is ready to be discharged.



Another measure of success is the reduction of non-acute bed days. A non-acute bed day is a day spent in the hospital when the client no longer needs that level of care. When a client does not need hospital level of care but cannot be discharged, it restricts the system flow, is costly and causes other clients who need hospital level of care to remain on the waiting list. Our goal for inpatient services is that only 10% of total bed days are classified as non-acute bed days.



Statutory Change(s):

Minnesota Statute 253B.15 Provisional Discharge, Partial Institutionalization. 253B.16 Discharge of committed persons

Fiscal Detail:

Net Impact by Fund (dollars in thousands)	FY 16	FY 17	FY 16-17	FY 18	FY 19	FY 18-19
General Fund		$28,127	$28,127	$32,611	$32,044	$64,655
HCAF						
Federal TANF						
Other Fund						

Total All Funds				$28,127	$28,127	$32,611	$32,044	$64,655
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	61	SOS Mental Health Svcs		25,704	25,704	31,788	31,221	63,009
GF	63	SOS Forensic Svcs		6,564	6,564	8,383	8,383	16,766
GF	Rev2	SOS Cost of Care Recoveries		(4,141)	(4,141)	(7,560)	(7,560)	(15,120)
Requested FTE's								
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	61	SOS Mental Health Svcs		297.12		297.12	297.12	
GF	63	SOS Forensic Svcs		73.70		73.70	73.70	

Change Item Title: Minnesota Security Hospital Staffing for Improved Client Care & Staff Safety

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	0	24,515	35,591	49,090
Revenues	0	2,224	3,267	4,779
Net Fiscal Impact = (Expenditures – Revenues)	0	22,291	32,324	44,311
FTEs	0	116.87	212.37	335.07

Request:

Effective July 1, 2016, the Governor recommends increasing the base funding for Direct Care & Treatment (DCT) State-Operated Forensics Services to increase clinical direction and support to direct care staff treating and managing clients with clinical complexity, some of whom engage in aggressive behaviors. Additional funding is also requested to enhance the current staffing model to achieve a safe, secure and therapeutic treatment environment that provides the appropriate level of care to the individuals served.

In 2015, Governor Dayton requested the Bureau of Mediation Services (BMS) facilitate a process to develop solutions for issues of patient care, staff safety, and labor-management relations to create an effective communication and structure for on-going collaborative problem solving. During this collaborative process, small work groups focused on Resident Appropriateness, Application of Person-Centered Principles & Safety, Staffing, Communication, and Organizational Wellness. These groups identified and made recommendations for needed policy and legislative changes, and an independent evaluation of current staffing resources. This group also provided recommendations to help meet the clinical needs for patients ensuring a safe working environment for the patients and staff. This proposal is based on the collaborative recommendations of the full (e.g. labor and management partners) BMS group.

Proposal:

This proposal requests funding for significant and sustained investments in clinical resources, tools for building a skilled workforce, and supervision and training of new skills and techniques related to incidents and safety within Minnesota Security Hospital (MSH). This proposal is crucial in addressing chronic underfunding and remedying staffing imbalance.

Specifically, funding is needed to address the following areas:

1. Fund current positions that are already filled but were “unfunded” during approval of Forensics budget last year;
2. Increase staffing levels to enhance safety, evaluation, and treatment. In particular, to expand programming beyond the Monday through Friday business model;
3. Increase the number of mental health practitioners and medical staff to achieve a staff to patient ratio that is consistent with forensic psychiatric facilities across the nation;
4. Implement a utility pool to allow flexibility to meet dynamic staffing needs in order to reduce overtime;
5. Establish a positive behavior support expert team consisting of a psychologist and three behavior analysts;
6. Ensure compliance with the statutory mandate requiring individuals committed as mentally ill and dangerous to be reviewed by the Special Review Board every three years, and to comply with the mandated MN Rule to use Positive Support strategies with developmentally disabled individuals;
7. Hire administrative leadership necessary to guide and support staff and to lead quality and performance improvement, and provide clinical direction;
8. Establish an occupational health presence on campus.
9. Develop a specialized unit to assist with developmentally delayed patients;
10. Hire HR support personnel on campus to assist with recruitment, retention, and overall employee relations;
11. Reduce amount of non-clinical work done by nursing and other clinicians in order to meet mandates and licensing regulations, including but not limited to documentation and notifications for compliance purposes;
12. Develop recruitment and retention incentives to be more competitive with industry standards, including but not limited to: continuing medical education, loan and tuition reimbursement and hiring bonuses;
13. Provide additional resources to maintain the campus facilities and grounds;

14. Establish a training fund to enhance safety and regulation compliance; and
15. Fund a support program for staff who have been assaulted at work.

Rationale/Background:

The requested funding is essential and without these investments, we can expect to see the following challenges continue:

- Inability to reduce staff workplace injuries;
- Continued high rates of overtime;
- Continued staff burn out, turnover;
- Inability to retain qualified personnel with competitive salaries;
- Inability to recruit qualified personnel with standard recruitment and retention incentives;
- Inability to maintain and develop vital security system infrastructure;
- Inability to meet the demands of the legislative mandates, such as Positive Support Rule and mandated Special Review Board three year review;
- Falling short of our commitment to the State of Minnesota to provide treatment services to our patients; and
- Continued citations from licensors and regulators.

Description of Services

Forensic Services provides state of the art, evidenced-based treatment for individuals with complicated diagnoses who have typically been involved in the criminal justice system. Many of the individuals served have experienced multiple treatment failures and/or can no longer be accepted for treatment in less restrictive settings. Forensic Services provides treatment in a secure setting to assist patients in recovery with the ultimate goal of a community placement and a meaningful life.

The complexity of patients' mental health, and associated illness such as chemical dependency, cognitive disabilities, personality disorders, and often multiple medical health issues, requires a professionally trained staff from a variety of clinical backgrounds. Provision of therapeutic treatment has to be driven from clinical staff who understand complicated co-morbid conditions. The best clinical practices to serve patients with illnesses of this acuity strongly suggests that in order for treatment to be effective, it must be individualized and comprehensive.

Staff who provide the 24/7 direct care must constantly enhance their skills while working with complex individuals. There is a high need for training to build proficiency in de-escalation, intervention, and engagement that leads to treatment recovery.

Comparison to Like-Facilities

When Forensic Services is compared to similar forensic facilities nationally, it is clear appropriate funds have not been dedicated to staffing in Minnesota.

Organization	Licensed Beds	Total Staff	Staff to Patient Ratio
Oregon State Hospital	540	1800	3.3 staff for every 1 patient
Fulton State Hospital	401	1345	3.3 staff for every 1 patient
Forensics (Current)	395	796.67	2 staff for every 1 patient
Forensics (Proposed)	395	1,131.71	2.86 staff to every 1 patient

Current and Historical Funding

This proposal also includes dollars to fund already filled/existing positions that were not funded during the approval of the Forensic FY16 budget (to align staffing with actual appropriations, some positions were held vacant while others will filled based on needs and existing staffing).

Forensics has not been appropriately funded to adequately carry out treatment services or maintain operations on campus for many years. From FY13 to FY15, the appropriation remained stagnant and was not adjusted legislatively to account for approved salary and cost of living increases. In FY16, the Forensic base budget was increased to meet immediate demands due to legislative mandates and conditional license requirements. This increase did not take into consideration the dire need for additional staff, nor the ongoing cost of living increases.

Fiscal Year	Annual Appropriation	Actual Expenditures	Budgeted FTEs	Paid FTEs	Overtime FTEs
2013	$69,582,000	$70,483,427	754.09	727.36	26.76
2014	$69,582,000	$77,560,997	792.41	775.82	27.57
2015	$69,582,000	$83,089,310	754.09	773.21	39.88
2016	$81,821,000	$85,535,857	796.66	765.79	42.77

NOTE: FY2016 as of 12/24/2015. Paid FTEs and Overtime FTEs calculated based on total hours for the fiscal year divided by 2088. FY2016 Expenditures is the Forecasted Balance as of 11/30/2015

There are three major factors which are currently projecting Forensics to be $3 million over budget by fiscal year end: non-budgeted salary increases, insurance increases, and overtime expenses.

Historically, Forensics has spent, on average, $2.3 million annually for overtime. In FY2016, $885,001 was budgeted for overtime. As of December 1, 2015, Forensics has surpassed the annual budget and expended $1,574,669 in overtime. There have been measures put in place to work towards reducing overtime hours, however, it is unlikely a reasonable overtime expense allocation will be achieved until there is an increase in the staffing complement.

The below table represents year to date overtime dollars and FTE for FY16.

Overtime	July	August	September	October	November
FTE	48.66	44.96	44.63	47.85	37.05
Dollars	303,259	293,199	303,259	407,993	266,959

Recruitment and Retention Considerations:

It is becoming increasingly difficult to both recruit and retain staff. Issues contributing to poor retention include the amount of overtime, especially forced overtime, and continued additional responsibilities to meet legislative mandates without additional staffing resources. These factors as well as the difficult work contribute to an overall staff burnout, negatively impacting retention.

Recruitment has been a challenge and there are a variety of positions that are increasingly difficult to fill. Examples of these include nurses, security counselors, recreational program assistants, and mental health professionals including psychiatric practitioners and psychologists.

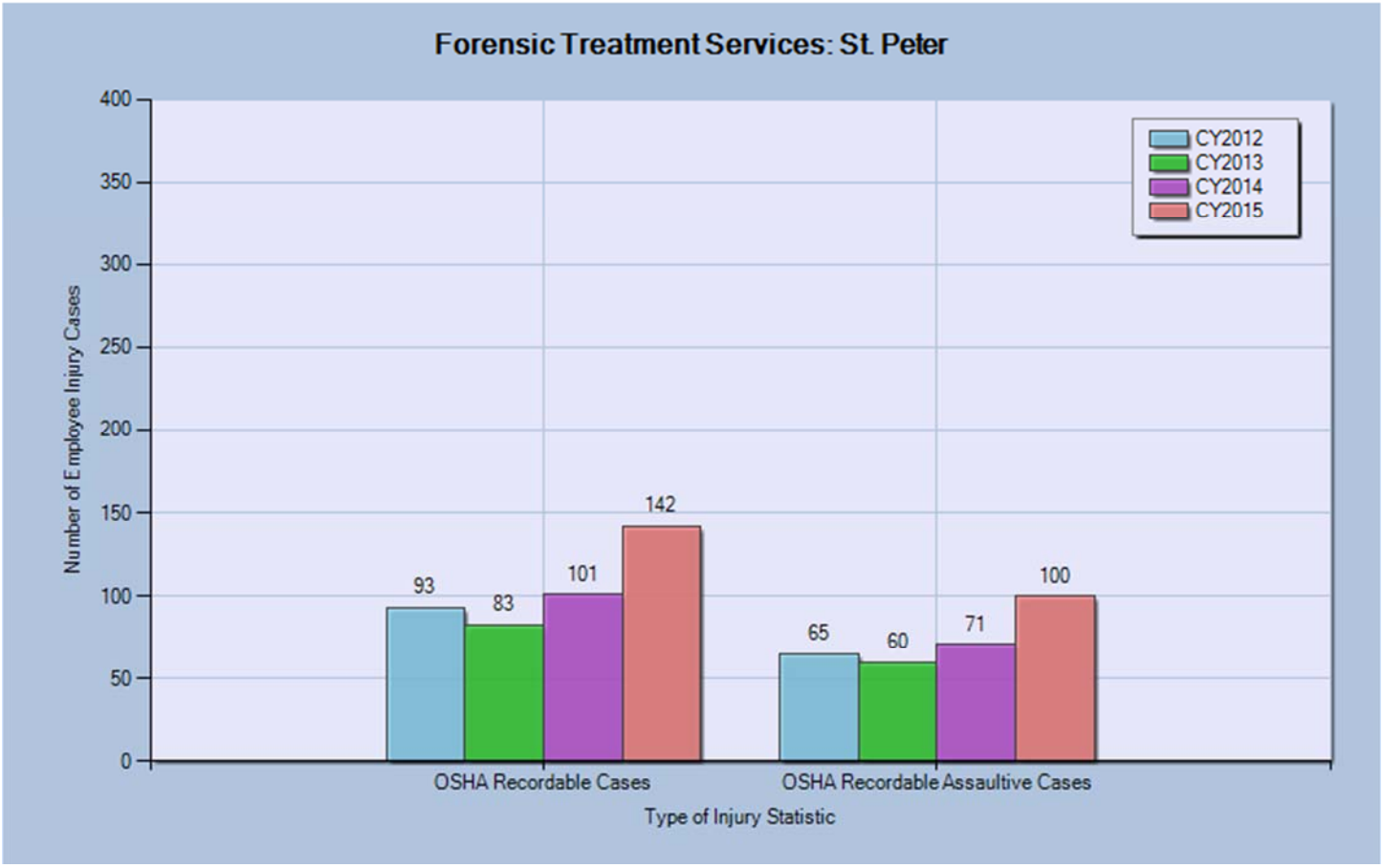
In order to recruit and retain staff, Forensics must offer competitive incentives such as hiring bonuses, loan and tuition reimbursement, and dollars towards continuing education. Currently, Forensics is unable to compete with recruitment and retention efforts of other health care or secure treatment providers. This results in a chronic challenge in attracting and retaining qualified candidates, even when positions are funded. It is crucial that both the needed positions are funded but that the state also make investments in the tools needed to build and sustain a skilled workforce.

Fiscal Impact:

This request increases the 2017 base funding for Forensic services by 26.7% to provide additional staff in the SOS Forensic Service programs as well as non-salary expenses to lease Omni Cells (automated medication dispensing equipment) and contract with local jails. Also included in this request is one-time non-salary expense for needed furniture/equipment replacement.

Results:

One measure of safety is the number of recordable injuries or illnesses reported to the federal Occupational Safety Health Administration (OSHA). As you can see from the chart below, the number of recordable incidents has increased significantly in calendar year 2015. Many efforts are underway at MSH to lower the number of incidents.



OSHA Recordable Cases: An injury or illness is considered to be OSHA Recordable if it results in any of the following:

- Death, days away from work, restricted work or transfer to another job, medical treatment beyond first aid (see below for first aid definition), or loss of consciousness.
- A significant injury or illness diagnosed by a physician or other licensed health care professional, even if it does not result in death, days away from work, restricted work or job transfer, medical treatment beyond first aid, or loss of consciousness.
- Injuries include cases such as, but not limited to, a cut, fracture, sprain, or amputation.
- Illnesses include both acute and chronic illnesses, such as, but not limited to, a skin disease (i.e. contact dermatitis), respiratory disorder (i.e. occupational asthma, pneumoconiosis), or poisoning (i.e. lead poisoning, solvent intoxication).
- OSHA's definition of work-related injuries, illnesses and fatalities are those in which an event or exposure in the work environment either caused or contributed to the condition. In addition, if an event or exposure in the work environment significantly aggravated a pre-existing injury or illness, this is also considered work-related.

Aggressive Behavior: A disabling injury stemming from the aggressive and/or intentional and overt act of a person, or which is incurred while attempting to apprehend or take into custody such person.

Statutory Change(s): None

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 16	FY 17	FY 16-17	FY 18	FY 19	FY 18-19
General Fund			$0	$22,291	$22,291	$32,324	$44,311	$76,635
HCAF								
Federal TANF								
Other Fund								
Total All Funds			$0	$22,291	$22,291	$32,324	$44,311	$76,635
Fund	BACT#	Description	FY 16	FY 17	FY 16-17	FY 18	FY 19	FY 18-19

1000	63	SOS Forensic Services		22,240	22,240	32,666	47,790	80,456
1000	62	SOS Enterprise Svcs – MSOCS		2,275	2,275	2,925	1,300	4,225
1000	Rev2	SOS Cost of Care Receipts		(2,224)	(2,224)	(3,267)	(4,779)	(8,046)
		Total		22,291	22,291	32,324	44,311	76,635
Requested FTE's								
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
1000	63	SOS Forensic Services		116.87	116.87	212.37	335.07	335.07

Change Item Title: Minnesota State Operated Community Services (MSOCS) Structural Deficit

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	0	28,000	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	28,000	0	0
FTEs	0	0	0	0

Request:

Effective July 1, 2016, the Governor recommends appropriating $14 million from the General Fund in FY 2017 to replenish funds transferred from the Direct Care and Treatment (DCT) mental health budget activity to cover FY 2016 operating expenses of the DCT Minnesota State Operated Community Services (MSOCS) program. The Governor also requests a one-time General Fund appropriation of $14 million to the DCT MSOCS program to ensure sufficient operating funds for fiscal year 2017. This request fills a gap of 14.4% between the cost of operations and the revenue generated by the program.

Proposal:

MSOCS has seen a steady erosion of its cash balance during the past few years and most recently in fiscal year 2015 requiring additional funds to balance out the fiscal year. Operating costs for the program have continued to increase at a pace faster than rates for the program. Negotiated bargaining unit increases have resulted in significant cost increases to the program but are not the only factor. Start-up costs for new placements, vacancies in homes that reduce revenue but not costs and staff turnover have all contributed to the problem.

As a provider of services, MSOCS needs to be able to pay for services provided to the individuals served. Current revenues received are insufficient to cover all costs for staff payroll, leases, utilities, client payroll, food and household needs including upkeep to the facilities. To assure on-going operations, DHS used current authority and transferred funds from the fiscal year 2017 DCT Mental Health appropriation to pay for MSOCS's fiscal year 2016 expenses. This proposal requests replenishing funds for DCT Mental Health programs for FY2017 to assure sufficient funds for operations. The proposal also provides needed one-time funding to ensure sufficient operating funds through the end of the 2016-2017 Biennium while the department redesigns the program.

Ongoing planning to redesign the MSOCS program is occurring but it will not result in decreased costs/revenue increases for the current biennium. The department will bring forward the redesign plan during the next biennial budget session.

Rationale/Background:

Minnesota State Operated Community Services (MSOCS), which is part of Community Based Services within Direct Care and Treatment, provides residential and vocational support services for people with disabilities. Services include:

- Adult Foster Care with a current average daily census of 357
- Five Crisis Residential sites with a capacity of 4 beds per site;
- Fifteen Intermediate Care Facilities for individuals with Developmental Disabilities with a current average daily census of 75
- Vocational Services currently serving 725 individuals in 18 sites and in the community

The role of MSOCS as a service provider has been evolving over the past few years to increase the focus on people requiring safety net services, which are currently unavailable in the community. Individuals who are currently in the program are being assessed to determine if they meet the criteria for needing safety net services delivered by DHS. If they do not meet this criteria and/or other similar services are available in the community, they have been and will continue to be transitioned to other providers. As this transition is evolving, MSOCS has been left with vacancies that have reduced revenues at a different rate than expenses, which has resulted in a financial loss overall to the program, currently projected at $14 million for fiscal year 2017.

Below are several factors that have converged to create a need for a more focused vision for MSOCS.

- A 2013 Legislative Auditor's Report recommended that DHS focus state-operated programs on "safety net" supports for those individuals whose needs could not be met by existing community resources.
- The "48-Hour Law" requires that individuals who are in jail and are committed to the Commissioner of DHS be admitted to an appropriate treatment or residential setting suitable to meet their needs within 48 hours.
- A significant portion of the individuals whom MSOCS currently serves could be served by private community providers.
- The federally required implementation of the Rate Management System (RMS) resulted in rate reductions over a 5-year period. While rates were cut, MSOCS' costs of operating the residential programs increased due primarily to increased labor costs.

In April 2015, the Commissioner of Human Services appointed a committee of stakeholders to inform changes to MSOCS. The recommendations of the group looked at the most person-centered and effective staging for changes in the program. DCT will use these recommendations to aid the redesign of the MSOCS program to align with the state's Olmstead Plan and target existing gaps in community support services refocusing state resources on supporting individuals in need of "safety net services."

Fiscal Impact:

This proposal would replenish the DCT Mental Health FY2017 funds used to support MSOCS during FY2016. It also fills the $14 million gap between the cost of operating MSOCS and the revenue generated by the program in FY 2017.

Statutory Change(s):

Rider

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
General Fund				$28,000	$28,000	0	0	0
HCAF								
Federal TANF								
Other Fund								
Total All Funds				$28,000	$28,000	0	0	0
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	61	SOS Mental Health Svcs		14,000	14,000	0	0	0
GF	62	SOS Enterprise Services – MSOCS		14,000	14,000	0	0	0
Requested FTE's								
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
				0	0	0	0	0

Change Item Title: State Operated Services (SOS) Operating Adjustment

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	3,456	6,190	8,228	8,228
Revenues	534	1,052	1,438	1,438
Net Fiscal Impact = (Expenditures – Revenues)	2,922	5,138	6,790	6,790
FTEs Maintained	38.44	67.54	89.23	89.23

Request:
Effective the day following enactment, the Governor recommends increasing general fund base funding for the Department of Human Services Direct Care and Treatment (DCT) State Operated Services (SOS) Mental Health and Forensic Services programs by $9.6 million for the 2016-17 biennium.

Proposal:
The Governor recommends increasing the SOS Mental Health and Forensic Services appropriations by the amount needed to cover compensation-related costs associated with delivering direct care services. This increase will provide the ongoing resources SOS needs to manage the additional 0.7% annual compensation increase negotiated over the 1.8% provided through the 2015 Legislative session. This proposal also requests an additional $4.6 million in resources to cover the employer share of the State Employee Group Insurance (SEGIP) increases of 6.93% in fiscal year 2016, 9.55% in fiscal year 2017 and 9.14% in fiscal year 2018. In addition, this proposal seeks resources for increased pension costs that have occurred, which are above and beyond the available funding. The cost of this recommendation is partially offset by cost of care recoveries, resulting in a net general fund impact of $8.0 million in the FY2016-17 biennium.

Rationale/Background:
Each year compensation costs rise due to growing insurance costs, non-discretionary step increases, and other items such as the labor contract settlements for FY2016 and FY2017, and the recent increase in the state share of pension obligations. While SOS appropriated programs received funding in FY2015 for a 1.8% anticipated salary increase, the actual increase was 2.5% per year. These programs also did not receive funding for growing insurance costs, non-discretionary step increases or the increase to the state share of pension obligations.

As a direct care service provider, personnel costs comprise approximately 82% of the total operating costs of these SOS programs. When faced with costs outside its control, the only recourse SOS has is to hold staff positions open, which reduces a program's ability to serve clients.

Fiscal Impact:
This request requires on-going funding to support the increase in salary and benefit costs for more 2,000 employees working in the SOS Mental Health and Forensic Services programs.

Results:
This additional funding will allow SOS to continue to serve approximately 2,800 individuals per year in state facilities and programs, while maintaining 67.54 FTEs as of FY 2017, as displayed in the above table. If SOS Mental Health and Forensic Services do not receive this funding increase, the Department will be faced with not filling direct care staffing positions and reducing the number of individuals served or restricting which individuals can be served. Priority will be focused on services that promote public safety (Forensics), commitments (Anoka), and community alternatives to institutional care.

Statutory Change(s):
Rider language

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 16	FY 17	FY 16-17	FY 18	FY 19	FY 18-19
General Fund			$2,922	$5,138	$8,060	$6,790	$6,790	$13,580
HCAF								
Federal TANF								
Other Fund								
Total All Funds			$2,922	$5,138	$8,060	$6,790	$6,790	$13,580
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	61	SOS Mental Health Services	1,256	2,888	4,144	4,105	4,105	8,210
GF	63	SOS Forensic Services	2,200	3,302	5,502	4,123	4,123	8,246
GF	REV2	SOS Cost of Care Recoveries	(534)	(1,052)	(1,586)	(1,438)	(1,438)	(2,876)
Preserved FTEs								
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
	61	SOS Mental Health Services	12.33	28.36		40.31	40.31	
	63	SOS Forensic Services	26.11	39.18		48.92	48.92	
		Total	**38.44**	**67.54**		**89.23**	**89.23**	

Change Item Title: Minnesota Sex Offender Program Operating Adjustment

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	3,395	4,669	5,457	5,457
Revenues	509	700	819	819
Net Fiscal Impact = (Expenditures – Revenues)	2,886	3,969	4,638	4,638
FTEs Maintained	27.58	41.38	51.68	51.68

Request:
Effective the day following enactment, the Governor recommends increasing the general fund base funding for the Department of Human Services Direct Care and Treatment (DCT) Minnesota Sex Offender Program (MSOP) by $8.1 million for the 2016-17 biennium. The increase is for compensation related costs associated with delivering services.

Proposal:
The Governor recommends increasing the MSOP appropriations by the amount needed to cover compensation related costs associated with delivering direct care services. This increase will provide the ongoing resources MSOP needs to manage the additional 0.7% annual compensation increase negotiated over the 1.8% provided through the 2015 Legislative session. This proposal also requests an additional $1.8 million in resources to cover the employer share part of the State Employee Group Insurance (SEGIP) increases of 6.93% in fiscal year 2016, 9.55% in fiscal year 2017 and 9.14% in fiscal year 2018. In addition, this proposal seeks resources for increased pension costs that have occurred, which are above and beyond the available funding.

This proposal also requests funding for 1) minimum wage increases for MSOP clients employed in vocational programming, 2) contract costs for a medically fragile client requiring 24-hour a day monitoring while on a ventilator, and 3) costs associated with transporting and supervising an aging population needing to visit the local hospital for medical services.

The cost of this proposal is partially offset by cost of care recoveries, resulting in a net state share of $6.9 million in the FY2016-17 biennium.

Rationale/Background:
Each year compensation costs rise due to growing insurance costs, non-discretionary step increases, and other items such as the labor contract settlements for FY2016 and FY2017, and the recent increase in the state share of pension obligations. While MSOP appropriated programs received funding in FY2015 for a 1.8% anticipated salary increase the actual increase was 2.5% per year. These programs also did not receive funding for growing insurance costs, non-discretionary step increases or the increase to the state share of pension obligations.

As a direct care service provider, personnel costs comprise approximately 78% of the total operating costs of the MSOP. When faced with costs outside its control, the only recourse MSOP has is to hold staff positions open which reduces a program's ability to serve clients.

Fiscal Impact:
This request requires on-going funding to support the increase in salary and benefit costs for more than 800 employees working in the MSOP programs.

Results:
Funding this proposal ensures the program can maintain appropriate staffing levels so the current levels of sex offender treatment, clinical services, and vocational programming are not interrupted or decreased. This additional funding will allow MSOP to continue to serve the 722 clients in the program while maintaining the 41.38 FTEs displayed in the Fiscal Impact table above.

MSOP would have to reduce its complement of security or clinical staff by a significant number by the end of the FY 2016-17 biennium if this recommendation is not funded.

Statutory Change(s):

This proposal will require a rider.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 16	FY 17	FY 16-17	FY 18	FY 19	FY 18-19
General Fund			$2,886	$3,969	$6,855	$4,638	$4,638	$9,276
HCAF								
Federal TANF								
Other Fund								
Total All Funds			$2,886	$3,969	$6,855	$4,638	$4,638	$9,276
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	71	MSOP	3,395	4,669	8,064	5,457	5,457	10,914
GF	REV2	Cost of Care Recoveries	(509)	(700)	(1,209)	(819)	(819)	(1,638)
		Total	2,886	3,969	6,855	4,638	4,638	9,276
FTE's Preserved								
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	71	FTEs Maintained	27.58	41.38	41.38	51.68	51.68	51.68

Change Item Title: Close Child & Adolescent Behavioral Health Facility and Establish Mental Health Grant

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	0	0	(2,986)	(3,849)
Revenues	0	0	(1,500)	(1,500)
Net Fiscal Impact = (Expenditures – Revenues)	0	0	(1,486)	(2,349)
FTEs	0	0	(30.88)	(30.88)

Request:
Effective July 2017, the Governor recommends closing the Child and Adolescent Behavioral Health Services (CABHS) program, a state-operated children's psychiatric hospital located in Willmar. The Governor also recommends increased funding for Children's Mental Health Grants to help sustain contracted extended-stay psychiatric hospital beds for youth to ensure services are available for those in need of the level of care previously provided by CABHS. This recommendation results in a net state savings of $3.8 million in the FY2018-19 biennium.

Proposal:
This proposal would close the Child and Adolescent Behavioral Health Services (CABHS) program effective July 2017. CABHS would stop admissions by April 2017 and vacate the facility by July 2017.

With the closure of CABHS, this proposal also seeks to ensure that children with the most serious mental health needs continue to have services available. To that end, this proposal would provide state grant funding to support the on-going sustainability of community-based extended-stay psychiatric hospital beds, which are designed to serve children and adolescents with very intensive needs who require longer term inpatient psychiatric care.

The 2015 legislature established "extended-stay psychiatric hospital" services as a benefit under Medical Assistance (MA). This benefit is provided by a private provider, under contract with DHS, who was selected through a competitive process. This service can meet the needs of children and adolescents who are currently served by CABHS.

Unlike CABHS, which receives an appropriation from the legislature, there is currently no mechanism to compensate the provider when a client doesn't need that level of care and is awaiting transition to the next appropriate level of service. The grant funding provided under this proposal would be used to ensure that clients do not have an interruption in their service when they are transitioning from an extended-stay psychiatric hospital service after they no longer need that level of care.

Rationale/Background:
CABHS, located in Willmar, is a 16-bed psychiatric hospital providing services to children and adolescents with complex mental health conditions. The target population for the hospital includes children with the highest unmet treatment needs including those with autism spectrum disorder, reactive attachment disorders, Post-Traumatic Stress Disorder (PTSD), co-occurring mental health and developmental disability, borderline personality disorder, schizophrenia, fetal alcohol spectrum disorder, brain injuries, and complex medical issues.

The current facility has serious physical plant limitations which impede accepting children whose complex needs include extreme aggression or active self-harm at the fully licensed capacity. Specifically, this is an inefficient use of scarce mental health resources and results in long waiting lists with some children needing to go out of state to receive treatment. Related to the ill-fitting design of the units, and depending on demographics and treatment needs, children may need to be placed alone on entire units with a full unit complement of staff.

The current lease for CABHS expires on June 30, 2017 and is not eligible to be renewed or renegotiated as the property has been sold and will be repurposed. As this proposal will close an appropriated state-operated program, legislative approval is required pursuant to M.S. 246.149.

Fiscal Impact:

This proposal includes operating savings (both salary and non-salary) from the closure of the CABHS program as well as separation expenses for staff displaced due to the closure.

The proposal also includes $1.5 million per year in additional general fund appropriations for Children's Mental Health Grants.

Statutory Change(s):

Rider

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 16	FY 17	FY 16-17	FY 18	FY 19	FY 18-19
General Fund			$0	$0	$0	$(1,486)	$(2,349)	$(3,835)
HCAF								
Federal TANF								
Other Fund								
Total All Funds			$0	$0	$0	$(1,486)	$(2,349)	$(3,835)
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	61	SOS Mental Health				(4,486)	(5,349)	(9,835)
GF	58	Children's Mental Health Grants				1,500	1,500	3,000
GF	Rev2	Lost SOS Cost of Care Recoveries				1,500	1,500	3,000
Requested FTE's								
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	61	SOS Mental Health				(30.88)	(30.88)	(30.88)

Change Item Title: Minnesota Sex Offender Program Reform & County Share for Provisional Discharges

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	0	5,326	2,701	2,701
Revenues	0	956	719	876
Net Fiscal Impact = (Expenditures – Revenues)	0	4,370	1,982	1,825
FTEs	0	16.0	16.0	16.0

Request:

Effective July 1, 2016, the Governor recommends increasing appropriations to the Direct Care and Treatment (DCT) Minnesota Sex Offender Program (MSOP) by $5.3 million for the FY2016-17 biennium and $5.4 million for the FY2018-19 biennium. These new resources will enable the program to conduct individual evaluations of each MSOP client every other year in order to evaluate each client's treatment progress and risk-management needs. As part of this reform, this proposal also eliminates the Special Review Board (SRB) and increases resources for the Special Court of Appeals Panel (SCAP) to review the increased petitions. Effective July 1, 2016, the Governor also recommends the Department of Human Services (DHS) charge counties 25% for the cost of care for clients that are provisionally discharged from the MSOP. The cost of this package of recommendations is partially offset by the county share of the cost of care, resulting in a net state share cost of $4.4 million in the FY2016-17 biennium and $3.8 million in the FY2018-19 biennium.

Proposal:

Effective July 1, 2016, this proposal provides funding for 16 additional staff (FTEs) needed to conduct individual evaluations of all MSOP clients on a bi-annual basis. These evaluations have been recommended by court-appointed experts, U.S. District Court Judge Donovan Frank, who is presiding over the class action lawsuit against MSOP, and a task force examining Minnesota's use of civil commitment for individuals who have committed sexual offenses.

The purpose of these evaluations is to determine if a client continues to meet the statutory criteria for placement within the secure perimeter of MSOP. These evaluations will include a forensic risk assessment and be conducted by an evaluator, knowledgeable about the client's treatment progress but independent of the treatment team.

In addition, during a court-ordered program evaluation, external experts noted concerns about the completeness of MSOP documentation. Specifically, they raised questions about "missing" treatment episodes and incomplete offense histories. This information is essential in creating thorough and individualized treatment plans, assessing potential risk, and developing a comprehensive risk management plan. However, in order for MSOP to address these recommendations, legislation is need. Statute must be amended to clearly authorize committing courts to share all reports and exhibits, which served as the foundation for civil commitment, with MSOP. Current statute addresses record sharing between DHS State-Operated facilities and the Department of Corrections (DOC) for individuals dually committed to DHS and DOC. However, M.S. 246.13 does not include MSOP sites within the definition of SOS facilities. As a result, current statutory language presents a barrier to crucial information sharing between MSOP and DOC.

This proposal also provides a one-time appropriation of $2,625,000 for fiscal year 2017 to support MSOP's costs to continue to operate its large facilities within the secure perimeter while clients who are appropriate for less restrictive alternative settings transition into these placements. MSOP has developed contracts with several community resources for ongoing clinical services, housing, and intensive supervision. This proposal assumes increased use of these contracted alternatives, in addition to the development of state-run less restrictive facilities for clients which the private community providers will not serve. Based on the pace at which courts are currently ordering provisional discharge for clients, it is anticipated that approximately five clients per year will transition to less restrictive secure facilities.

Currently, all petitions for transfer, provisional discharge, and discharge are reviewed by the Special Review Board (SRB). This practice is based on the statutory process for individuals civilly committed as Mentally Ill & Dangerous (MI&D). However, with the individuals civilly committed to MSOP, statute states the SRB has no decision-making authority. Thus, it is an unnecessary step, and cost, in the petition process for MSOP clients. It is proposed that the SRB be eliminated in the review process of petitions by individuals committed as sexually dangerous persons (SDP) and/or sexual psychopathic personalities (SPP). With this change, all petitions and accompanying evaluations will be sent directly to the court for review and, when appropriate, hearing. The elimination of the SRB results in a cost savings but will also increase the need for additional SCAP resources – which are also being requested in this proposal.

Effective July 1, 2016, this proposal clarifies counties are responsible for 25 percent of the cost of care regardless of if a MSOP client, for which they have financial responsibility, is within a DHS facility or on provisional discharge. Current statute is silent on provisional discharge.

M.S. 246B.035 requires MSOP to complete an annual performance review by January 15, of each year. However, this current due date does not allow for compilation and analysis of year-end data and report preparation. As a result, DHS has routinely had to request an extension. This proposal requests this statutory deadline be changed to February 15 of each year to avoid the necessity of an extension request.

Rationale/Background:

The Minnesota Sex Offender Program (MSOP) is currently the subject of a class action litigation brought by individuals who are civilly committed as SDP and/or SPP. These individuals assert numerous claims, including but not limited to claims regarding the constitutionality of the civil commitment process and the adequacy of the treatment provided by MSOP. In connection with this litigation, the Sex Offender Civil Commitment Task Force (SOCCTF) issued recommendations for statutory changes in 2013. Also, a panel of court-appointed experts submitted a court-ordered report containing recommendations for MSOP and civil commitment reform. Many of these concepts have been recommended before via a 2011 report of the Office of the Legislative Auditor and/or in Senate File 1014 (Sheran) from the 2013 legislative session and were also included in the Governor's recommended budget in 2015.

Under current law, MSOP is required to provide sex offender treatment for individuals under civil commitment as a sexual psychopathic personality and/or a sexually dangerous person. Since August 1, 2011, counties have been responsible for 25 percent of the cost of care at the facility for clients civilly committed to MSOP. For clients committed prior to August 1, 2011, counties remain responsible for the past statutory requirement of 10% of the cost of care.

When an individual is provisionally discharged from MSOP, the program is required to provide supervision, aftercare, and case management services. MSOP must also act as the designated agency to assist with establishing client eligibility for public welfare benefits and provide those services that are currently available exclusively through county government. In current statute, there is no county share specified for the cost of these services. The statute only addresses county responsibility for cost for the time the client spends at the facility.

Fiscal Impact:

Funding includes salary and benefits cost for 16.0 FTEs as well as one-time non-salary costs to maintain MSOP operations within the secure perimeter while transitioning clients to less restrictive settings.

Results:

Because this recommendation funds new activities, new performance indicators and outcome measures will be developed. Specifically, related to the funding for additional evaluators, we expect there will be an increase in the number of risk assessments conducted, in particular for clients who do not submit formal petitions. Additionally, with funding for additional judges for the Judicial Appeal Panel, we expect there will be a decrease in the amount of time between submission of a petition and final disposition of the petition. Both of these outcomes have been noted as significant issues in various external reports on MSOP and the civil commitment process.

Statutory Change(s):

Provisions in M.S. chapters 246B, 246B.10 and 235D

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 16	FY 17	FY 16-17	FY 18	FY 19	FY 18-19
General Fund				$4,370	$4,370	$1,982	$1,825	$3,807
HCAF								
Federal TANF								
Other Fund								
Total All Funds				$4,370	$4,370	$1,982	$1,825	$3,807
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	71	MSOP		5,326	5,326	2,701	2,701	5,402
GF	REV2	Increased Cost of Care Collections		(956)	(956)	(719)	(876)	(1,595)
		Total		4,370	4,370	1,982	1,825	3,807
Requested FTE's								
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	71	MSOP FTEs		16.0		16.0	16.0	

Change Item Title: Community Addiction Recovery Enterprise (C.A.R.E.) Brainerd Program

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	0	2,190	431	231
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	2,190	431	231
FTEs	0	(17.5)	(17.5)	(17.5)

Request:

Effective July 1, 2016, the Governor recommends additional funding to assist the transition of the Direct Care & Treatment (DCT) Community Addiction Recovery Enterprise (C.A.R.E.) program in Brainerd, also known as Four Winds, from the state to a tribal provider. This recommendation provides 1) a grant to the provider to assure a successful transition of the program, and 2) funding for DCT to ready the facility for transition to the new provider and to cover separation costs for staff leaving as a result of the transition.

Proposal:

Direct Care & Treatment (DCT) provides substance abuse and addiction treatment services through its Community Addiction & Recovery Enterprise (C.A.R.E.) program. The C.A.R.E. program located in Brainerd, Four Winds, focuses on delivering culturally-specific inpatient services to Native American adults with chemical addiction. Treatment is delivered through a holistic approach to chemical abstinence with a focus on native spiritual teachings, ceremonies and rituals. Though an important service, this program is not seen as a part of the safety net as other non-state providers have expressed some interest in delivering these services. This proposal would provide funding to support continuity of treatment and operations during the transition from the state to a tribal provider.

To assure a smooth transition and the financial viability of the new provider, a subsidy grant would be provided to the provider to offset possible operating losses over three years. The proposal includes $800,000 for FY17, $400,000 in FY18 and $200,000 in FY19. It is expected that the provider would be financially viable by the end of the third year of operation.

The program would continue to be provided in the current Four Winds facility which will be leased from the state. Non-capital modification to the building will need to be completed prior to occupancy by the new provider which will require one-time operating funds to complete. Lease payments from the new provider will cover the on-going operating costs of the facility.

Rationale/Background:

C.A.R.E. operates under an enterprise model which requires it generate sufficient revenues to cover the costs of operations. The increase in program costs over the past few years has required the legislature to appropriate funds during the last two sessions to maintain the program and close the fiscal years without a deficit. 2015 Legislation requires the C.A.R.E program to reduce bed capacity at several sites to allow for federal funding to the Consolidated Chemical Dependency Treatment Fund (CCDTF) as the sites would no longer be Institutes for Mental Diseases (IMDs). The Four Winds program was allowed to continue operations at a higher bed capacity until January 1, 2017 while a new service provider was being sought. If by that date, no other provider assumes operation of the program the bed capacity would be reduced to 16.

The Four Winds program is one of only a few Native American culturally specific addiction programs in the state. The program has had varying levels of occupancy as it is not a locked facility. Further, at this time the program only recognizes tribal commitments from two tribes under statutory authority in MS§ 253B.212. Due to this limitation, all other individuals are admitted as voluntary and the facility has no authority to hold the individual in treatment. If moved to a tribal provider, agreement could be reached between the tribes as to the recognition of the commitments and the use of the program.

Fiscal Impact:

Discussions are currently underway with a tribal group to assume operations of the program. It is anticipated that current staff would have an option to apply to work for the new provider. However, this proposal includes separation and severance costs for all employees at the program. This proposal also includes funds for repairs and betterments to the building that are not capital in nature such as painting, floor repair and coverings, and other non-capital updates to assure the current non-used space in the building is

ready for use by the new provider. Grant funds are included for the first three years of operation to assure a successful program transition and on-going fiscally viable program.

Statutory Change(s): Rider

Fiscal Detail: -

Net Impact by Fund (dollars in thousands)			FY 16	FY 17	FY 16-17	FY 18	FY 19	FY 18-19
General Fund			$0	$2,190	$2,190	$431	$231	$662
HCAF								
Federal TANF								
Other Fund								
Total All Funds			$0	$2,190	$2,190	$431	$231	$662
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	62	SOS Enterprise Services – CARE		1,390	1,390	31	31	62
GF	59	CD Treatment Support Grants		800	800	400	200	600
Requested FTE's								
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	62	SOS Enterprise Services– CARE		(17.5)	(17.5)	(17.5)	(17.5)	(17.5)

Department of Human Services
FY16-17 Supplemental Budget Change Item

Change Item Title: Creation of Law Enforcement Agency within the Office of Special Investigation (OSI)

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	0	250	250	250
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	250	250	250
FTEs		0	0	0

Request:

Effective July 1, 2016, the Governor recommends increasing funding for the Office of Special Investigation (OSI) which is currently funded through the Minnesota Sex Offender Program (MSOP). This funding will support the request to amend current statute so a Law Enforcement Agency division can be created within the OSI. This division would have full law enforcement authority and work in collaboration with the larger OSI department within the Direct Care and Treatment (DCT) administration.

Proposal:

This proposal provides statutory law enforcement authority to the Department of Human Services (DHS) to create a Law Enforcement Agency within the current Office of Special Investigations (OSI). Law enforcement authority is needed within DCT to conduct criminal investigations, arrests, transportation, and fugitive apprehension efforts as these actions relate to people civilly committed as Mentally Ill (MI), Chemical Dependent (CD), Developmentally Disabled (DD), Mentally Ill & Dangerous (MI&D), a Sexually Dangerous Person (SDP), a Sexually Violent Person (SVP), and / or a Psychopathic Personality (PP). While the above-mentioned activities are critical to the safe and secure operation of forensic treatment settings, the authority to engage in this functions is reserved for staff and agencies designated, in statute, as law enforcement agencies.

This proposal creates a five-person team of licensed Peace Officers employed by DHS who would be authorized to provide several law enforcement functions. In many ways, OSI investigators already perform similar duties to law enforcement professionals without the same protections or authorization to complete all aspects of an investigation which can result in public safety risks, both within and external to Direct Care & Treatment (DCT) facilities.

Enacting this legislation would also create a small, but specialized, law enforcement agency experienced in working with people transitioning from DCT facilities into community settings. Currently, if individuals on provisional discharge experience a crisis or engage in aggressive behavior, local law enforcement may be called to the scene. Depending on the training of the responding officer and availability of mobile crisis resources, a patient may have his/her provisional discharge revoked, which can lead to a return to the facility, jail, loss of housing, and or other community supports. If OSI law enforcement unit responds to similar calls, these officers will not only have familiarity with DCT programs and specialized crisis mental health training, the officer may also have an existing relationship with the individual in crisis. All of these factors increase the likelihood of safely managing the crisis in the community. Creating a law enforcement agency unit within OSI will also build upon the existing partnerships between the law enforcement and mental health systems.

This proposal also recommends amending M.S.253B.141 in a manner to the language in M.S. 253D.24, subd 3. Specifically, the latter applies to clients only in the Minnesota Sex Offender Program (MSOP). In these cases, if a client absconds, OSI is permitted to enter this data not only into a Missing Persons data base but also criminal data bases. It is proposed a similar practice is authorized for individuals committed as Mentally Ill and Dangerous.

Rationale/Background:

Over the past eleven years, the Department of Human Services, Office of Special Investigations (OSI) has conducted thousands of investigations of individuals who have committed crimes while civilly committed to the DHS Commissioner. OSI has also been responsible for locating, apprehending, and transporting back to DHS individuals who have absconded/escaped either from a secure treatment facility or from their supervised provisional discharge status. Despite these responsibilities, the OSI unit is not recognized as a law enforcement agency. At this time, there is not a state law enforcement entity that is statutorily charged with monitoring, tracking and apprehending these civilly committed individuals. In fact, some local law enforcement professionals have stated their role is to quell situations occurring within DHS facilities -not to investigate criminal activity or effectuate arrests.

Direct Care and Treatment staff are facing a more criminal minded client population that can be challenging for both the staff and clients. This creates a potentially dangerous environment in which to provide treatment. Existing law enforcement agencies are ill-equipped to respond to the type and number of criminal incidents occurring at DCT facilities, and receive limited training to manage the unique crises that can arise from these incidents.

Fiscal Impact:

The conversion of the current staff into the positions listed below requires funding for the increased rate of compensation and the transfer of the positions into the State Patrol Retirement Plan.

Current Staff:		Reclassified position:
Investigation Specialists	(4)	Special Agents (4)
Investigations Supervisor	(1)	Special Agent in Charge (1)
State Program Administrator	(1)	Chief of Police (1)

Statutory Change(s):

M.S. 626.84, M.S.253B.141, M.S. 246B (sections TBD)

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
General Fund			$0	$250	$250	$250	$250	$500
HCAF								
Federal TANF								
Other Fund								
Total All Funds			$0	$250	$250	$250	$250	$500
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	71	MSOP		250	250	250	250	500
Requested FTE's								
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**

Change Item Title: Expand Transition to Community Initiative

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	0	1,108	2,543	3,763
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	1,108	2,543	3,763
FTEs	0	3.0	3.0	3.0

Request:

Effective July 1, 2016 or upon federal approval, whichever is later, the Governor recommends expanding the *Transition to Community Initiative* in order to help more people to transition out of state-operated mental health facilities in a timely fashion once they have completed treatment. This proposal would also expand the *Transition to Community Initiative* to help individuals who are hospitalized and on the waiting list for admission to Anoka Metro Regional Treatment Center (AMRTC) but who could be successfully served in their community with the necessary resources, services, and support.

Proposal:

Many individuals who receive care at state-operated mental health facilities face numerous barriers that prevent them from transitioning back to the community when they no longer need that level of care. This leaves people in highly restrictive and expensive settings unnecessarily and keeps other individuals who need the level of care provided in these facilities from accessing them.

The *Transition to Community Initiative*, which was established in 2013, provides access to a range of services, including home and community-based waivers, flexible grant funding, and contracts with providers and counties, to help people with complex needs leave state-operated facilities live successfully in the community.

Thus far, this project has successfully assisted 70 individuals to return to a community living situation of their choice while supporting their unique needs. Very few of the individuals served by this program have returned to a state-operated facility or hospital. The program has shown success in helping people with extremely significant barriers successfully return to the community. In September and October 2015, the program helped three individuals return to the community who had been at the Anoka Metro Regional Treatment Center (AMRTC) for a total of 1,165 days when they did not need that level of care.

Despite this success, the program has limitations which prevent it from having more of an impact. The funding and resources associated with the *Transition to Community Initiative* are currently only available to individuals at the Anoka Metro Regional Center (AMRTC) and the Minnesota Security Hospital (MSH). In addition, there is currently only one funded FTE who is responsible for providing intensive care coordination to overcome client barriers and develop appropriate clinical placements as well as provide fiscal management for the program, and conduct data analysis. These limitations prevent the program from serving additional individuals, restricts how quickly individuals can return to the community, and our responsiveness to community partners.

This proposal expands the number of people eligible to be served by the *Transition to Community Initiative* as well as the types of resources that can be accessed and adds staff to expedite the work. The goal of this proposal is to provide more individuals with the necessary resources, services and supports to leave state-operate facilities (or be diverted from an institutional stay altogether) and return to their community. This will also allow individuals who need this higher level of care to access it in a more timely fashion.

This proposal builds on the 2013 *Transitions to Community Initiative* in four ways:

(1) Expands eligibility for the program to people receiving care at a Community Behavioral Health Hospitals (CBHH).

(2) Expands eligibility for the program to people who are hospitalized and on the waiting list for admission to Anoka Metro Regional Treatment Center (AMRTC) but who could be successfully returned to the community with the necessary resources, services and support.

(3) Expands the program to support people age 65 and older by offering an enhanced individual budget through the Elderly Waiver (EW) program for individuals who have complex needs, require intensive support to live in the community, and are ready to leave AMRTC, MSH, a CBHH, or who are hospitalized and on a waiting list for AMRTC. The EW program funds home and community-based services for people age 65 and older who require the level of care provided in a nursing facility, but choose to reside in the community. This change is necessary in order to address the issue that individual budgets available under EW may not be sufficient to help people with complex needs transition to a community setting. Federal approval will be required to make this change.

(4) Provides additional administrative capacity in order to successfully implement the expansion in eligibility as well as increase the efficiency and effectiveness of the program.

Policy changes to expand eligibility to CBHHs and individuals on the AMRTC waitlist will be implemented through the Adult Mental Health Division and Disability Services Division within the Community Supports Administration. The changes to the Elderly Waiver will be implemented by the Aging and Adult Services Division within the Continuing Care for Older Adults Administration, in partnership with the Community Supports Administration.

The following are the projected implementation timelines:

Eligibility Expansion

	Aug 2016	Sept/Oct 2016	Nov/Dec 2016	Jan/Feb 2017	March 2017
Expanded Eligibility to CBHH and AMRTC Waitlist	Hire 3 FTEs at DHS	Create procedures; Create new RFPs or expand current contracts of previous grantees.	Education w/ CBHHs & Hospitals; Award new RFPs or amend current contract	Identify eligible individuals/Discharge plan.	Initiate services for new clients.

Elderly Waiver Changes

	Beginning July 2016	Upon CMS approval
Enhanced Elderly Waiver Budget	Seek CMS approval on Elderly Waiver amendment.	Finalize operational protocols. Issue bulletin.

To assess the effectiveness of this proposal we will measure the number of individuals, regardless of age, who successfully transition from AMRTC, MSH, CBHH, or the AMRTC waitlist. Based on trend data, it is projected the *Transition to Community Initiative* would be able to serve an additional 103 individuals by FY 2020: 56 individuals from AMRTC and the CBHHs, 7 individuals from MSH, and 20 individuals who are on the AMRTC waitlist, along with another 20 individuals who will require grant-only funding to remove current barriers to discharge from AMRTC, MSH, a CBHH or the AMRTC waitlist. All of these individuals could live successfully in the community with the right support but would otherwise be unable to be discharged based on insufficient resources and/or services without this proposal.

Fiscal Impact:

The *Transitions to Community Initiative* supports people using two main sources of funding: (1) home and community based waiver services; and (2) grant funding to support individuals who are not eligible for waiver services and/or to pay for services and supports that cannot be funded through a waiver or other means.

With this proposal, there will be an increase in the number of individuals served by the *Transitions to Community Initiative*. The proposal includes additional appropriations to account for higher EW budgets for eligible individuals as well as more timely discharge by people who are eligible for home and community-based waiver services and who therefore begin receiving waivered services more quickly than is forecasted under current law. The home and community based waiver costs were calculated based on historical experience with the *Transitions to Community Initiative* as well as historical data about the population who will be newly eligible under this proposal. The EW costs were estimated based on DHS' past experience transitioning a similar population from a state owned psychiatric nursing facility into the community. Additional grant dollars will also be needed to support the projected program growth as a result of expanding eligibility. It is anticipated that the newly eligible clients will begin receiving support through the *Transition to Community Initiative* in March 2017.

The proposal also assumes the addition of two new FTEs ongoing in the Adult Mental Health Division, Community Supports Administration and one new FTE ongoing in the Direct Care and Treatment Administration.

Two positions, one in the Adult Mental Health Division and one in Direct Care and Treatment, will focus on clinical coordination. These positions will oversee the client level coordination that occurs between the staff members at state run facilities (AMRTC, St. Peter, and CBHH's), community hospitals, counties, and community providers. This work requires mental health professionals with a clinical skill set and the ability to understand the service, support, and medications needs of individuals. These positions will also need to be able to coordinate with the other clinical level providers working on discharge planning and continued support for a client. The budget for these positions includes salary and benefits along with travel expenses to meet regularly with clients, staff, county or tribal representatives, and providers of potential community placements.

The third position will oversee the fiscal, grant, and data management components of the project. This position will manage contracts with providers and counties, provide oversight of the funds allocated to each individual, and collect and analyze outcome and trend data to support continuous improvement of the program. Presently, there are no dedicated resources for data or fiscal management, which has limited DHS' ability to assist more individuals and to assist individuals more quickly. A dedicated FTE to oversee these functions will make the program more efficient, ensure that the program can be successfully expanded, and allow the clinical coordination staff to focus on client-level work. This position will be in the Adult Mental Health Division, Community Supports Administration.

Rationale/Background:

The 2013 Legislature created the *Transition to Community Initiative* to help people being served at Anoka Metro Regional Treatment Center (AMRTC) and the Minnesota Security Hospital (MSH) who no longer require the level of care provided at these facilities, to transition to the community. The initiative provides access to a range of services, including home and community based services waivers, to help people leave these facilities and live successfully in the community. DHS central office staff also work with staff at AMRTC and MSH, counties, tribes, and other stakeholders as part of this initiative to identify and address barriers for people who are ready to return to the community but who have not been able to do so.

The *Transition to Community Initiative* is on-going and continues to support people transitioning from AMRTC and MSH. Data from the first 18 months of the program show 70 individuals were served with very few individuals needing to return to hospital level of care. Over the course of the past 18 months, DHS has identified several additional populations that would benefit greatly from the initiative. They include people over age 65, individuals at a state-operated Community Behavioral Health Hospital (CBHH), and adults who are hospitalized and on the AMRTC wait list. As with people currently served at AMRTC and MSH, many of these individuals face serious barriers that prevent them from transitioning back to the community when they no longer need the level of care provided in those facilities.

People over age 65 face an additional set of unique challenges. For many individuals age 65 and older who are discharging from AMRTC and MSH, the individual budgets available through the Elderly Waiver (EW) are not sufficient to meet their complex needs. Under the current federally-approved Medicaid waiver plans and current state law, individuals age 65 and over who were being served on Brain Injury (BI) waiver or Community Alternatives for Disabled Individuals (CADI) prior to turning 65 can continue to be served under these waivers, but they cannot enter these programs after turning 65. The lack of sufficient resources for home and community-based services creates a barrier to an appropriate and timely discharge.

People who are psychiatrically stable and no longer require the higher level of treatment provided at the CBHHs or community hospitals often face delays in transitioning back to the community due to insufficient resources and programs to support them in the community. They face many of the same barriers as people being served at AMRTC and MSH for whom the *Transition to Community Initiative* was originally designed.

In addition, the waitlist to get into AMRTC was 65 people as of September 2015. The average length of stay on the AMRTC wait list has increased recently and individuals waiting to be admitted to AMRTC, who often are in non-state operated hospitals, has gone from weeks to months. This reduces capacity of those non-state operated hospitals to care for other people who may need their services, thus creating more of a backlog in the service system. However, if the right combination of services and supports were available to these individuals, it is likely they could be successfully discharged from these non-state operated facilities and avoid going to AMRTC altogether.

Results:

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Number of individuals transitioned from AMRTC, MSH, or the AMRTC waitlist under this initiative	N/A	70	
Quality	Percent of people with disabilities who receive home and community-based services	93%	93%	2013-2014
Results	Percent of seniors who receive home and community-based waiver services.	68%	70%	2013-2014

Statutory Change(s): M.S. §256.478; M.S. §256B.092; M.S. §256B.49; M.S. §256B.0915

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
General Fund			$0	$1,108	$1,108	$2,543	$3,763	$6,306
HCAF								
Federal TANF								
Other Fund								
Total All Funds			$0	$1,108	$1,108	$2,543	$3,763	$6,306
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	33 LW	MA waivers- EW		313	313	1,543	2,753	4,296
GF	33 ED	MA elderly and disabled		5	5	23	33	56
GF	33 LW	MA waivers- CADI		46	46	184	184	368
GF	15	CSA Admin.– AMH Division		240	240	271	271	542
GF	Rev1	FFP @ 35%		(84)	(84)	(95)	(95)	(190)
GF	52	Other Long Term Care Grants		500	500	500	500	1,000
GF	55	Disability grants- move transitions funding to Adult MH grants		(85)	(85)	(85)	(85)	(170)
GF	52	Other Long Term Care Grants		85	85	85	85	170
GF	61	SOS Mental Health Svcs		88	88	117	117	234
Requested FTE's								
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	15	Community Supports Admin.		2.0		2.0	2.0	
GF	61	SOS Mental Health Svcs		1.0		1.0	1.0	

Change Item Title: Managing Corporate Foster Care Capacity

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	0	1,746	4,407	6,295
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	1,746	4,407	6,295
FTEs	0	2.0	2.0	2.0

Request:

Effective July 1, 2016, the governor recommends targeted management of corporate foster care and community residential setting capacity, allowing for controlled growth while supporting the redesign of Direct Care and Treatment (DCT), and creating more flexibility in serving people in their community of choice. The proposal also makes changes clarifying the commissioner's authority to manage licensed corporate foster care and community residential setting capacity, including relocation of capacity to address the needs and choices of people receiving waiver services across the state. This proposal also provides support to counties and tribes for planning and implementing alternatives to corporate foster care and community residential settings through local planning grants and supporting diversion from Direct Care and Treatment when possible. The components of this proposal allow the state to support demographic changes and increasing waiver population growth that has been experienced over the past several years.

Proposal:

DHS has maintained the legislated cap on the statewide growth of corporate foster care since 2009, while the state experienced significant growth in the waiver populations. Based on the analysis of DHS and input from stakeholders, there are situations where modest growth in the corporate foster care and community residential licensed setting capacity is warranted through an exception process managed by DHS. These additional exceptions are targeted to supporting people living in their own homes, or near or with their families, and honoring the community of choice of people who have a need for the level of services provided in a licensed corporate foster care or community residential setting. It provides for more options for people to receive supports from community providers who may otherwise access safety net services from Direct Care and Treatment.

This proposal includes the following elements to support people living in their own home, near or with their families –

- Corporate foster care and community residential setting development for children who are currently living in, or are at risk of living in a more restrictive and expensive setting. This will provide a community-based option for children to receive services near their family and community.
- Planned out-of-home respite settings so that family caregivers for people with high support needs can have scheduled respite while diverting people from relying on more institutionalized settings. This will provide additional support for caregivers and make it more likely they will continue to support the person receiving services in their home.
- People who have transitioned to independent housing can return to a foster care or community residential setting if health and safety concerns arise with the new housing setting. This will allow people to try independent housing without fear of not being able to access foster care or community residential settings in the future, including providing an option for people moving directly from Direct Care and Treatment to independent housing. It also encourages innovative providers to develop and offer more independent setting and service options.

This proposal allows people to live in their community of choice in the following ways-

- Allow people being demitted by a foster care or community residential setting provider, who continue to choose foster care or community residential setting services, to continue to receive the level of services they require in the community of their choice.
- Allow people who are transitioning from the Residential Care waiver service to choose to access waiver services in a foster care or community residential setting in the community where they prefer to live. The residential waiver service will be discontinued. To facilitate a stable transition for people to receive new services, a voluntary closure rate adjustment will be established.
- Allow people who are currently receiving services in an unlicensed setting similar to services provided in a corporate foster care or community residential setting to choose to receive services in a licensed setting.

Estimated Growth for Corporate Foster Care Bed Exceptions

	Proposed Number of CFC Beds			Total
	SFY2017	SFY2018	SFY2019	
1.Child Corporate Foster Care	20	20	10	50
2.Planned Respite for Family Caregivers	30	10	0	40
3. Backup to Support Independent Housing Choices	5	5	5	15
4. CFC Beds for those Demitted from Licensed Settings	15	15	15	45
5. Residential Care Closure Conversions	20	80	0	100
6. Unlicensed Settings	*currently analyzing data to determine the proposed number of beds for this exception			
TOTAL				250

Proposed Exception #1. Child Corporate Foster Care or Community Residential Settings
This exception will provide services to adolescents and young adults with highly aggressive behaviors who want to live near family when their parents are not able to care for them. It is often not appropriate for them to live in a family foster care setting especially one with young vulnerable children or older vulnerable adults. Forty-eight out of 87 Minnesota counties have zero (0) licensed child corporate foster care or community residential settings but are in need of these types of settings. As a result, children who could be served in the community end up in institutional settings, rather than diverted from state operated services. Meanwhile, children in corporate foster care or community residential settings may have high behavioral and or medical needs that remain when they become adults. Some of these young adults continue to be served in foster care or community residential settings as they age and the bed converts from being licensed for a child to being licensed for an adult. As that happens, the child corporate foster care or community residential settings system loses that capacity and is less able to serve the needs of children. This proposal provides for additional child foster care and community residential setting beds as alternatives to more restrictive settings and preserves needed capacity to serve children.

Proposed Exception #2. Planned Respite for Family Caregivers
There is a growing number of families who are caring for family members with complex medical needs and/or aggressive behaviors at home who are at high risk of "burning out" due to the stresses of their situation. Regularly scheduled out-of-home respite can often provide the relief these families need to maintain the family member in the home rather than have them move to a more restrictive and expensive setting (e.g.. preventing DCT placements by increasing respite capacity for community providers, as well as the reduction of DCT crisis services when options not available). Respite homes must be licensed as foster care or community residential settings but they do not qualify for current exceptions to the moratorium. As a result, this affects the development of potential respite settings where demand is very strong. In the 2015 Gaps Analysis Report, respite care was most often cited by lead agencies, providers, and tribal representatives as a service least likely to exceed or meet demand for persons with disabilities, and as being less available in 2013/14 than in previous years. For example, the metro area county staff have identified approximately 300 families that would benefit from 3-4 days per month of out-of-home respite services. Each licensed bed would be able to support 6-8 families for respite care.

Proposed Exception #3. Backup to Support Independent Housing Choices
Case managers and organizations providing support for people to move to independent housing report that a major impediment to such moves is the fear that if people find that they want to return to a foster care or community residential setting the bed they previously held will be filled behind them and there will be no appropriate openings in their communities. For the vast majority of people moving to the community, appropriate supports designed around the person are successful. Allowing the option to go back to foster care or community residential settings (rather than state operated services) will address the concerns many guardians and families have if independent housing does not work out. It also opens the door for those who were hesitant to try something different, to do so with the confidence that they will still have foster care or community residential settings as a backup option.

Proposed Exception #4: CFC Beds for Those Demitted from Settings
This situation is an immediate need due to demission related to a provider's inability to serve an individual. The individual has escalating, very high, sometimes aggressive behaviors over time. Staff are unable to meet these needs for the individual in their current setting resulting in a demission. Statutory language passed last year which gave the commissioner the authority to delay the demission for up to 60 days while the lead agency works with the person to determine other options and find another home for the person. The person could choose his or her own home with supports, corporate foster care or community residential settings, or another provider controlled-setting, rather than being faced with a more institutional state operated setting as the only alternative. In order for the

individual to be able to continue living in their community when corporate foster care or a community residential setting is the appropriate setting, another licensed bed is needed when corporate foster care or community residential setting vacancies are unavailable in that community. There is an increasing number of demissions for difficult to serve people that do not meet the moratorium exceptions, and because of their urgent health and safety needs a service provider and bed must be identified quickly to avoid hospitalization.

Proposed Exception #5: Residential Care Closure Conversions
Residential Care service will be discontinued as of June 30, 2018. This waiver service is being discontinued because this service is intended to provide only a minimal amount of service, which is often different than the level of service needed or actually provided to the person. In addition, this service does not have adequate health, safety, and rights standards and safeguards for people who meet the level of care required by the waiver programs. As part of the transition to alternative services, a lead agency with a person receiving residential care may request an exception to the foster care moratorium provided the person meets the following: (1) the person's foster care or community residential setting services are cost neutral in comparison to the service cost of the Residential Care waiver service, (2) the person was given an informed choice of services, service providers, and location of the services; and (3) the person choses to receive foster care or community residential setting waiver services. To facilitate a stable transition for a person to receive new services, a voluntary closure rate adjustment process will be established. This will allow a temporary, time-limited, closure rate adjustment for a service provider who chooses to close their residential care setting due to the discontinuation of residential care.

Proposed Exception #6: Unlicensed Settings
There are currently unlicensed settings statewide that function identically to a corporate foster care or community residential setting with 24/7 services, shift staff and absence of the license holder at the site. As these settings are discovered, they may need to be licensed to provide necessary protections to people. This proposes a time-limited process period when unlicensed settings of this type convert to a licensed corporate foster care or community residential setting rather than closing the site with possible homelessness or institutional care for the individuals currently living there. This exception will only be available when the services provided in a person's foster care or community residential setting are cost neutral compared to the current services they receive in the unlicensed setting. DHS has developed policy clarification on when a setting is considered a person's own home and doesn't require a license, which will help eliminate these settings in the future. DHS is currently analyzing data to determine the potential number of beds that may be necessary to address this need.

Rationale/Background:

The moratorium on the growth of child and adult corporate foster care and community residential settings was put into place by the legislature in 2009 as a cost-saving measure. It is also a mechanism to assure a range of services options are available so people can receive the most appropriate services to meet their needs encouraging a better flow and transitions from safety net services to more community-based settings. There are currently five exceptions to the moratorium in state statute:

- Foster care or community residential settings that require Minn. Chapter 144D housing with services registration (this is required when 80% or more of the residents are age 55 or older)
- New foster care and community residential setting licenses replacing foster care licenses that were in existence on May 15, 2009, or community residential setting licenses that were in existence on December 31, 2013, and determined to be needed by the commissioner.
- Foster care licenses or community residential setting licenses determined to be needed by the commissioner for the closure of a nursing facility, ICF/DD, or regional treatment center; restructuring of state-operated services that limits the capacity of state-operated facilities; or allowing movement to the community for people who no longer require the level of care provided in state-operated facilities.
- New foster care or community residential setting licenses for persons requiring a hospital level of care including Community Alternative Care (CAC) waiver and Brain Injury (BI) waiver for people at a neurobehavioral hospital level of care (BI-NB).
- New foster care or community residential setting licenses of community residential settings for the transition of people from Personal Care Attendant (PCA) to home and community-based services.

In SFY 2014, 4,345 adults received corporate foster care or community residential setting services through the CAC, CADI and BI waivers and 9,200 received Supportive Living Services (SLS) in corporate foster care and community residential settings through the DD waivers. Since 2009 when the moratorium was put in place, the disability waiver programs have grown by approximately 7,000 people.

Management of corporate foster care and community residential setting capacity includes continuing to use the process established by DHS to monitor statewide capacity, as well as targeting and addressing current specific unmet needs to assist individuals move to less segregated and more independent settings of their choice. It also creates some needed flexibility in the system and diversions from

Direct Care and Treatment when possible. The statutory authority giving DHS the ability to manage the corporate foster care and community residential setting capacity is necessary to address statewide needs identified in the needs determination process conducted by the commissioner. With the necessary changes, service recipients, family members, advocates, and lead agencies will have assurance that corporate foster care and community residential setting capacity will adapt to client needs as identified in the needs determination report to the legislature.

Fiscal Impact:

Management of corporate foster care and community residential setting capacity includes the following assumptions:

1. New beds will develop over time and will require a RFP process for selection of location, providers and people to be served, and the type of foster home or community residential setting capacity (behavioral/medical). It will take six months for completion of the RFP process in the first year, resulting in the first beds available as of January 1, 2017;
2. growth in beds is phased in over three years with the more aggressive growth occurring in the first and second year; these beds are in addition to existing corporate foster care and community residential setting capacity; and
3. the local planning grants increase the existing local planning grants; the additional local planning grants are to assist counties that are already participating to move from planning to implementation of developing alternatives to corporate foster care or community residential settings. The existing funding will be used to bring on a new group of counties to begin the planning process.

The overall cost of the proposal is offset by determining the cost of the service that waiver recipients currently receive. The total percentage offset to these costs is estimated at 40%. The overall capacity will not be reduced as a result of this proposal. This proposal does not have a local government impact.

This proposal also adds 2 FTEs with the following responsibilities for managing capacity:

- Create and manage policies and processes for DHS to manage access to corporate foster care and community residential settings, specifically assuring that people are moving to or continuing to live in their county of choice. This will involve developing criteria for approving requests and workflow processes with significant stakeholder involvement, such as when a person is moving from a corporate foster care or community residential setting in one county to a corporate foster care or community residential setting in another county and/or from a Direct Care and Treatment setting.
- Define and manage projects that implement recommendations from the annual needs determination process. These projects will improve access to the range of residential services and settings available through the HCBS waivers and may result in adjustment to regional service capacity. The definition of projects will require stakeholder involvement.

Results:

Type of Measure	*Name of Measure*	*2009*	*2013*	*2018*
Results	Percent of people on the disability waivers with high needs. This measure shows that people with disabilities and high needs are staying in their homes or communities.	77.5%	79%	Increasing

Statutory Change(s):

M.S. section 245A.03

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 16	FY 17	FY 16-17	FY 18	FY 19	FY 18-19
General Fund			$0	$1,746	$1,746	$4,407	$6,295	$10,702
HCAF								
Federal TANF								
Other Fund								
Total All Funds			$0	$1,746	$1,746	$4,407	$6,295	$10,702
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	33 LW	MA waivers- corporate foster care		1,440	1,440	4,101	5,989	10,090
GF	15	CSA Admin		240	240	240	240	480
GF	55	Disability Grants - Local		150	150	150	150	300
	REV1	Admin FFP @35%		(84)	(84)	(84)	(84)	(168)
Requested FTE's								
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
	15	CSA Admin		2.0	2.0	2.0	2.0	2.0

Change Item Title: Mental Health and Criminal Justice Initiative

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	0	1,670	1,895	649
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	1,670	1,895	649
FTEs	0	2.0	2.0	2.0

Request:

Effective July 1, 2015, the Governor recommends investments to increase the capacity of community mental health services to support people with mental illnesses who are involved with the criminal justice system.

Proposal:

This proposal is intended to respond to several recommendations contained in the Office of Legislative Auditor's (OLA) report – *Mental Health Services in County Jails*. Two key findings of the OLA's report were (1) a need to develop a broader continuum of options to support individuals who have been found "not competent to stand trial" and need "competency restoration" services in order to participate in their defense and (2) a need to expand the availability of community mental health services. The proposal seeks to respond to these findings through two distinct initiatives:

1) Community-based Competency Restoration: Grants to counties, regional county partnerships, and/or community-based mental health providers to develop local, community-based, competency restoration services.

Competency restoration services are designed to help people who have been determined by a court to be "not competent" to stand trial, restore their functioning to a level where they can participate in their own defense. Services are currently provided, almost exclusively, at two state-operated facilities, the Minnesota Security Hospital (MSH) in St. Peter and the Anoka Metro Regional Treatment Center (AMRTC), and are only provided to individuals who are civilly committed to the commissioner of human services.

However, some individuals who are found to be "not competent" do not meet the criteria for civil commitment. In addition, some individuals who are civilly committed may not need the intensive services and/or secure setting provided as MSH or AMRTC. Lastly, there are individuals who have been committed to AMRTC for competency restoration and no longer need hospital level of care but still need continued competency restoration services. In all of these cases, Minnesota lacks viable options.

This proposal would provide start-up funding to establish local, community-based competency restoration programming. The proposal would provide $1 million per year in one-time grant funding in FY 2017 and FY 2018 with the goal of funding approximately four projects each year – targeted at both metro and non-metro communities. Eligible uses of this grant funding include, planning and systems design (e.g. communication between county social services, providers, and the courts, billing practices, etc.), hiring and training staff to work with clients who are actively involved in the legal system, and training staff to deliver competency programing. Grantees will need to demonstrate the ability to sustain the initiative once the one-time state grant dollars have been expended.

The specific design of these initiatives is expected to vary by community but could include both residential and outpatient competency options. Local competency restoration services are intended to serve individuals who are found not competent but who are not suitable for civil commitment; individuals who are under civil commitment but who do not need the intensity or security of a state-operated program; and/or individuals who have been committed to AMRTC, no longer need hospital level of care, but who have a continued need for competency restoration services.

2) Forensic Assertive Community Treatment services: Start-up grant funding to establish 4 new Forensic Assertive Community Treatment (FACT) teams as well as funding to increase the capacity of Minnesota's existing traditional ACT teams to serve individuals with extensive legal/criminal justice histories

Assertive Community Treatment (ACT) is an evidence based service for people with severe mental illness and is a multidisciplinary, team-based approach with a small staff to client ratio and 24/7 hour staff availability. ACT is a non-residential service and works with clients in the community. ACT is sometimes described as a "hospital without walls".

Forensic assertive community treatment (FACT) is an adaptation of the traditional model that is designed to help clients that have higher risk of repeated involvement with the criminal justice system or incarceration, than traditional ACT clients. This proposal provides start-up grant funding to establish 4 FACT teams. Grant funding is provided directly to the provider agency operating the team and is used for hiring staff and building a roster of clients before the teams become self-sustaining.

The 2015 legislature appropriated funding for a FACT team to support people leaving state Department of Correction's facilities. Funding provided under this proposal will be targeted for FACT teams to support people who have been incarcerated in the local jail or have frequent contact with local law enforcement. Once fully operational, each of the 4 new FACT teams funded under this proposal will serve an annual average caseload of 70 clients. This proposal will establish one new FACT team in FY 2017, two in FY 2018, and one in FY 2019. Start-up grant funding for FACT teams will end after FY 2019 and the need for further expansion will be evaluated.

In addition, this proposal includes funding to increase the capacity of Minnesota's 27 existing traditional ACT teams to serve individuals with extensive legal/criminal justice histories through training, technical assistance, and consultation from national experts. This will be especially beneficial for small and rural communities that would not have a large enough population to support a standalone FACT team.

Rationale/Background:

The Office of the Legislative Auditor (OLA) issued a report in February 2016 on mental health services in county jails. This proposal specifically responds to two findings from the report:

- A need to develop a broader continuum of options to support individuals who have been found "not competent to stand trial" and need "competency restoration" services in order to participate in their defense.
- A need to expand the availability of community mental health services.

The development of community-based competency restoration programing is also intended to respond to the increase in the number of people being referred for these services. In 2010, the number of people referred to DHS for competency restoration services was 59, in 2015 it was 159.

A number of individuals who are civilly committed for competency restoration receive treatment at the Anoka Metro Regional Treatment Center (AMRTC), which is a state-operated hospital. Often times these individuals reach a point in their treatment where they no longer need the level of care provided at AMRTC but still need on-going competency restoration services. In addition, some individuals who are found to be not competent to stand trial are not eligible for civil commitment. As a result, there are individuals who either have no means of receiving competency restoration services or receive these services in a higher level of care than they need, preventing people who do need that level of care from accessing it.

Fiscal Impact:

The proposal appropriates adult mental health grant funding as follows: $1,405,000 in FY 2017, $1,605,000 in FY 2018, and $405,000 in FY 2019. These grant funds will not continue and are not part of the on-going base beyond FY 2019.

The grant funds would provide

- $1 million per year for each of the next two fiscal years (FY17 and FY18) to fund approximately four competency restoration projects each year – targeted at both metro and non-metro communities
- $200,000 per team in start-up funding for four new FACT teams ($200,000 in FY17, $400,000 in FY18, and $200,000 in FY19)
- $205,000 per year (FY 17-19) to the 27 existing ACT teams for capacity building activities to serve clients involved in the criminal justice system.

The proposal also includes $218,000 annually for 2.0 FTEs in the Adult Mental Health Division to provide project coordination and on-going support to grantees as well as to measure outcomes to inform future efforts. Additional administrative funds of $190,000 in FY17, $228,000 in FY18, $158,000 in FY19 are included for technical assistance and to host annual training conferences for assertive community treatment providers. These funds continue and are part of the on-going base.

Both the grants and the administrative resources utilize general fund appropriations.

Results:

- 280 people will have access to Forensic ACT Team services.
- Nearly 3,000 clients receiving traditional ACT services will have access to services that are better equipped to keep people out of the criminal justice system and/or support people who are involved with the criminal justice system.
- Up to 8 community competency restoration programs will be available in various regions across the state.

Statutory Change(s):

256B.0622, Rider.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
General Fund			$0	$1,670	$1,670	$1,895	$649	$2,544
HCAF								
Federal TANF								
Other Fund								
Total All Funds			$0	$1,670	$1,670	$1,895	$649	$2,544
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	57	Adult Mental Health Grants		1,405	1,405	1,605	405	2,010
GF	15	Mental Health Admin (FTEs – 2, 2, 2)		218	218	218	218	436
GF	15	Mental Health Other Admin		190	190	228	158	386
GF	REV1	FFP @ 35%		(143)	(143)	(156)	(132)	(288)
GF	**FTE**			**2 .0**		**2.0**	**2.0**	

Change Item Title: Child Care Development Block Grant Reauthorization Changes and Child Care Maximum Rates

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	0	28,280	103,753	127,501
Revenues	0	0	0	0
Special Revenue Fund				
Expenditures	0	0	899	396
Revenues	0	0	(899)	(396)
Net Fiscal Impact = (Expenditures – Revenues)	0	28,280	103,753	127,501
FTEs	0	36.0	35.0	35.0

Request:

The Governor recommends investments of $28.3 million in 2017 and $231 million in 2018-19 to improve the safety and school readiness for children served in child care settings across the state. The proposed changes meet both the federal requirements and align with the overarching goals of the federal Child Care Development Block Grant. These investments comply with new federal requirements and goals.

Rationale/Background:

The federal Child Care Development Block Grant (CCDBG) provides funding to states to help increase the availability, affordability and quality of child care for families with low income. Two purposes of the fund are: 1. promote families' economic self-sufficiency by making child care more affordable; and 2. foster healthy child development and school success by improving the overall quality of early learning and afterschool programs. Minnesota receives approximately $85 million per year from the CCDBG. Minnesota uses these funds to help pay for Basic Sliding Fee child care, Minnesota Family Investment Program child care and initiatives to improve the quality of child care services.

Changes to Minnesota's Child Care Assistance Program (CCAP) are needed to meet the goals of and comply with new federal requirements established with the reauthorization of the CCDBG. The intent of the proposed changes are to stabilize families' lives by providing more continuous child care in consistent settings.

In addition, health, safety and licensing changes are needed to meet new federal requirements and provide safer, higher quality and accessible child care. These new requirements are expected to improve the safety of all children served by approximately 13,000 providers. Our goal is to minimize the number of children receiving child care in unsafe conditions and increases the number of caregivers having fingerprint-based background checks before providing direct contact.

Proposal:

This proposal includes four sections:

1. federal requirements in Child Care Assistance Program
2. federal requirements for health, safety and licensing;
3. federal goals of the reauthorization act in Child Care Assistance Program
4. maximum rates paid under CCAP

Federal Requirements – Child Care Assistance Program ($3.1 million in 2017, $50 million in 2018-19)

The following changes will help the 16,000 families and 30,000 children receiving CCAP each month by improving their experiences with the program. All of these changes support new federal requirements intended to provide more consistent access to child care, although only some are required to comply with CCDBG reauthorization.

The major components of this part of the proposal are:

- Eligibility will be redetermined every 12 months instead of every six months as currently required.

- Families who received Minnesota Family Investment Program/Diversionary Work Program (MFIP/DWP) for at least one of the last six months will qualify for Transition Year Child Care. In addition, education is added as an authorized activity for Transition Year Child Care and Transition Year extension child care.
- Reporting will be simplified by eliminating requirements to report some minor changes in income and parent's work or school schedule.
- Copayments will not increase during a family's 12 month eligibility period.
- Consistent child care arrangements will be maintained by: maintaining the amount of care authorized during a family's 12 month eligibility period unless certain things change; allowing child care assistance to continue when a family temporarily stops working or attending school; eliminating the 20 hour per week average, or 10 hours for students, employment requirement between redeterminations, as long as the family remains employed; extending eligibility for child care assistance at the same level for three months after a family's activity ends permanently; and allowing families to continue to receive assistance until the next redetermination when a child turns 13, or a child with a disability turns 15, within the 12 month eligibility period.
- Allowing continued eligibility when there are changes in income, but income remains below the federal exit level (85 percent SMI).
- Establishing a $1 million asset limit where families will be required to certify on the application and redetermination that their assets are not greater than $1 million. Currently there is no asset limit.
- Requiring an expedited five working day application process by counties for homeless families. Proof of eligibility is required within three months, or assistance would end. Currently there is not an expedited application process.
- Updating provider payment policies.
- Providing funding for contractual agreements with child care providers to address shortages in the supply of high quality child care.

Federal requirements – Health, safety and licensing changes ($7.5 million in 2017, $14.1 million in 2018-19)
The goal of these proposals is to provide safer, higher quality, accessible child care across the state to meet the new requirements under reauthorization. These proposals will impact over 13,000 family and center-based child care providers throughout the state who have the capacity to care for over 200,000 children. Approximately 58 percent of providers, and just over half of the capacity, are located in greater Minnesota.

Changes include:

- Annual inspections for licensed family child care providers and child care centers. Currently, these are required every two years.
- Reduce child care center licensor caseloads to 1:75 from the current 1:180. At the current ratio, Department of Human Services licensors are unable to complete even a biennial inspection for every child care center. (24 FTEs)
- Require that non-relative legal non-licensed providers and license exempt centers who accept families receiving CCAP meet basic health and safety standards, including annual monitoring visits. (10 FTEs)
- Make DHS responsible for conducting legal nonlicensed and family child care background studies. We also propose to create a new background study requirement for current license exempt programs who will be certified. This is funded through state government special revenue funds, using a $20 fee collected from providers. It is estimated that the state will need to complete about 65,000 studies of current legal nonlicensed, license exempt, and family child care providers and new providers/staff during fiscal years 2017 and 2018. (5 FTEs in 2017 and decreasing to 1 ongoing starting in FY20)
- Update health and safety requirements related to emergency preparedness, handling of bio-contaminants, administration of medication with parental consent and reinforce these with updated training requirements.
- Emergency preparedness planning and a statewide disaster plan for child care.
- Mandate training and qualification standards for licensors/inspectors of licensed family child care, licensed child care centers, and license exempt centers.
- Posting on a public website of annual monitoring and inspection reports for all providers, and aggregate data on the number of deaths, serious injuries and substantiated maltreatment that occurred among all providers.

These changes to meet new federal health, safety and training requirements, and to reduce child care center licensor caseloads from 180 per licensor to 75 over three fiscal years will require new state administrative resources, including:

This proposal also recommends $250,000 in one-time funding for modifying the Department of Human Service's licensing websites to feature more information on child care providers important to families, and the development of a digital monitoring tool for Department of Human Service's and county licensors.

County Impact

Counties will continue to be responsible for licensing family child care providers but will now need to conduct annual inspections, instead of once every two years. There are approximately 9,500 family child care providers with the capacity to serve more than 110,000 children. In order to help counties meet this expanded monitoring responsibility, this proposal includes $4.8 million in ongoing annual grants to counties to conduct annual inspections for family child care providers. This figure was developed in conjunction with county licensing representatives.

Alignment with Federal Goals of the Reauthorization Act – Child Care Assistance Program ($566,000 in 2017, savings of $3.7 million in 2018-19)

This proposal will:

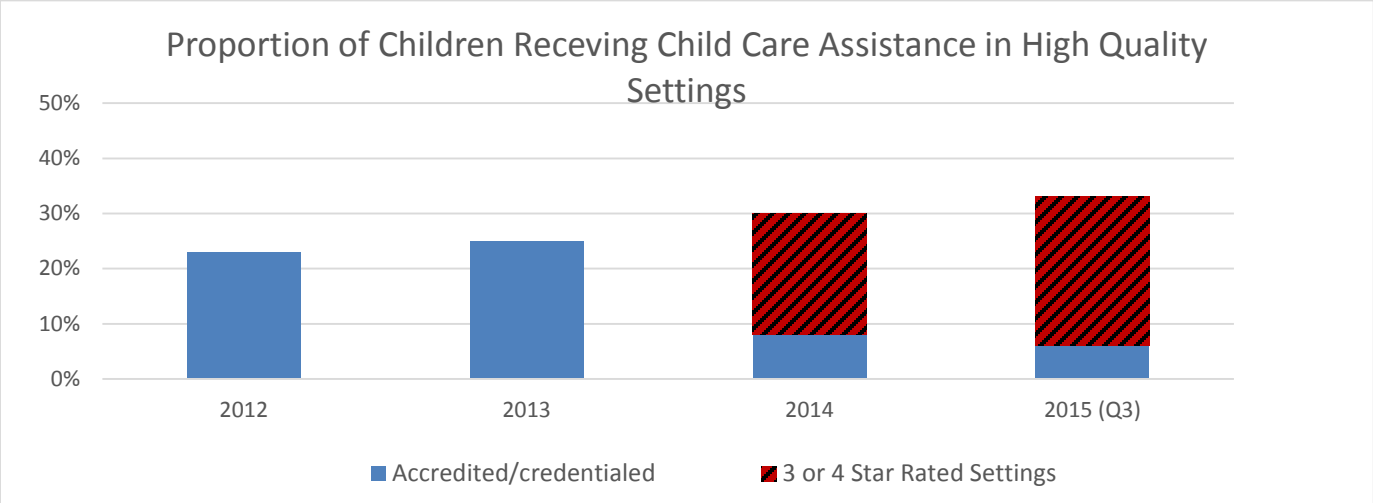
- Allow parents, at initial application, to spend more time searching for a job while on CCAP including up to 30 hours of child care per week for three months for a job search.
- Allow more parent choice in their child care schedule by limiting required verification of a parent's work or school schedule and instead tying authorized hours to the number of hours care is needed for a child, not specific days and times.
- Exempt homeless families from activity requirements during the three month period following application. Care would be approved for up to 30 hours per week.
- Simplify policies related to overpayments by eliminating: collections caused solely by agency error; overpayments that occurred more than one year prior to discovery, overpayments overpayments under $500, unless due to fraud or loss of an appeal.
- Ensure program integrity by: not allowing centers be authorized to care for children of employees, limiting the amount of authorized care when a child has more than one provider:, decreasing the maximum length of time that retroactive eligibility can be approved, increasing the administrative penalties for child care providers, and aligning self-employment income definition with other public assistance programs.
- Repeal a duplicative section of statute passed in the 2015 legislative session related to recoveries of overpayments from providers who fail to comply with attendance record requirements.

Increase Maximum Reimbursement Rates in the Child Care Assistance Program ($17.1 million in 2017, $171 million in 2018-19)

Federal reauthorization requires that states set subsidy payment rates in accordance with the results of the current market rate survey. To implement this requirement, the Governor recommends adjusting the maximum rates paid to child care providers to the 50th percentile following each biennial provider market rate survey. With the first update, maximum rates would be based on the 2016 market rate survey. Most maximum rates would increase, some would stay the same, and some would decrease. The federal reauthorization requires states to update rates on an ongoing basis, but states have some discretion in setting the percentile benchmark for the maximum rate.

Results:

The following performance measure is used to assess access to high quality child care through the Child Care Assistance Program:



Footnote:

High quality settings are defined as those eligible for higher rates of reimbursement by meeting quality standards identified in statute. Settings were categorized according to the criteria they met to qualify for the higher reimbursement rate. Parent Aware statewide expansion began in 2012 and in 2014, programs became eligible for higher reimbursement rates for 3 or 4 Star ratings. Some settings are both 3 or 4 Star Parent Aware Rated and accredited or credentialed. Starting in 2014 those settings are shown here as 3 or 4 Star Parent Aware Rated. Some settings serving children receiving CCAP are not eligible for Parent Aware ratings.

The following performance measure is used to assess the effectiveness of health, safety and licensing changes:

Type of Measure	Name of Measure	Previous	Current	Dates
Quantity	Required Annual Licensing Inspections Completed	0	0	2014, 2015
Quality	Child Care Center Licensor Caseload	180	180	2014, 2015
Results	Child Deaths in Child Care Settings	12	1	2012-2013, 2014

Statutory Change(s):

Minnesota Statutes, Chapter 119B will require extensive changes. Minnesota Statutes, Chapter 256P and 256.98 will require changes. Licensing: 245A, 245C, 121A.15.

Fiscal Detail:

Net Impact by Fund(dollars in thousands)			FY 16	FY 17	FY 16-17	FY 18	FY 19	FY 18-19
General Fund			$0	$28,280	$28,280	$103,753	$127,501	$231,254
HCAF								
Federal TANF								
Other Fund								
Total All Funds			$0	$28,280	$28,280	$103,753	$127,501	$231,254
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	22	MFIP Child Care Assistance Grants	0	13,380	13,380	64,113	79,173	143,286
GF	42	BSF Child Care Assistance Grants	0	6,899	6,899	31,477	39,165	70,642
GF	11	Finance & Mgmt Ops (MEC2)	0	403	403	6	6	12
GF	43	Child Care Provider Grants	0	0	0	1,000	2,000	3,000
GF	12	Children & Family Operations (1 FTE for provider Grants)	0	130	130	115	115	230
		FFP 35% (Children & Families Admin)	0	(46)	(46)	(40)	(40)	(80)
GF	11	Operations (Licensing 35 FTEs)	0	3,839	3,839	3,481	3,481	6,962
GF	REV1	FFP @35% (Licensing)	0	(1,344)	(1,344)	(1,218)	(1,218)	(2,436)
GF	47	County Licensing Grants	0	4,769	4,769	4,769	4,769	9,538
GF	11	Systems (Licensing)	0	250	250	50	50	100
DED	EXP	Special Revenue (Background Study expenditures)	0	0	0	899	396	1295
DED	REV	Special Revenue (Background Study revenues)	0	0	0	(899)	(396)	(1295)
Requested FTE's								
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	12	Children & Families Operations	0	1	1	1	1	1
GF	11	Operations –Licensing FTE's	0	35	35	34	34	34
		Total FTEs	0	36	36	35	35	35

Department of Human Services
FY16-17 Supplemental Budget Change Item

Change Item Title: Early Childhood Facilities Improvement

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	0	$7,000	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)		$7,000		
FTEs	0	0	0	0

Request:

The Governor recommends investments of $7.0 million in Fiscal Year 2017 to expand funding for early childhood facilities to rehabilitate or construct facilities that are not eligible for state bonding money. These funds would be available to Head Start, child care, tribal and other non-profit programs serving at-risk populations. $2 million of this proposal is dedicated to renovation of Perspectives Family Center in St. Louis Park, MN.

Rationale/Background:

In the past, most Early Childhood Facilities projects were rehabilitation projects, but this is changing. While projects funded in 2005 and 2006 were all rehabilitation projects, in 2012 three of five projects were for new construction and in 2014, five of seven projects were for new construction. We expect this trend to continue as need and demand for early childhood programs increases. In 1998, general funds were appropriated for this purpose, with a total of 19 projects funded with $3 million in general fund plus $2 million in bond funding.

Proposal:

This proposal would invest general fund dollars to expand funding for early childhood facilities to rehabilitate or construct facilities. The Governor's Capital Budget recommendations include $15 million for Early Childhood Facilities, but because of capital budgeting rules, those funds would only be available to publicly owned early childhood programs. The funds requested here would be available to Head Start, child care, tribal and other non-profit programs serving at-risk populations. These organizations could apply for a grant without partnering with a political subdivision. $5 million in general funds would be invested to allow non-profits and other early childhood programs to receive grants to improve the infrastructure for early childhood learning facilities.

This proposal would also invest $2 million in general funds for the expansion and rehabilitation of the Perspectives Family Center in St. Louis Park to serve homeless and at-risk families. This project includes a new therapeutic early childhood education center, expanded children's mental health services and earth science programs. Perspectives, Inc. will be able to expand programming for homeless families including early childhood development program specifically designed to address trauma caused by homelessness. Perspectives purchased the building in 1996, but the building continues to deteriorate despite many costly repairs. It no longer is feasible to serve the growing needs of families. This general fund appropriation will leverage private fundraising for the $10 million project.

Statutory Change(s):

Appropriation Rider

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 16	FY 17	FY 16-17	FY 18	FY 19	FY 18-19
General Fund			$0	$7,000	$7,000	$0	$0	$0
HCAF								
Federal TANF								
Other Fund								
Total All Funds			$0	$7,000	$7,000	$0	$0	$0
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	47	Children & Econ Support (Early Child Facilities)	0	5,000	5,000	0	0	0
GF	47	Children & Econ Support (Early Child Facilities - Perspectives)	0	2,000	2,000	0	0	0
Requested FTE's								
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**

2

Change Item Title: Medical Assistance Services for Children with Poorly Controlled Asthma

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	0	343	994	1,354
Revenues	0	0	0	0
Health Care Access Fund				
Expenditures	0	6	19	26
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	349	1,013	1,380
FTEs		0.5	0.5	0.5

Request:

Effective January 1, 2017, the Governor recommends Medical Assistance and MinnesotaCare add coverage for enhanced asthma care services for children with poorly controlled asthma. The enhanced coverage would include a home assessment for asthma triggers, targeted asthma education services, and allergen-reducing products.

Proposal:

This proposal would add a new enhanced asthma benefit to the Medical Assistance (MA) and MinnesotaCare benefit sets. The benefit would be available for children with poorly controlled asthma, as defined by past hospitalizations or emergency room visits related to asthma or asthma complications. The new benefit would include services such as:

- A one-time home assessment for asthma triggers by a certified asthma educator;
- One-time targeted asthma education services provided in the child's home; and,
- When medically necessary and recommended by a certified asthma educator or healthy home specialist, allergen-reducing products such as dehumidifiers, HEPA vacuum cleaner, mattress and pillow encasements, and air cleaners and filters.

This would be a new benefit and would be implemented through enrollment of certified asthma educators and healthy home specialists as rendering providers for Medical Assistance and MinnesotaCare. The recommended allergen-reducing products could be delivered via existing medical supply vendors or via a volume purchase contract with one or more medical supply/asthma supply vendors that would dispense the products.

Implementation would include:

- Enrollment of new provider types
- Systems work to allow new services and supplies to be paid for in the claim system and prevent duplicate payment for the same child
- Possible additional systems work if needed to verify the child meets the criteria for poorly controlled asthma
- Potential amendment to prior authorization vendor contract
- Potential RFP for an asthma supply volume purchase vendor
- 0.5 FTE to manage the policy around provider requirements, approved products, replacement frequency and approval, coordination of limits across fee-for-servcie and managed care, and provide policy support to the authorization vendor or contracted durable medical equipment vendor(s)
- State plan submission and approval

Rationale/Background:

- In CY 2014, Medical Assistance spent $2.7 Million on inpatient treatment for about 650 children with a primary diagnosis of asthma and $2.4 million in emergency department visits for about 5,800 children with a primary diagnosis of asthma.
- This proposal represents an effort to reduce the amount of emergency room (ER) and hospital visits by children with asthma who live in homes where asthma triggers are present. By mitigating the triggers with specialized education and supplies, fewer children will present with asthma attacks severe enough to warrant ER visits or hospitalizations.

- The newly covered service will be available to children with poorly controlled asthma in January 2017. Once fully phased in over three years, this service is expected to reach roughly 2/3 of the roughly 6,000 children with poorly controlled asthma annually.
- Controlled clinical trials studying the effect of this type of intervention on children with asthma showed a reduction in inpatient hospital days and ER visits related to asthma. Applying this lower utilization to children in MA results in an average reduction of 28 percent in the annual cost of asthma related inpatient hospital and ER visits per child receiving these new services.

Fiscal Impact:

- Estimates for the cost of these new services is roughly $1,000 per family receiving the intervention. This figure is based on a published report from the Minnesota Department of Health[1] which showed an average cost for asthma education and home assessments of $545 and an average cost per family of $424 for allergen reducing services. The estimated annual savings per MA recipient receiving the service is $320. This figure is the MA savings from reduced emergency room visits and inpatient hospital stays and is from a controlled trial of home based asthma interventions which found a reduction in ER and hospital utilization for those receiving the services.[2]
- This proposal requires changes to MA claims payment systems and additional staff resources to develop and manage new coverage policy and support product vendors and other providers. The cost for these items is reflected in the fiscal detail table.

Results:

This proposal is expected to have a positive impact on the following measures:

- Number of child ER visits for asthma
- Number of home assessments
- Difference in ER visits for children who received assessments and allergen reducing products vs. those that did not

Statutory Change(s):

Minnesota Statutes 256B.0625.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
General Fund			$0	$343	$343	$994	$1,354	$2,348
HCAF			$0	$6	$6	$19	$26	$45
Federal TANF								
Other Fund								
Total All Funds			$0	$349	$349	$1,013	$1,380	$1,393
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	33-FC	MA Grants		300	300	960	1,320	2,280
HCAF	31	MinnesotaCare Grants		6	6	19	26	45
GF	11	Systems - MMIS		5	5	1	1	2
GF	13	HCA Admin		59	59	51	51	102
GF	REV1	FFP @ 35%		(21)	(21)	(18)	(18)	(36)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	13	HCA Admin		0.5		0.5	0.5	

[1] "The Housing and Urban Development Project to Reduce Environmental Triggers of Asthma," Minnesota Department of Health, January 17, 2015.
[2] "Cost Effectiveness of a Home-Based Environmental Intervention for Inner-City Children with Asthma," Journal of Allergy and Clinical Immunology, November 2005.

Change Item Title: Reimbursement for Family Home Visiting Services in Medical Assistance

Fiscal Impact ($000s)	FY2016	FY2017	FY 2018	FY 2019
General Fund				
Expenditures	0	186	467	559
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	186	467	559
FTEs	0	1.0	1.0	1.0

Request:
Effective January 1, 2017, the Governor recommends increasing Medical Assistance reimbursement for certain public health nurse home visits for mothers and young children to age three. Through regular, planned home visits, parents learn how to improve their family's health and provide better opportunities for their children. The impact of this proposal is $186,000 in SFY2017 and $1.03 million in the SFY 2018-19 biennium.

Proposal:
The Governor proposes to increase the Medical Assistance (MA) reimbursement rate for certain public health nurse home visiting services provided to mothers and young children under four years of age. The higher rate is eligible only to those providers using evidence based home visiting models recognized by the United States Health Resources and Services Administration.

Rationale/Background:
Medical Assistance currently covers nurse home visits, including postpartum follow-up home visits for at risk mothers and infants. The home visits represent an opportunity to provide education about infant care and anticipatory guidance for healthy parenting in addition to assessment of the woman's health and follow-up on medical conditions or risk behaviors.

Some public health nursing agencies use evidence-based home visiting models recognized by the United States Health Resources and Services Administration (HRSA). The evidence-based models are proven to improve child health and be cost effective. However, the evidence-based models necessitate visits which are more intense in content and duration than visits using other models. There are concerns that the current MA payment rate may not be adequate to cover the cost of the evidence-based models. We therefore propose to increase the rate paid for evidence-based home visits.

Evidence based models for home visiting work to build partnerships between families and home visitors with the goals of:

- Improving health and development
- Preventing child injuries, child abuse, neglect, or maltreatment, and reducing ED visits
- Improving school readiness and achievement
- Reducing crime, including domestic violence
- Improving family economic self-sufficiency
- Improving the coordination and referrals for other community resources and supports

The purpose of this proposal is to improve access to evidence-based home nursing visits with the ultimate goals of improved family health and improved opportunities for MA-enrolled children.

Fiscal Impact:
This proposal provides a $140 payment rate for public health nurse visits by providers meeting certain evidence based criteria. In FY2015, there were about 41,400 public health nurse visits to pregnant women and children under four in Medical Assistance with an average payment per visit of $63. About 7,500 or 18 percent of these visits are from providers meeting the evidence based criteria that would qualify for an average increase of $77 per visit (to a total of $140 per visit) under this proposal. The total number of visits is trended forward based on the current MA forecast for families and children. The estimate assumes that the proportion of visits qualifying for the higher reimbursement increases by 5 percent per year from the base of 18 percent in FY17.

Identifying the providers and services receiving the higher rate, collecting attestations from providers of evidence based services, and developing and administering new payment policies, and training providers on new billing procedures requires additional administrative resources. This proposal includes the cost for one new full time employee to facilitate enrollment of the evidence-based providers and be available for training on billing and enrollment procedures.

IT Related Proposals:

Implementing this proposal will require some changes to the DHS claims payment systems. New provider indicators or new modifiers may be necessary and the MMIS will need to be coded to pay differently for the evidence based visits than other visits.

Results:

This proposal is expected to have a positive impact on the following measures:

- Total number of home visits
- Percentage of home visits which are evidence-based
- Number of claims for child injuries, child neglect, and ED visits for young children on Medical Assistance

Statutory Change(s):

256B.0625

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
General Fund			$0	$186	$186	$467	$559	$1,026
HCAF								
Federal TANF								
Other Fund								
Total All Funds			$0	$186	$186	$467	$559	$1,026
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	33 FC	MA Grants		104	104	399	491	890
GF	13	HCA Admin		117	117	103	103	206
GF	REV1	FFP @ 35%		(41)	(41)	(36)	(36)	(72)
GF	11	Systems (MMIS state share @ 29%)		6	6	1	1	2
Requested FTE's								
GF	13	HCA Admin		1		1	1	

Change Item Title: Federal Alignment for Foster Care

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	0	12	2	2
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	12	2	2
FTEs	0	0	0	0

Request:

Effective July 1, 2016, the Governor recommends amending Minnesota Statutes related to child foster care to be in alignment with Titles IV-B and IV-E of the Social Security Act as modified by the following federal laws:

- Public law 113-183 Preventing Sex Trafficking and Strengthening Families Act, and
- Public law 110-351 Fostering Connections to Success and Increasing Adoptions Act

Proposal:

This proposal would amend foster care state statutes related to educational stability, case transfers and state court processes.

Educational stability

The proposal amends Minnesota Statute, section 260C.212, subdivision 1 to require that the case plan ensures that a foster child who is the minimum age for compulsory school attendance under State law and for whom there is eligibility for a foster care payment under the State Plan, is:

- enrolled in an elementary school,
- instructed in elementary or secondary education at home,
- enrolled in an independent study program, or
- incapable of attending school on a full time due to a medical condition.

The Fostering Connections to Success and Increasing Adoptions Act of 2008 [Public Law 110-351] amended Titles IV-B and IV-E of the Social Security Act, to revise case plan requirements to improve educational stability for a child in foster care. A child in foster care, who is eligible for foster care payments, benefits by having options to complete their education.

The proposal ensures county and tribal agencies develop an educational stability plan as part of each child's case plan. The proposal would require that a child's case plan include assurances that the local social service agency work with the local school system to ensure that a child remains in school during placement, and that all Title IV-E eligible students of minimum compulsory school age are attending an appropriate school program. While there is no change to existing programs, changes are needed in the service plans to allow counties to document that the educational stability provisions required by Title IV-E have been met, as well as allow the Department of Human Services (DHS) to report that these case plan requirements are being met.

Case transfer process

The proposal recommends adding a section to Minnesota Statute to require the transfer of an Indian child's Title IV-E eligibility records to an in-state or out-of-state tribal Title IV-E agency or an Indian tribe with a Title IV-E Agreement. Adding this provision ensures that an Indian child retains eligibility for Title IV-E and Medicaid. The following documentation and information must be transferred:

- All district court judicial determinations to the effect that continuation in the home from which a child was removed would be contrary to the welfare, and that reasonable efforts described in section 471 (a)(15) in the Social Security Act have been made
- Other documentation a county agency has related to a child's Title IV-E eligibility under sections 472 and 473 of the Social Security Act
- Information and documentation available to an agency regarding eligibility or potential eligibility for other federal benefits
- The case plan developed pursuant to section 475(1) of the Social Security Act
- Information and documentation of a child's placement setting.

In 2012, the U.S. Department of Health and Human Services Administration on Children, Youth and Families, issued program instructions requiring state Title IV-E agencies to establish and maintain procedures for transfer of responsibility for the placement and care of a child under a state Title IV-E plan to a tribal Title IV-E agency or an Indian tribe with a Title IV-E Agreement. The purpose is to ensure an Indian child's title IV-E eligibility is maintained when transferred to another Title IV-E agency. Transferring of information helps to facilitate continuity of services for a child being transferred to an out-of-state tribe.

State Court processes
To ensure compliance with the federal Preventing Sex Trafficking and Strengthening Families Act this proposal recommends modifying the following statutes:

- Minnesota Statutes, sections 256N.22, subdivision 10 to clarify process to assign successor relative custodian for a child's Northstar Kinship Assistance.
- Minnesota Statutes, section 260C.201, subdivision 1(5), eliminate the provision that allows a child age 16 or older, that the court has found to be in need of protection and services, to live independently without foster care services
- Minnesota Statutes, sections 260C.203 and 260D.10, define the discharge and transition requirements for foster youth age 14 and older
- Minnesota Statutes, sections 260.221, clarify relative search provisions.
- Minnesota Statutes, section 260C.451, define the purpose of the annual court review for foster children after age 18
- Minnesota Statutes, section 260C.521, specify the annual court review judicial findings for foster children in the permanent custody of the agency.

To ensure that a foster child's private data is not available to the public, this proposal amends Minnesota Statutes, section 260C.212, subd.1, to clarify the sections of the out-of-home placement plan that are filed with the court.

Rationale/Background:
These proposals will bring Minnesota Statutes and child welfare practice into compliance with Title IV-B and IV-E of the Social Security Act, which is required for the state to continue to be eligible for federal funds. These funds contribute to the cost of foster children's care, and county, tribal and state administrative services.

IT Related Proposals:
There is a small cost for the Social Services Information System (SSIS) to update service plans related to the educational stability changes in the proposal. These changes allow counties to document that the federal Title IV-E educational stability provisions for case planning are met, and allow DHS to ensure that these Title IV-E requirements are in place for children in foster care throughout the state. The changes in SSIS will impact local governments by requiring policy and practice changes as case workers will need to complete educational stability related portions of the case plans.

Results:
Foster children and their families will be better off with continued federal funding that supports educational stability, clarifies the transfer of information to facilitate continuity of services for an Indian child being transferred to an out-of-state tribe, and specifies court processes. These changes are required by the Children's Bureau of the U.S. Department of Health and Human Services, and will help ensure that the appropriate measures and considerations are implemented for foster children in Minnesota.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	85% of children in a foster care placement	NA	NA	7/1/2016
Quality	Documented in SSIS and/or case file	NA	NA	7/1/2016
Results	Remain in their school of origin	NA	NA	7/1/2016

Statutory Change(s):
- Minnesota Statutes, sections 256N.22, subdivision 10; 260C.201, subdivision 1(5); sections 260C.203 and 260D.10; section 260.221; section 260C.451; and section 260C.521.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 16	FY 17	FY 16-17	FY 18	FY 19	FY 18-19
General Fund			$0	$12	$12	$2	$2	$4
HCAF								
Federal TANF								
Other Fund								
Total All Funds			$0	$12	$12	$2	$2	$4
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	11	Finance & Mgmt Operations (SSIS)	0	12	12	2	2	4

Change Item Title: Child Protection Grant Allocation Formula Change

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	0	0	0
FTEs	0	0	0	0

Request:
Effective July 1, 2017, the Governor recommends modifying the county performance withhold formula for child protection grants to modify the period of data used to measure performance on face-to-face visits by a case manager for children receiving child protection services while residing in their home.

For the remaining two performance outcomes, it is recommended that the commissioner make threshold determinations in February of each year and payments to counties meeting the performance outcome threshold in the following March of each year.

Proposal:
This proposal will change the data used in determining the amount of the allocation that is withheld. This change will only impact how the performance allocation formula is calculated and has no impact on the amount of the overall appropriation. This could change county allocation amounts, however, since the data has not yet been used, the individual county changes are unknown.

Rationale/Background:
The 2015 legislature approved funding for child protection grants based on the work of the Governor's Task Force on Child Protection. Eighty percent of the funding serves as base funding to support the hiring of additional county child protection staff and the provision of services. Twenty percent of the funding appropriated serves as performance-based allocations to counties that meet the threshold in two measures:

- Ten percent on timely face-to-face contact with at least 90 percent of all alleged child victims of screened-in maltreatment reports; and,
- Ten percent on face-to-face visits by the case manager for children in foster care and for children receiving child protection services while residing in their home with at least 90 percent of the total number of such visits that would occur if every child were visited once per month.

The legislature required that the standard for monthly in home visits not be applied until 2016.

Data is extracted from the Social Service Information System (SSIS) to allow the commissioner to make threshold determinations for county performance. Data is incomplete in SSIS for the previous calendar year until February because the system does not contain real time data. Data available in February provides a more complete set of performance data. February data will be more accurate and complete in their reflection of county performance. Payments could be made to counties meeting the performance outcome threshold in March following the February data extraction.

Statutory Change(s):
M.S. 256M.41

Fiscal Detail:

Net Impact by Fund (dollars in thousands)	FY 16	FY 17	FY 16-17	FY 18	FY 19	FY 18-19
General Fund						
HCAF						
Federal TANF						
Other Fund						
Total All Funds	$0	$0	$0	$0	$0	$0

Fund	BACT#	Description	FY 16	FY 17	FY 16-17	FY 18	FY 19	FY 18-19

Change Item Title: Economic Stability for Families

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	0	4,002	12,706	12,300
Revenues	0	0	0	0
TANF Funds				
Expenditures	0	23,660	24,102	24,281
Revenues	0	(23,660)	(24,102)	(24,281)
Net Fiscal Impact = (Expenditures – Revenues)	0	4,002	12,706	12,300
FTEs	0	0	0	0

Request:

The Governor recommends investing $27.6 million in FY 2017 and $73.4 million in FY 2018-19 to increase the Minnesota Family Investment Program (MFIP) and Diversionary Work Program (DWP) cash grant by $100 per month, effective October 1, 2016. Funding for this proposal is shared between the General Fund and the Temporary Assistance for Needy Families (TANF) Fund. TANF resources have been made available through a related Department of Revenue proposal to fund the Working Family Tax Credit out of the General Fund.

Proposal:

This proposal would increase the Minnesota Family Investment Program transitional standard cash grant by $100 per month effective October 1, 2016. This change would require approval from the United States Department of Agriculture, Food and Nutrition Services (FNS). Minnesota has a waiver that allows cash and food benefits to be combined. The state may need to reduce the food portion of benefits in order to retain approval of the waiver from FNS. This proposal will impact an average of 32,500 families including 65,000 children each month.

Rationale/Background:

Between 1991 and 2012, the number of homeless Minnesota children and youth has almost quadrupled; in 2012, about 3,500 children with their parents were homeless on any given night.[1] Being homeless is the most concrete manifestation of the growing number of Minnesota's children in poverty and in deep poverty. Poverty has long-lasting impacts, not only for children and families living in poverty, but for the economy of the state as a whole, because of the strong correlation between childhood poverty and poor educational outcomes.

Poverty is ultimately about having too little money to meet expenses for basic needs. Since the mid-1980s both wages and safety net assistance have stagnated, putting low-wage workers in financial distress, whether working or not working.

Wages

Minnesota took a major step toward solving some elements of the wage problem by increasing the state minimum wage. Low- wage workers, however, continue to face the reality of jobs that are often part-time, and offer unpredictable and inconsistent hours. In fact, the demographers' office points out that two-thirds of Minnesota's children in poverty have working parents.[2] In addition, low-wage workers are twice as likely to lose their jobs as higher paid workers, but only half as likely to collect unemployment insurance when that happens.[3]

[1] Wilder Research, Statewide Homeless Study,

[2] Poverty and Aging Trends in Minnesota, Andi Egbert, Minnesota State Demographic Center, January 14, 2014, a PowerPoint for the Nutritious Food Conference, January 14, 2014.

[3] "Unemployment Insurance: Low Wage Workers and Part-time Workers Continue to Experience Low Rates of Receipt", Report to the Chairman, Subcommittee on Income Security and Family Support, Committee on Ways and Means, House of Representatives, by Government Accountability Office, August 2007.

Link to report on unemployment insurance and low-wage and part-time workers

Assistance
Unemployed low-wage workers with children can turn to the Minnesota Family Investment Program as a safety net. In fact, 80 percent of parents who enroll in cash assistance have been in Minnesota's labor market. But families today receive the same amount of monthly assistance from MFIP as families received in 1986. If the assistance levels had the same buying power as in 1986, a family of three would receive more than $1,100 a month and children would be at 70 percent of poverty. What once paid the rent for families in crisis now will pay only half the cost of a two-bedroom apartment in the Twin Cities metropolitan area, according to the Department of Housing and Urban Development's published Fair Market Rent levels. The current assistance levels are at 32 percent of the Federal Poverty Guidelines (FPG) and do not help families out of deep or extreme poverty, defined as living below 50 percent of the FPG. The Minnesota Family Investment Program exists to get income support to the poorest children and their families, yet it cannot adequately house a family when facing a crisis such as a lost job, serious illness, or domestic violence.

This change will help address the growing number of children who are homeless, increase the economic stability of families, and support state efforts to increase school achievement

Fiscal Impact:
The primary fiscal impact from this change results from higher grants to MFIP and DWP participants due to the higher benefit level used in determining the grant amount. The average increase in monthly benefit for MFIP is estimated at $94, while the average increase for DWP cases is $44 per month. In addition, it is estimated that about 320 families would be newly eligible for MFIP/ DWP.

Approximately $24 million per year in TANF funds are currently transferred to support the Working Family Tax Credit. The Department of Revenue is proposing to eliminate the transfer and instead fund the Working Family Tax Credit out of the General Fund. The federal TANF funds that are no longer transferred to the Working Family Tax Credit are then used to pay for a portion of the funds required to increase the cash benefit. The proposal also requires a General Fund appropriation of $4 million in FY 2017 and approximately $25 million in FY 2018-19.

IT Related Proposals:
There is a one-time cost of $17,000 in 2017 to update the MAXIS computer system to administer the change in the cash benefit.

Results:
For MFIP: The department will measure and monitor the number of children living in deep poverty, defined as below 50% of the poverty level. The department will develop a measure for children on MFIP who are living in deep poverty and measure the change in the number of MFIP children living in deep poverty.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Number of children on MFIP living in deep poverty	TBD	TDB	

Statutory Change(s):
MS 256J.24, subd. 5.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
General Fund			$0	$4,002	$4,002	$12,706	$12,300	$25,006
HCAF								
Federal TANF			$0	$0	$0	$0	$0	$0
Other Fund								
Total All Funds			$0	$4,002	$4,002	$12,706	$12,300	$25,006
Fund	**BAC T#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	21	MFIP/DWP Grants	0	3,242	3,242	11,024	10,513	21,537
TANF	91	Technical Activities (TANF not used for WFC)	0	(23,660)	(23,660)	(24,102)	(24,281)	(48,383)
TANF	21	MFIP/DWP Grants	0	23,660	23,660	24,102	24,281	48,383
GF	22	MFIP Child Care Assistance	0	743	743	1,682	1,787	3,469

Net Impact by Fund (dollars in thousands)			FY 16	FY 17	FY 16-17	FY 18	FY 19	FY 18-19
GF	11	Operations - Systems (MAXIS)	0	17	17	0	0	0

Change Item Title: American Indian Initiatives

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	0	$2,845	$1,900	$1,900
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	$2,845	$1,900	$1,900
FTEs	0	1.0	0	0

Request:
Effective July 1, 2016, the Governor recommends three proposals that will enhance the human services work being done in the White Earth, Red Lake and Mille Lacs Band of Ojibwe Tribal Nations.

Proposal:
The Governor recommends supporting the human services infrastructure serving Minnesota's native community by proposing:

- An annual appropriation of $1.4 million to be granted to the White Earth Nation to pay for administrative costs associated with the implementation of the White Earth Human Services Initiative;
- An annual appropriation of $500,000 to be granted to the Red Lake Nation to pay for administrative costs associated with the implementation of the Red Lake Human Services Initiative; and
- Investing $945,000 in 2016 in one-time funding to support planning efforts to expand the American Indian Child Welfare Initiative to include the Mille Lacs Band of Ojibwe and Red Lake Nation. This Funding supports the planning that is necessary before county child welfare responsibilities are transferred to the Mille Lacs Band of Ojibwe and the Red Lake Nation.

Rationale/Background:
The Department of Human Services is working with several Tribal governments in the state to transfer health and human service programming to tribal health and human services. American Indian adults and children are over-represented in DHS public assistance programs. Tribal governments and DHS have determined that tribal health and human service programs are in a better position to provide culturally appropriate and qualitative services. To this end, DHS is working with White Earth, Red Lake, and Mille Lacs to transfer human service responsibility for their members from their surrounding counties to the tribal governments. The counties support each of these initiatives. Because Tribal Governments do not have a tax base, state fiscal support is needed to assure success. It is important to remember that American Indians living on reservations are also citizens of the state.

Legislation passed in 2011 created the authority for the White Earth Nation (WEN) to assume responsibilities for providing human services for members of the White Earth tribe and their families who made the choice to receive services from the WEN (instead of the county). No funds have been made available from either the state or the counties to the WEN to assume the administrative responsibility being transferred from counties to the White Earth Nation. The White Earth Nation will be held responsible to the same performance measurement that counties are held to via the County Performance Measurement system. Among the performance indicators that White Earth will be evaluated on are: People have access to health care; children and adults are safe and protected; people are fed; eligible clients receive cash assistance while simultaneously engaging in work activities.

The Red Lake Human Service Initiative will build on the Red Lake Tribal TANF program which was arranged via approval of a tribal TANF plan submitted directly to the federal Administration for Children and Families. Under this federal program, recipients of state MFIP have been transferred to the Red Lake Nation's TANF program. All clients transferred to the Red Lake Nation per this federal authority are also eligible for other state supervised and county-administered services including Child Care, SNAP, Health Care and Child Support Enforcement. The transfer of these programs is necessary to assure continuity of access to services for members of the Red Lake Nation who are also citizens of the state of Minnesota. If this proposal is not funded, the counties will remain responsible for the administration of these programs which will pose navigation problems for the clients as the distance between the eligibility centers is approximately 40 miles. By partnering with Red Lake, Red Lake members and their families will have local access to an array of comprehensive services that will be designed to be both qualitative and culturally sensitive.

The American Indian Child Welfare Initiative (AICWI) is a significant child welfare reform effort in Minnesota. This program is a collaboration among tribal, county and state governments with the shared goal of improving child welfare outcomes for American Indian children, and reducing the disproportionate number of American Indian children in the state's child welfare system. This proposal provides one-time grants to fund the planning phase of expanding the Initiative to Mille Lacs Band of Ojibwe and Red Lake Nation. Red Lake children represent approximately 60% of children in out-of-home care in Beltrami County. Mille Lacs Band of Ojibwe children represent approximately 40% of the number of children in out-of-home care for the 5 counties that share lands with Mille Lacs Band. These counties all support these tribes expansion into the AICWI which will build tribal capacity to serve their families in a way that is culturally relevant. Since 2008, child welfare services for American Indian children and their families living on the Leech Lake Band of Ojibwe and White Earth reservations, who are both part of the current AICWI, were transformed from a county-based delivery system to a tribal delivery system. Annually, more than 3,000 individuals receive child abuse prevention, family preservation, child protection, foster care, foster care licensing, children's mental health screening, reunification and customary adoption services administered by their tribal government. This proposal is also in alignment with tribal recommendations to the Governor's Task Force on the Protection of Children.

Fiscal Impact:

The grants to support administrative activities at the White Earth and Red Lake Nations support new activity that would have been funded with county tax levy funds when provided by counties. These are new grants amounting together to $1.9 million per year starting in FY2017.

The AICWI planning grants are a one-time grants in the amount of $500,000 each to the Mille Lacs Band of Ojibwe and Red Lake Nation. These grants will fund three full-time and one part-time staff in each tribe to coordinate and plan for the transfer, including required fiscal and legal reviews and an implementation plan.

Finally, the proposal includes funding for one full-time department position to assist in the planning during SFY2017. This will involve coordinating work across programs and information systems within the department and with MN.IT as well as coordinating work with the tribes and affected counties as they work through the complex legal, program and financial issues involved in the transfer of child welfare responsibilities from counties to tribes. The net state cost of the position is estimated to be $86,000.

The tribes have requested that instead of being required to comply with the state's child protection statute they comply with a tribal child protection statute that is equivalent to the state child maltreatment law. MN.IT staff time is needed to conduct the analysis of the impact of this request on the Social Service Information System (SSIS). Initial costs for the analysis are estimated at $100,000, of which the state share is $59,000.

Results:

- Quantity: Responsibility for approximately 10,000 recipients of Health Care, MFIP, SNAP, and Child Care who are members of the White Earth Nation have been transferred from Becker, Mahnomen, and Clearwater counties human services departments to White Health and Human Services. Responsibility for approximately 2,400 recipients of Health Care, MFIP, SNAP, and Child Care) who are members of the Red Lake Nation have been transferred from Beltrami and Clearwater counties to Red Lake Human Services.
- Quality: White Earth and Red Lake Members and their families will have improved access to eligibility determinations for health care, economic supports, child care and aging and other disability services.
- Result: Tribal members and their families transferred to White Earth or Red Lake Human Services will have improved access to eligibility determinations and coordination of services and programs previously offered by the counties.
- Result: This initiative will reduce disparities in service access and outcomes for American Indians.

Statutory Change(s):

Rider language needed for the WEN and Red Lake Nation transfer grants.

No statutory changes needed for the Indian Child Welfare Initiative.

Fiscal Detail:

DHS Fiscal Detail for Budget Tracking: 16-OP41

Net Impact by Fund (dollars in thousands)	FY 15	FY 16	FY 17	FY 16-17	FY 18	FY 19	FY 18-19
General Fund		$0	$2,845	$2,845	$1,900	$1,900	$3,800

HCAF									
Federal TANF									
Other Fund									
Total All Funds				$0	$2,845	$2,845	$1,900	$1,900	$3,800
Fund	**BACT#**	**Description**	**FY 15**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	46	Grant to White Earth Nation		0	$1,400	$1,400	$1,400	$1,400	$2,800
GF	46	Grant to Red Lake Nation		0	$500	$500	$500	$500	$1,000
GF	12	CFS Admin (FTE's 0,1,0,0)		0	132	132	0	0	0
GF	REV1	FFP @35%		0	(46)	(46)	0	0	0
GF	11	Operations (SSIS)		0	59	59	0	0	0
GF	45	Children's Services Grants		0	800	800	0	0	0
Requested FTE's									
Fund	**BACT#**	**Description**	**FY 15**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	12	Children & Family Services		0	1	1	0	0	0

Department of Human Services
FY16-17 Supplemental Budget Change Item

Change Item Title: SNAP Employment and Training Improvements

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	0	8	0	0
Revenues	0	(4,400)	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	4,408	0	0
FTEs	0	0	0	0

Request:

Effective July 1, 2016, the Governor recommends changes in the Federal Supplemental Nutrition Assistance Employment and Training (SNAP E&T) program to expand training opportunities by redirecting $4.4 million in existing SNAP federal reimbursements. Effective October 1, 2016 the Governor also recommends changes in state law to allow more time to engage Able Bodied Adults without Dependents (ABAWD) participants in employment and training opportunities.

Proposal:

In the 2013 legislative session, a provision was passed to leverage 50 percent federal match of up to $4.8 million per year in existing spending in the Minnesota Family Investment Program (MFIP) Consolidated Fund for support services to DWP participants who are eligible SNAP recipients, and up to $4 million per year in state spending for child care assistance for eligible SNAP recipients. The federal revenues are currently deposited into the general fund through SFY 2017.

Due to a decrease in Minnesota's unemployment rate, in 2013 Minnesota was no longer eligible for a waiver from SNAP work requirements for its ABAWD recipients from the United States Department of Agriculture Food and Nutrition Services (USDA FNS). Under the waiver of the time limit, participants could receive SNAP benefits as long as they remained eligible. When the waiver ended, ABAWD clients were required to meet work requirements of face immediate sanctions. With the loss of the waiver, approximately 38,000 Minnesotans lost SNAP benefits.

This proposal includes two parts:

1. Redirect $4,400,000 in federal revenues in state fiscal year 2017 from the general fund to the Department of Human Services to expand SNAP Employment and Training (E&T) opportunities for Able Bodied Adults without Dependents (ABAWDS), a population with significant and multiple barriers to employment. The $4,400,000 would be used for the following needs:
   - Expand career pathways options for ABAWDS
   - Provide work experience opportunities for ABAWDS
   - Provide support services for ABAWDS
   - Provide for administrative cost associated with career pathways, work experience opportunities and support services.
   - Two full time staff positions to implement and monitor this work. These would be funded through the federal revenues.

2. Change SNAP E & T requirements from mandatory to voluntary participation.
   This change would allow counties and employment service providers more time to engage a population with multiple barriers to employment. Under federal requirements, states can choose whether to operate a mandatory or voluntary SNAP E & T program. Minnesota currently provides for mandatory SNAP E&T provisions which requires immediate sanctions and case closure, effectively ending SNAP benefits, if ABAWDs do not comply in the first month of SNAP eligibility. This proposal would instead implement a voluntary Employment and Training SNAP program. Instead of immediately sanctioning ABAWD's for any noncompliance, this change would allow the employment and service provider a full three months to engage the client in work activities before sanctioning and case closure would occur.

   Partners involved in the implementation include Minnesota DHS, The Department of Employment and Economic Development, community partners, counties, and employment and training providers.

The proposal is intended to re-engage people who are ABAWDs in SNAP employment and training, assist them in overcoming barriers to employment, enable them to meet the eighty hour per month work requirement to maintain eligibility for SNAP benefits, have opportunities for career pathways that would eventually enable them to greater self-sufficiency through better paying jobs.

Rationale/Background:

Under current federal law, people who are categorized as ABAWDs who do not meet work requirements are limited to 3 months of SNAP benefits out of 36 month period. People who are ABAWDs have significant and multiple barriers to employment, including homelessness, domestic violence, possible alcohol and drug abuse issues, and health issues.

Since 2014, approximately 38,000 ABAWDs have lost their SNAP eligibility due to being sanctioned for failure to comply. Hunger and legal advocates and other non-profits along with DHS staff formed the ABAWD Task Force to identify solutions to this issue. A recommendation from this task force is to move to a voluntary employment and training program for SNAP. This would allow more time to engage ABAWD participants on SNAP with employment and training service providers, and provide employment services to those most in need, resulting in better employment outcomes.

There is also a major focus at the federal level from the USDA on states renewing efforts to address the SNAP employment and training needs of ABAWDS.

Minnesota is one of ten states in the country participating in the SNAP to Skills project with the Seattle Jobs Initiative sponsored by the United States Department of Agriculture Food and Nutrition Services. Beginning in April 2016, Minnesota will receive approximately eighteen months of technical assistance from the Seattle Jobs Initiative that focuses on assisting ABAWDs in employment and training and expanding career pathways for ABAWDs.

Fiscal Impact

This proposal redirects $4.4 million in federal reimbursement from the General Fund to instead be used to provide employment and training services ABAWDs receiving SNAP in FY 2017. The language requiring the federal reimbursement to be deposited into the General Fund expires June 30, 2017, so the fiscal impact of this proposal on the General Fund is only in FY 2017.

IT Related Proposals:

There is a small one-time cost to update notices in the MAXIS system to implement the changes from mandatory to voluntary participation.

Results:

Measures will be developed for ABAWD participants served by SNAP Employment & Training for the following items.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Percent re-engaged in SNAP Employment & Training		TBD	
Quality	Percent re-engaged and meeting the 80 hour work requirement to maintain SNAP eligibility		TBD	
Results	Percent that expanded career pathway and receive/retain higher-paying employment.		TBD	

Statutory Change(s):

256D.051, rider

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 16	FY 17	FY 16-17	FY 18	FY 19	FY 18-19
General Fund			$0	$4,408	$4,408	$0	$0	$0
HCAF								
Federal TANF								
Other Fund								
Total All Funds			$0	$4,408	$4,408	$0	$0	$0
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	REV2	SNAP E & T non dedicated revenue	0	4,400	4,400	0	0	0
GF	11	Operations (systems)	0	8	8	0	0	0

Department of Human Services
FY16-17 Supplemental Budget Change Item

Change Item Title: MFIP Child Support Disregard

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	0	0	0
FTEs	0	0	0	0

Request:

Effective August 1, 2016, the Governor recommends a change in statute to clarify that the child support disregard passed in the 2015 legislative session applies to child support arrears payments.

Proposal:

This proposal clarifies that child support arrears payments are included in the disregard of child support when determining the MFIP benefit. Up to $100 per month in child support for families with one child and up to $200 per month for families with two or more children are disregarded when determining the MFIP benefit. This proposal is budget neutral because under current law, both arrears and current child support are disregarded.

Rationale/Background:

The 2015 Legislature passed a child support disregard, effective October 1, 2015 for Minnesota Family Investment Program (MFIP) families. The law disregards child support up to $100 for families with one child and up to $200 for families with two or more children when determining the MFIP benefit. The changes to allow for this disregard were made in two different chapters of statute: 256J and 256P. From Oct. 1, 2015 through July 31, 2016 the child support disregard is contained in chapter 256J. Starting August 1, 2016, the child support disregard is included in chapter 256P. There are some language differences between the two chapters related to how income is calculated for the purpose of determining MFIP grant amounts. Chapter 256J, currently in effect, allows both current and arrears child support payments to be disregarded. The language in 256P, effective August 1, 2016, will only allow current child support to be disregarded, not including arrears. This proposal clarifies in 256P that arrears may also be disregarded.

Statutory Change(s):

256P.06, Subd. 3(2)(xvi)

Fiscal Detail:

Net Impact by Fund (dollars in thousands)	FY 16	FY 17	FY 16-17	FY 18	FY 19	FY 18-19
General Fund						
HCAF						
Federal TANF						
Other Fund						
Total All Funds	$0	$0	$0	$0	$0	$0

Fund	BACT#	Description	FY 16	FY 17	FY 16-17	FY 18	FY 19	FY 18-19

Change Item Title: State Innovation Waiver

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	0	213	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	213	0	0
FTEs	0	0	0	0

Request:

The Governor recommends the commissioner seek necessary federal waiver authority from the U.S. Department of Health and Human Services for the state to design and operate a seamless and sustainable health coverage continuum that reduces barriers to care and eases the transition across insurance affordability programs for consumers.

Proposal:

The proposal reflects efforts supported by the Minnesota Health Care Financing Task Force to provide a more seamless coverage continuum for consumers. The task force identified critical cost barriers or "affordability cliffs" for consumers transitioning between public and private coverage markets and recommended the state take specific steps to smooth these cliffs. This included expanding MinnesotaCare up to 275 percent of Federal Poverty Guidelines (FPG) with a Minnesota-specific affordability scale.

Currently, federal law limits MinnesotaCare eligibility to persons with incomes at or below 200 percent of the FPG. Expanding MinnesotaCare as an alternative program to MNsure requires certain provisions of the Affordable Care Act (ACA) to be waived by the U.S. Department of Health and Human Services. Federal authority is also necessary to allow the state to receive, as a funding source, all of the federal subsidies enrollees would have otherwise received through MNsure.

The proposal requires the commissioner to incorporate the following reforms in the waiver request:

1. An expansion of MinnesotaCare for persons with incomes up to 275 percent of the FPG.
2. A standardized sliding fee scale for premiums and cost sharing for persons with incomes up to 275 percent of the FPG.
3. Alignment of eligibility, benefits, and enrollment requirements across insurance affordability programs, including at least a common income methodology, consistent household composition rules, and a common definition of American Indian.
4. Multi-payer alignment across insurance affordability programs, including consistent payment methodologies across payers and products and similar coverage and contracting requirements across insurance affordability programs that promotes health equity.
5. Innovative efforts that promote cost-neutrality and sustainability of the program, including prospective and outcome-based payment for collaborative organizations and primary care providers.

Financial modeling prepared for the Minnesota Health Care Financing Task Force shows an expansion of MinnesotaCare up to 275 percent of the FPG is projected to affect approximately 41,200 people—37,000 of whom would have likely been enrolled in coverage through MNsure and 4,200 of whom would have likely been uninsured.

Under this proposal, the commissioner would also be required to seek federal authority to secure all federal funding available to support the goals of the waiver request, including any Medicaid funding or federal subsidies enrollees would have received through MNsure.

By March 1, 2017, the commissioner would be required to report to the chairs and ranking members of the health and human services committees on the progress of receiving a federal waiver, including the results of completed actuarial analyses on the broader market impact, a fiscal estimate, and recommendations on necessary legislative changes to accomplish the changes in the waiver request.

If the state were to receive federal approval, the commissioner would still need to seek further legislative action to implement the waiver, including required statutory changes and any necessary state financial contributions.

Rationale/Background

For over 20 years, Minnesota has provided comprehensive health care coverage to low-income working families through MinnesotaCare. In 2014, the ACA made federal tax credits and cost sharing subsidies available to help families with the purchase of private health insurance through MNsure. However, to ensure lower income families still had access to coverage as affordable and comprehensive as MinnesotaCare, Minnesota became the first state in the nation to establish a basic health program. This was a critical step for maintaining high quality health care for people who might otherwise struggle with the out-of-pocket costs of private health insurance.

Last session, the Governor and Legislature established the Minnesota Health Care Financing Task Force to provide recommendations on ways to further improve the state's health care system. While Minnesota's robust coverage continuum ensures access to affordable coverage for individuals with incomes up to 200 percent of the FPG, significant increases in premium and cost sharing expenses exist for individuals transitioning from MinnesotaCare to the private market. To better align consumer costs in MinnesotaCare with the products sold in the private market, the task force recommended the state create a sliding fee scale that gradually reduces premiums and cost sharing for consumers between 200 and 275 percent of the FPG. The task force also recommended expanding MinnesotaCare for consumers with incomes up to 275 percent of the FPG as a mechanism for implementing this new affordability scale.

Smoothing this affordability cliff would likely increase the chances that consumers transitioning between public and private markets remain insured and continue care. Additionally, improving the affordability of coverage for people between 200 and 275 percent of the FPG would be expected to increase coverage rates and improve access to care for those who are currently unable to afford private insurance. This proposal also gives the state an opportunity to better align and streamline eligibility and coverage for families, especially in households where family members are split between private and public markets due to different eligibility requirements. For example, in Minnesota, children whose family income is between 200 and 275 percent of the FPG are covered under Medical Assistance, while their parents are eligible for private health insurance. Expanding MinnesotaCare to 275 percent of the FPG allows the state to simplify these coverage scenarios for families.

The task force also supported innovative reforms to Minnesota's care delivery and payment systems including the Integrated Health Partnerships program, Integrated Care Partnership Systems, Behavioral Health Homes, and Health Care Homes. These efforts are critical to the long-term sustainability of affordability programs because of their promising results in lowering costs while improving care for individuals. The task force recommended incorporating enhancements to these programs in conjunction with on-going robust evaluation of the models. This proposal allows the state to review and design enhancements to these programs as suggested by the task force, including incenting community partnerships that can address social determinants of health, and aligning attribution, risk adjustment and payment methodologies.

To maximize federal funding opportunities, the task force also recommended that the state explore options for receiving additional Medicaid funding through a section 1115 waiver under the Social Security Act, along with additional ACA funding through an innovation waiver under section 1332 of the ACA.

Beginning Jan 1, 2017, states with statutory authorization may seek an innovation waiver to waive certain ACA requirements for various reforms of their health insurance markets and benefit packages. To fund these reforms, states may be able to receive 100 percent of the federal subsidies people would have received through a state health insurance exchange.

Fiscal Impact:

This proposal makes no changes to Medical Assistance or MinnesotaCare and therefore has no fiscal impact on the forecast for those programs.

Applications for the State Innovation Waiver must include actuarial analysis including a detailed analysis of the effect of a waiver on health insurance coverage in Minnesota and an economic analysis to demonstrate that the waiver would be deficit neutral to the federal government. This proposal includes the cost for actuarial analysis to provide the necessary support to complete the waiver application. The estimated cost of this analysis is roughly $500,000. DHS will leverage existing actuarial resources to reduce the total appropriation needed to support this work. This is a one-time appropriation.

Results: N/A

Statutory Change(s):

Minnesota Statutes 2015, section 256.01

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 16	FY 17	FY 16-17	FY 18	FY 19	FY 18-19
General Fund			$0	$213	$213	$0	$0	$0
HCAF								
Federal TANF								
Other Fund								
Total All Funds			$0	$213	$213	$0	$0	$0
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	13	HCA Admin		328	328	0	0	0
GF	REV1	FFP @ 35%		(115)	(115)	0	0	0

Change Item Title: MA Rate Increase for Preventive Medical Care and Outpatient Mental Health Services

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	0	15,301	28,752	31,244
Revenues	0	0	0	0
Health Care Access Fund				
Expenditures	0	4,182	11,392	12.650
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	19,483	40,144	43,894
FTEs	0	0	0	0

Request:
Effective July 1, 2016, the Governor recommends a 5 percent rate increase for preventive medical care and outpatient mental health services in the Medical Assistance (MA) and MinnesotaCare programs. This rate increase has a state cost of $19.5 million in FY17 and $84 million during the FY 2018-19 biennium.

Proposal:
This proposal increases provider payment rates for preventive medical care and outpatient mental health services in the MA and MinnesotaCare programs by 5 percent. Preventative medical services included in this increase include preventive visits billed by physicians, advance practice registered nurses, and physician assistants. All outpatient mental health services, for both children and adults, which do not have a cost-based or negotiated rate are included in this rate increase. This includes, but is not limited to, Adult Rehabilitative Mental Health Services (ARMHS), Children's Therapeutic Services and Supports (CTSS), day treatment, psychiatry, neuropsychological services, mobile crisis services, certified peer specialist services, psychotherapy, and diagnostic assessments. These rate increases are effective July 1, 2016 in fee-for-service and January 1, 2017 in managed care.

Fiscal Impact:
According to recent claims data, the estimated payments to providers for these services through the state's public health care programs is expected to reach over $1.6 billion in FY2016. This rate increase is expected to increase total payments for preventive care and mental health services by about $43 million in FY 2016 and $184 million in the FY2018-19 biennium. The state share of costs for this rate increase is $19.5 million in FY17 and $84 million during the FY 2018-19 biennium.

Rationale/Background:
This proposal increases the payment rate paid for preventive medical visits. This payment increase provides an incentive for medical practitioners to provide comprehensive preventive medical services to Medical Assistance and MinnesotaCare enrollees.

Recent developments (such as the closure of key critical mental health facilities) underscore the fragility of the mental health system. Mental health services are paid at inadequate reimbursement rates, forcing providers to operate with small financial margins that leave them vulnerable. In fact, reimbursement rates for some mental health services do not cover the costs of providing those services.

IT Related Proposals:
Implementing the higher payment rates will require changes to DHS claims payment systems. The state share of the IT costs for this work is reflected in the cost of the proposal.

Statutory Change(s):
256B.761, 256B.76

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 16	FY 17	FY 16-17	FY 18	FY 19	FY 18-19
General Fund			$0	$15,301	$15,301	$28,752	$31,244	$59,996
HCAF			$0	$4,182	$4,182	$11,392	$12,650	$24,042
Federal TANF								
Other Fund								
Total All Funds								
Fund	**BA CT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	33	MA Grants		15,295	15,295	28,751	31,243	59,994
HCAF	33	MA Grants		203	203	903	1,149	2,052
HCAF	31	MinnesotaCare Grants		3,979	3,979	10,489	11,501	21,990
GF	11	Systems (MMIS) @.29		6	6	1	1	2

Change Item Title: Treatment of Spousal Assets for Medical Assistance Eligibility (HC-43)

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	0	4,633	12,968	13,865
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)		4,633	12,968	13,865
FTEs	0	0	0	0

Request:
The Governor recommends changes to Medical Assistance (MA) asset rules for certain married people who are seeking MA for long term care (LTC) services to comply with federal Medicaid regulations. The overall impact on MA spending resulting from this change is a net cost to the General Fund of $4.6 million in FY17 and $26.8 million in the FY2018-19 biennium.

Proposal:
This proposal brings the state into compliance with federal "anti-spousal impoverishment" methods for people seeking MA coverage for LTC services through a home and community-based services (HCBS) waiver program for people with disabilities and/or Community First Services and Supports (CFSS). This proposal also seeks to mitigate the impact of this change on certain populations by raising the amount of a married couple's assets that can be protected for a community spouse to the maximum amount allowed under federal law.

Rationale/Background:
Implementing Anti-Spousal Impoverishment Rules

The Affordable Care Act (ACA) requires state Medicaid programs to apply "anti-spousal impoverishment protections" to the assets of married people when determining MA eligibility for LTC services for all persons enrolled in an HCBS waiver program and/or through CFSS.These protections are designed to allow the spouse living in the community to keep some of the couple's assets. The remainder of the couple's assets are counted toward the MA asset limit for the spouse applying for LTC services.

Prior to the ACA, applying these methods in the HCBS waiver programs was optional. The ACA mandated antispousal impoverishment protection methods in all HCBS waiver programs for a period of five years from January 1, 2014, through December 31, 2018.

In Minnesota, spousal impoverishment protections have long been in place for married couples with a long-term care (LTC) spouse[1] who resides in a long-term care facility (LTCF) or receives services through the Elderly Waiver (EW) or the Alternative Care (AC) program. However, Minnesota has used a different approach, called "exemption from spousal deeming," to protect the spouses of people receiving services under the HCBS waivers that serve people with disabilities under age 65. Under this approach, Minnesota only counts the income and assets of the spouse applying for MA payment of LTC services. The exemption from spousal deeming is more advantageous than the anti- impoverishment rules because it allows these younger married couples to accululate more assets to plan for retirement, children's education and other needs of younger families.

Recognizing the impact of the ACA requirement on Minnesota HCBS waiver program enrollees under age 65, the 2014 Legislature directed the Commissioner to seek a waiver of the ACA mandate. The Centers for Medicare

[1] A LTC spouse is a person married to a community spouse who either: (1) resides in a LTCF and has resided, or is anticipated to reside, in an LTCF for at least 30 consecutive days; or (2) requests services through the EW or AC programs and has received a long-term care consultation (LTCC) that demonstrates the individual requires an institutional level of care and the individual has received or is anticipated to receive, EW or AC services for at least 30 consecutive days.Upon implementation of the ACA rules, the definition would expand to include a person who requests services through the BI, CAC, CADI and DD programs and has received an LTCC that demonstrates the individual requires an institutional level of care and the individual has received or is anticipated to receive, BI, CAC, CADI or DD services for at least 30 consecutive days

& Medicaid Services (CMS) has rejected a waiver or any other alternatives proposed by Minnesota. CMS is requiring the state to take corrective action by June 1, 2016 to comply with anti-spousal impoverishment methods in order to move forward with any amendments to the state's HCBS waiver serving people with disabilities. CMS is requiring the implementation of these rules to determine eligibility for new applicants by June 1, 2016. CMS is also requiring Minnesota to apply these rules to determine continued MA eligibility for current enrollees receiving HCBS through waiver programs for persons with disabilities under age 65 no later than March 1, 2017.

Recent CMS guidance requires states to implement anti-spousal impoverishment rules for those eligible for the new CFSS program in Minnesota that is currently under development and implementation in the state and is subject to federal approval. Under current state law, Minnesota does not apply anti-spousal impoverishement methods or exempt spousal assets from deeming as it does now under the HCBS waiver rules. Applying anti-spousal impoverishment methods will allow the spouses of married applicants seeking CFSS services to retain more assets without affecting the eligibility of the individual seeking services. This change also makes additional people eligible for MA due to anti-spousal impoverishment methods because the spouse in need of these services is treated as a household of one.

Increasing the Community Spouse Asset Allowance

This proposal mitigates the impact of applying anti-spousal impoverishment standards to the HCBS populations and simplifies eligibility processes for counties and married people seeking LTC services by increasing the Community Spouse Asset Allowance (CSAA).

The standard anti-spousal impoverishment methods require an evaluation of all assets owned by a married couple, known as an asset assessment, as of the date of the first 30-day continuous period in which one spouse receives or is anticipated to receive LTC services. This amount is then used to calculate the amount of the couple's assets that can be kept by the community spouse and not considered when determining MA eligibility for the other spouse. This amount is known as the community spouse asset allowance (CSAA). The state is allowed to set the CSAA at any amount that does not exceed the federal maximum. In Minnesota, the CSAA is currently one-half of the couple's countable assets, not to exceed $119,220[2]. The CSAA calculated as of the first 30-day period is used for all subsequent eligibility determinations for a person requesting MA payment of LTC services.

This proposal seeks to increase the CSAA to the federal maximum amount, and remove the step of assessing marital assets at a past point in time. Only verification of marital assets at the time of application for LTC services will be needed to determine asset eligibility. Removing this step greatly streamlines the MA application process because asset assessments based on an earlier date are complex and time-consuming for the couple and for county and tribal staff who determine MA eligibility. Although implementation of the maximum CSAA is not as beneficial as the exemption from spousal deeming, it would help reduce the harm of implementing anti- impoverishment methods for married individuals in need of HCBS, and reduce the administrative burden.. The CSAA would simply be deducted from couple's total, countable assets at the time of each application for MA for LTC and/or CFSS rather than having to document and verify the value of the couple's assets owned on an earlier date.

Fiscal Impact:
Based on current experience applying anti-spousal impoverishment methods to those seeking nursing facility services, it is assumed that applying anti-spousal impoverishment methods to people currently receiving HCBS through the waiver programs for persons with disabilities will result in some people losing eligibility. DHS holds no information on spouse's assets for persons with disabilities on HCBS waivers since it is currently not considered for determining MA eligibility. For people eligible for CFSS who are not otherwise on an HCBS waiver, applying these rules will increase eligibility over current projections. Finally, the proposal increases the amount of assets that may be held by community spouses to the maximum allowed under federal law. Yjr higher CSAA applies to all populations subject to pousal impoverishment rules, including persons receiving

[2] Minnesota also sets a minimum allowance amount of $33,851. The minimum/maximum figures are indexed annually in January by the percentage increase in the Consumer Price Index for All Urban Consumers (all items; United States city average) between the two previous Septembers.

long term care in nursing homes. Allowing the community spouse to retain more assets without affecting the MA eligibility of the long term care spouse results in a net increase in MA enrollment.

The net result of these changes is an increase in MA enrollment for married people requesting MA for LTC services. The overall increase in MA eligibility resulting from this change has a net cost to the General Fund of $4.6 million in FY17 and $26.8 million in the FY2018-19 biennium. The effect to the state General Fund for each of the individual changes is broken out in the table below.

Changing the Treatment of Spousal Assets for MA LTC Eligibility (State Share in 000s)			
	FY2017	**FY2018**	**FY2019**
Savings from applying SI to HCBS > 65	($512)	($1,536)	($1,088)
Cost for applying SI protections to CFSS	1,741	7,220	7,612
Cost for raising the CSAA	$3,404	$7,287	$7,341
Net Cost	**$4,633**	**$12,968**	**$13,865**

Statutory Change(s):

Minnesota Statutes §256B.056

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
General Fund			$0	$4,633	$4,633	$12,968	$13,865	$26,833
HCAF								
Federal TANF								
Other Fund								
Total All Funds			$0	$4,633	$4,633	$12,968	$13,865	$26,833
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	33ED	MA Grants	0	4,633	4,633	12,968	13,865	26,833
Requested FTE"s								
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**

Change Item Title: MinnesotaCare Federal Compliance and Renwals Simplification

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
Health Care Access Funds				
Expenditures	0	425	50	50
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	425	50	50
FTEs	0	0	0	0

Request:

The Governor recommends changes to MinnesotaCare to comply with federal rules for the basic health plan (BHP) as well as enrollment and renewal changes to better align with other health care insurance affordability programs. The changes to the renewal processes are effective January, 2017.

Proposal:

Current eligibility provisions in state law for the MinnesotaCare program need updating to comply with federal regulations. The proposal makes several changes to eligibility statutes to conform to federal BHP regulations and Minnesota's approved BHP blueprint. All these provisions have already been implemented so will not result in a change in program operation.

The proposed changes to MinnesotaCare eligibility statutes include:

- Clarifying that applicants are not required to submit a social security number if they do not have one;
- Replacing an obsolete reference to federal rules defining "lawfully present noncitizens";
- Amending the definition of child to strike the unborn child of a pregnant woman. Pregnant women are counted as a household of one for MinnesotaCare following the state and federal tax code;
- Repealing statute that requires MinnesotaCare enrollees to cooperate with third party liability or medical support or apply for other benefits as a condition of eligibility;
- Amending statute to permit the commissioner to forgive the past due "grace month" premium for people disenrolled for failure to pay, within 90 days following disenrollment;
- Amending statute requiring MinnesotaCare enrollees apply for Medical Assistance and clarify that the exclusion may apply to individuals who fail to cooperate with an MA eligibility determination;
- Repealing an outdated reference to the Children's Health Insurance Program (CHIP). The CHIP program provided enhanced federal funding for certain enrollment groups while the MinnesotaCare program operated under a Medicaid waiver. This reference no longer applied after MinnesotaCare became a BHP in 2015.

Additionally, this proposal makes changes to the MinnesotaCare program which will better align the program's eligibility processes with those currently used in Medical Assistance. Eligibility changes include changes to renewal processes and the income counting methodologies used for program eligibility.

Eligibility changes included:

- Renewing coverage for MinnesotaCare enrollees once every 12 months, based on the month of application or aligned with other enrollees within a mix household, rather than during MNsure open enrollment each Fall;
- Determining income eligibility based on current Modified Adjusted Gross Income (MAGI) rather than Projected Annual Income, and
- Requiring updates to the Federal Poverty Guidelines (FPG) each July, rather than each January.

Distributing renewals based on the month of application or the existing MA renewal date for other household members instead of using an annual renewal period for all enrollees results in a one time change in the interval between renewals. Under this proposal, all enrollees would have one more annual renewal in January 2017 and then renewal based on the date of application or the MA renewal date for other household members starting in July 2017. For most enrollees, for one renewal only the interval between the January 2017 and the next renewal will be greater than or less than 12 months depending on their date of application.

Rationale/Background:
The changes to MinnesotaCare eligibility statutes are needed to align state law with federal regulations.

For families with some members eligible for MA and others eligible for MinnesotaCare, the enrollment and renewal changes will ensure they are required to complete only one renewal process per year, rather than two. The proposal will help ensure the timely processing of MinnesotaCare renewals and will free up administrative resources to help support enrollees who experience eligibility and program changes due to changes in circumstance.

Fiscal Impact:
Changes to MinnesotaCare eligibility rules required for federal compliance do not have a fiscal impact. These changes align statute with federal requirements and reflect current eligibility policy for the program.

Changing the program renewal timing as described will not have an impact on the program forecast as these renewals will be spread evenly through the year starting in July of 2017 based on the date of application rather than all renewals occurring in January 2018. Implementing this change does have some IT costs which are reflected in this proposal. Changes to the timing of renewals requires approval from the Centers for Medicare and Medicaid Services (CMS) which may affect the fiscal impact.

IT Related Proposals:

MN.IT and IBM consultants have reviewed the portion of the proposal related to MinnesotaCare renewal and income counting changes. System changes are needed to implement this proposal. The estimated first year total cost (state and federal share) of these changes is $ 894,000 with an ongoing maintenance cost of $100,000 annually thereafter. The estimated time of completion is six months from the assumed effective date of January 2017. The cost of implementing this proposal is the state share of these information technology costs.

Statutory Change(s): section 256L.01, subdivision 1a; section 256L.04, subdivisions 1a, 2, 2a, 8, and10; section 256L.22; section 256L.24, section 256L.26; section 256L.28

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
General Fund								
HCAF			$0	$425	$425	$50	$50	$100
Federal TANF								
Other Fund								
Total All Funds			$0	$425	$425	$50	$50	$100
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
HCAF	11	Systems (ITS @ 50%)	0	425	425	50	50	100
Requested FTE's								
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**

Department of Human Services
FY16-17 Supplemental Budget Change Item

Change Item Title: Refinancing the Medical Assistance Expansion

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	(4,735)	(51,426)	(107,688)	(132,625)
Revenues				
Other Funds				
Expenditures	4,735	51,426	107,688	132,625
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	0	0	0
FTEs	0	0	0	0

Request:

Effective July 1, 2016, the Governor recommends funding the state share of Medical Assistance (MA) for adults without children out of the Health Care Access Fund (HCAF). This proposal is budget neutral across the Health Care Access Fund and the state General Fund.

Proposal:

Under this proposal, the state cost of coverage for adults without children with incomes below 138 percent of the Federal Poverty Guidelines (FPG) in Medical Assistance will be appropriated out of the Health Care Access Fund starting in July 2016.

Rationale/Background:

In 2013, the Minnesota Legislature authorized the expansion of the Medical Assistance (MA) program to include coverage for adults without children with incomes below 138 percent of FPG. This expansion allowed the State of Minnesota to receive enhanced federal funding for people who were income eligible for either MA or MinnesotaCare in 2013, at which time the state paid roughly half of the cost of coverage for this group. The expansion group currently includes over 200,000 low income adults without children who receive comprehensive health care coverage that is 100 percent federally funded through 2016. Going forward, the federal share of funding for this group decreases each year beginning in 2017 until it reaches 90 percent in 2020 and remains at that level in future years. This proposal changes the funding source for the state share of the MA for childless adults which will be no greater than 10 percent of the total cost of coverage.

Fiscal Impact:

This proposal changes the funding source for childless adults in MA from the General Fund to the HCAF. This reduces the General Fund share of overall funding for MA and increases the amount funded by the HCAF, but is budget neutral across the funds.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 16	FY 17	FY 16-17	FY 18	FY 19	FY 18-19
General Fund			(4,735)	(51,526)	(56,261)	(107,688)	(132,625)	(240,313)
HCAF			4,735	51,526	56,261	107,688	132,625	240,313
Federal TANF								
Other Fund								
Total All Funds			$0	$0	$0	$0	$0	$0
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	33 AD	MA Grants	(4,735)	(51,526)	(56,261)	(107,688)	(132,625)	(240,313)
HCAF	33 AD	MA Grants	4,735	51,526	56,261	107,688	132,625	240,313

Department of Human Services
FY16-17 Supplemental Budget Change Item

Change Item Title: Updating the HCAF Transfer

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	0	(74,000)	(74,000)	(74,000)
Revenues	0	0	0	0
Other Funds				
Expenditures	0	74,000	74,000	74,000
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	0	0	0
FTEs	**0**	**0**	**0**	**0**

Request:
Effective July 1, 2016, the Governor recommends increasing a transfer from the Health Care Access Fund (HCAF) to the General Fund to reflect the current value of the HMO premium and provider tax revenue paid on services delivered to Medical Assistance enrollees.

Proposal:
This proposal increases the value of an existing transfer from the HCAF to the General Fund from $48 million per year to $122 million per year.

Rationale/Background:
Minnesota levies a two percent tax on revenues from patient services by hospitals, surgical centers, health care providers, and wholesale drug distributers and a one percent tax on HMO premiums. These revenues are deposited into the Health Care Access Fund and used primarily for administration and health care coverage for the state's public health care programs and some public health activities administered by the Minnesota Department of Health. In 2003, the state legislature removed an exemption to these two taxes for services provided to recipients of Medical Assistance, MinnesotaCare, and General Assistance Medical Care.

The majority of state funding for the MA program comes from the general fund, and the HCAF receives revenue from collections of premium and provider taxes on MA service revenue. In 2003 the legislature enacted a transfer from the HCAF to the General Fund that was based on the value of the rate increase for providers and managed care plans to offset the cost of paying provider and premium taxes on revenue paid on services delivered to MA enrollees. The value of this transfer has not been updated since 2005. This proposal increases the value of the transfer to reflect the current value of provider and premium tax revenue paid on services delivered to MA enrollees based on the growth of the program.

Fiscal Impact:
The net fiscal impact is an additional $74 million transferred out of the HCAF into the General Fund each year.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)	FY 16	FY 17	FY 16-17	FY 18	FY 19	FY 18-19
General Fund	0	(74,000)	(74,000)	(74,000)	(74,000)	(148,000)
HCAF	0	74,000	74,000	74,000	74,000	148,000
Federal TANF						
Other Fund						
Total All Funds	$0	$0	$0	$0	$0	$0

Fund	BACT#	Description	FY 16	FY 17	FY 16-17	FY 18	FY 19	FY 18-19

Change Item Title: 16-CS34: Certified Community Behavioral Health Clinics

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	0	188	4,965	3,096
Revenues	0	0	0	0
Health Care Access Fund				
Expenditures	0	0	161	211
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	188	5,126	3,307
FTEs	0	1.5	3.5	3.5

Request:

Effective July 1, 2017, the Governor recommends participating in a national demonstration project to establish "one-stop-shop" community clinics, known as a Certified Community Behavioral Health Clinics (CCBHCs), which will provide comprehensive, coordinated, and integrated care to children and adults with complex mental and chemical health conditions for a daily cost-based rate. This demonstration project is designed to test a new model of providing integrated care in order to improve outcomes for clients while providing a sustainable payment system for providers.

Proposal:

The 2015 Legislature provided time-limited administrative resources to support planning and preparation for Minnesota to take part in a federal demonstration project to test a new model for providing and paying for integrated and coordinated mental health and substance use disorder treatment and services. Utilizing these resources, Minnesota applied for and received a federal planning grant which goes through October 2016 and allows Minnesota to apply to participate in the federal demonstration project.

Under the demonstration project, states will establish community-based clinics, known as a Certified Community Behavioral Health Clinics (CCBHCs), which provide comprehensive and coordinated chemical and mental health services. CCBHCs receive a daily, cost-based bundled payment rate for the services they provide and states receive additional federal financial participation for these services during the demonstration period.

States will apply to become demonstration sites in October 2016 and up to 8 states will be selected to participate by January 2017. The demonstration period will be for state fiscal years 2018 and 2019 (July 1, 2017 – June 30, 2019).

This proposal takes the next steps needed to ensure Minnesota is eligible and well-positioned to be selected as a demonstration state. The proposal will:

- Develop certification standards and procedures for CCBHCs;
- Certify at least two CCBHCs, one urban and one rural, by October 1, 2016;
- Establish a new cost-based prospective payment system (PPS) for CCBHC services and fund the state share of Medical Assistance (MA) payments for these services;
- Develop and submit a proposal to participate in the federal demonstration project; and
- Begin providing CCBHC services by July 1, 2017.

This proposal also seeks Federal guidance and approval to continue to operate CCBHCs certified under the demonstration, as well as the new payment system, after the demonstration period ends.

A CCBHC established by this proposal must provide a comprehensive set of services for both children and adults including screening, assessment and diagnosis, treatment planning, outpatient and rehabilitative mental health and substance use services, and peer and family supports. Although most services will be provided directly by the clinic, federal rules allow for some services to be provided through a formal network of providers.

CCBHCs must coordinate care across the spectrum of health services, including helping clients access physical health care, as well as social services, housing, educational systems, and employment opportunities as necessary to facilitate wellness and recovery of the whole person. CCBHCs improve behavioral health care by advancing integration with physical health care, utilizing evidence-based practices on a more consistent basis, and promoting improved access to high quality care. Care coordination is the linchpin holding these aspects of CCBHC care together and ensuring CCBHC care is, indeed, an improvement over existing services.

Per the requirements of the Federal demonstration project, this proposal establishes a new prospective payment system (PPS) for CCBHC services. This payment system offers a clinic-specific, cost-based, daily rate to cover all CCBHC services provided to a Medicaid-eligible person on a given day. A PPS creates an incentive for high-quality care by paying providers for coordinating activities and non-therapeutic supports that clinics either have not been providing or have been providing at a financial loss.

The PPS model also permits the state to use quality bonus payments to stimulate good care, a mechanism that the state has been using successfully with Medicaid managed care plans. CCBHCs must serve anyone who is eligible for the services provided and must provide sliding fee payment options for people who lack insurance and/or the ability to pay. CCBHCs must also serve members of the armed forces and military veterans.

Preparing Minnesota to participate in the Federal demonstration project will require substantial effort. A Project Manager, in the Community Services Administration of the Department of Human Services (DHS), is and will continue to be dedicated full time to this project. Their duties include: policy work in the Mental Health divisions and the Alcohol and Drug Abuse Division; policy and technical work in the Health Care Administration; systems work with MN-IT Services; and technical assistance and information gathering from a dedicated steering committee of provider agencies, advocates, and consumers/families.

The planning phase will be focused on developing a uniform provider cost-reporting system and rates analysis, which will be used to produce actuarially-sound prospective payment rates for each participating clinic. This will require both contracted and state resources. Another large portion of the project will work hand-in-hand with providers on policy, systems, and organization changes necessary to meet CCBHC certification and capacity standards.

State, contractor, and clinic resources will be dedicated to building clinics' capacity to collect and report performance and outcomes measures—both to trigger quality payments during the demonstration phase and to comply with the federal government's national evaluation process.

DHS has been working closely with a stakeholder steering committee co-led by members of the Minnesota Association of Community Mental Health Programs (MACMHP) and the Minnesota Association of Resources for Recovery and Chemical Health (MARRCH). This steering committee also includes mental and chemical health advocacy organizations, health plans, and county representatives.

This proposal is the beginning of a statewide transformation in the way mental and chemical health care are delivered to all corners of the state, both urban and rural. Children and adults with serious mental illness, and persons with long-term and serious substance use disorders will receive improved, coordinated health care from this proposal. People with less-severe mental illnesses and substance use disorders will also benefit from coordinated behavioral and physical healthcare. The proposal creates a "one-stop shop" model of care designed to operate in Greater Minnesota, as well as the metropolitan and urban areas. It is projected that this proposal will directly benefit about 5,000 children and adults in the areas served by the certified clinics. This demonstration is expected to provide a model for future improvement in access and quality of services throughout the state.

Rationale/Background:

Research has found that persons with serious mental illnesses often experience difficulty in obtaining treatment for their illness. A U.S. Surgeon General's report on mental health indicated that only 20 percent of Americans with mental health disorders – and fewer than half of people with severe mental health disorders – receive any treatment for their conditions in a given year. Recently published data also suggests that people with serious mental illness die, on average, 25 years earlier than the general population.

While the state offers a rich benefit under its Minnesota Health Care Programs, many communities lack access to a full continuum of mental health and chemical health care. Minnesota's current reimbursement systems do not recognize the higher costs associated with providing all services necessary to meet the behavioral health needs of individuals, which means that very few providers are able to deliver comprehensive treatment and support services that also provides linkages to other systems. As a result, people with complex mental and chemical health conditions are often not able to access the full array of services and supports they need to be healthy and successful in the community.

This demonstration project will test a new way of meeting the needs of Medicaid's most expensive and complex populations and how the services are paid for—a solution that not only improves access to high-quality care but creates a financially-viable network of providers. More should be expected of community behavioral health systems and this proposal is a big step toward meeting those expectations.

The federal government is offering the largest contribution to community-based mental health and substance use treatment since the 1960s. The opportunity to advance Minnesota's community behavioral health system will be lost if we do not take this next step. This is a one-time opportunity. Not until 2021 will Congress consider whether to offer it again.

Fiscal Impact:

The services provided through the CCBHC demonstration project were designated by Congress as Medicaid benefits. The proposal appropriates the state share of Medical Assistance (MA) for the cost-based prospective payment system for CCBHC services, which is a bundled daily rate.

The proposal assumes the following services will be included in the new payment system for CCBHC services:

- Outpatient mental health services
- Outpatient chemical dependency treatment
- Children's Therapeutic Services and Supports (CTSS)
- Adult Rehabilitative Mental Health Services (ARMHS)
- Crisis services, including withdrawal management for intoxication
- Targeted case management

Currently, counties are responsible for 100% of the non-Federal share of MA for targeted case management and 30% of the non-Federal share of MA for outpatient chemical dependency treatment. This proposal pays for these services within the new payment system and assumes that the state will pay the entire non-Federal share when these services are provided through a CCBHC. This will save counties about $1 million during the next biennium.

The Federal demonstration project provides enhanced federal financial participation (FFP) in MA payments for CCBHC services that are paid for under the new prospective payment system. The state share of MA will be determined by the following federal provisions:

- FFP will be 65% (instead of the usual 50%) for CCBHC services provided during FY18-19.
- The enhanced match will apply to all MA payments for CCBHC services, including payments for existing services that are integrated into the new system. Although this will result in state share savings for currently forecasted payments, these savings will be more than offset by the need for a 35% state match for the increase in total payment which will enable improvements in quality, access and availability.
- The enhanced match for Managed Care-MA payments for CCBHC services will be delayed one year if the federal claiming process requires verification of the portion of the capitation that was used for CCBHC services. DHS will ask for federal approval to claim enhanced match based on the actuarial value of the CCBHC portion of the managed care capitation, thus enabling earlier receipt of enhanced match.
- FFP for adults without children will remain at current projected levels – currently 100% and declining to 90% by 2020.
- Federal match for Managed Care-MA payments for Adults without Children will not be delayed since that is not specific to the CCBHC demonstration project.

It is projected that this proposal will result in more than $15 million in additional federal funding during the next biennium.

The proposal also assumes that Minnesota will be one of the 8 states selected as a CCBHC demonstration state. CMS has indicated that it will work with the participating states to continue the operation and funding of CCBHCs after the demonstration period ends. Continued payment for CCBHC services after the demonstration period is assumed to be limited to clinics certified during the demonstration period and is contingent upon federal approval of on-going FFP.

The proposal also requests funding for 3.5 FTEs on-going. The intensive and time-sensitive planning and coordination needed to develop cost-based rates, certify clinics, measure outcomes, provide technical assistance to providers, process stakeholder input, participate in an intensive federal evaluation effort, and develop Medicaid state plan amendment to ensure no interruption in services after the demonstration period ends.

Funding for administrative resources is requested for the next biennium after current state appropriations and Federal grant funding ends. A 2015 legislative appropriation and a Federal planning grant provided funding for 2 FTEs in the Mental Health Division of the

Community Supports Administration until June 30, 2017. This proposal continues those positions on-going and adds 1 additional FTE in the Health Care Administration to support rate development and cost reporting as well as a 0.5 FTE contract manager, beginning July 1, 2016.

The 2015 Legislature also provided time-limited contract resources to support the development of the prospective payment system. This proposal includes on-going funding in the next biennium for contracted actuarial and rate analysis to support rebasing of CCBHC rates every two years.

Lastly, this proposal assumes additional funding for IT systems work to accommodate the inclusion of targeted case management and chemical dependency in the payment system as well as additional on-going IT systems expenses that have been identified.

Results:

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	The number of Medicaid-eligible persons receiving PPS-covered services.	N/A	Establish base	Begin Jul 2017
Quality	The number of clinics receiving quality bonus payments.	N/A	N/A	Begin Jul. 2017
Results	Compare outcome indicators from recipients receiving care from CCBHCs to recipients in a control group, as required by participation in the demonstration.	N/A	N/A	Begin Jul. 2017

Statutory Change(s):

M.S. 245.735

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
General Fund			$0	$188	$188	$4,965	$3,096	$8,061
HCAF			$0	$0	$0	$161	$211	$372
Federal TANF								
Other Fund - CD Admin DED Revenue								
Total All Funds			$0	$188	$188	$5,126	$3,307	$8,433
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	33	MA Grants	0	0	0	4,616	2,785	7,401
HCAF	33	MA Grants	0	0	0	161	211	372
GF	15	CS Admin	0	74	74	543	503	1,046
GF	13	HC Admin	0	162	162	142	142	284
GF	35	CD Consolidated Treatment Fund Net State	0	0	0	(114)	(126)	(240)
GF	REV1	FFP @ 35%	0	(83)	(83)	(240)	(226)	(466)
DED	REV	CD Fund Admin	0	0	0	32	36	68
DED	EXP	CD Fund Admin	0	0	0	(32)	(36)	(68)
GF	11	MMIS @ 29% State Share	0	35	35	18	18	36
Requested FTE's								
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	15	CS Admin	0	.5		2.5	2.5	
GF	13	HC Admin	0	1.0		1.0	1.0	

Change Item Title: Individual Community Living Support Added to 245D Licensure

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund	0	0	0	0
Expenditures	0	0	0	0
Revenues	0	0	0	0
State Gov Spec Rev Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	0	0	0
FTEs	0	0	0	0

Request:

Effective July 1, 2016, the Governor recommends adding the Individual Community Living Support (ICLS) as a service to be licensed by the Department of Human Services under MN Statutes, chapter 245A. ICLS was enacted in the 2013 legislative session as part of the Reform 2020 initiative to reform Medical Assistance (MA) to meet the challenges of rising MA costs and growing demand. ICLS by design is a service projected to save the state money by diverting Elderly Waiver (EW) and Alternative Care (AC) participants from higher-cost residential services or admission to a nursing facility.

While there is an incremental state cost to licensing ICLS providers, those costs are not counted on this change page in order to avoid cross-fund interactions with the broader Home and Community Based Care Providers Licensure update proposal. In order to avoid double counting, the costs for ICLS licensure are currently included in Home and Community Based Care Providers Licensure Update proposal.

Proposal:

This proposal allows ICLS to be licensed under Minn. Stat. 245A with standards in section 245D.03, subdivision 1, paragraph (c), as a basic support service, beginning July 1, 2016. ICLS providers need to obtain a 245D basic service license. Home care entities currently licensed under MDH need to obtain a 245D designation to provide ICLS under their MDH license. This licensing authority is necessary before the service can be implemented. In addition, before the federal Center for Medicare and Medicaid Services (CMS) will approve the service, CMS needs assurance that the service meets the necessary standards and can be implemented by the state. Should there be a delay with licensing and implementation, the state will not realize the savings projected in the MA forecast associated with ICLS.

The goal of ICLS is to provide home and community-based services to older adults in a way that they prefer to receive them. It is a new service for eligible participants of the EW and AC programs. With ICLS, participants can access a flexible and scalable service to meet a range of needs from a single provider of their choice, rather than receiving services a la carte, and without having to move to a different setting. ICLS is a bundled service under the EW and AC programs that offers cuing and reminders to support people with daily activities, help them maintain skills that allow self-sufficiency, and intermittent physical assistance.

In SFY19, with ICLS changes, about 2,300 people per month are expected to receive ICLS services in their own homes through the EW and AC programs.

This change includes collaboration and communication between DHS's Licensing Division, Aging and Adult Services Division, Minnesota Health Care Programs (MHCP) Provider Enrollment Division, and the Minnesota Department of Health (MDH). ICLS has a fiscal impact to the Licensing Division because it requires monitoring a new service. Home Care Providers licensed by MDH will have the option to apply for a HCBS designation as outlined by statute.

It is anticipated that existing 245D and home care-licensed providers will apply to expand their license to provide ICLS, and some new providers will apply to become licensed.

Rationale/Background:

The goals of Reform 2020 were achieved by modifying existing services, providing new services to targeted groups and testing innovative approaches. Minnesota's reform efforts focused on building on a history of improvements to the system centered on our core values of person-centeredness, choice, and independence. Changing demographics and economic pressures put the future of our service system at risk of not being sustainable without new innovative services options. ICLS enables older Minnesotans to receive the same services they could expect in an assisted living facility only at a lower cost and in their own homes.

This proposal permits providers already licensed under 245D to provide this new service. The Department determined that in order to provide effective oversight, each service provided must be named specifically in statute and on a provider's license. Adding ICLS to the 245D license ensures health, safety, and protects the rights of vulnerable adults. ICLS changes are needed to align statute and licensing standards with changes in service delivery models; the goal of which is to support people in the most integrated settings they choose.

Fiscal Impact

ICLS has a fiscal impact to the DHS Licensing Division as it requires monitoring a new service. There are no additional program costs because this proposal does not change eligibility criteria. However, these costs are currently included as part of the Home and Community Based Care Providers Licensure Update proposal and as a result, the ICLS proposal is budget neutral. If the licensing proposal does not move forward, the costs for this proposal in isolation would be as follows:

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	0	30	6	6
Revenues				
State Gov Spec Rev Fund	0	5	14	23
Expenditures	0	(1)	(2)	(3)
Revenues				
Net Fiscal Impact	0	34	18	26

No local government impact is expected for ICLS.

Results:

ICLS intended results include allowing more people age 65 and older to receive services and supports in their homes, where they prefer to be, preventing the need to move to another setting.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Percent of seniors who receive home and community-based waiver services.	68%	70%	2013-2014

Statutory Change(s): Minn. Stat. § 245D.03

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
General Fund			$0	$0	$0	$0	$0	$0
HCAF								
Federal TANF								
Other Fund			$0	$0	$0	$0	$0	$0
Total All Funds			$0	$0	$0	$0	$0	$0
Fund	**BACT #**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**

Department of Human Services
FY16-17 Supplemental Budget Change Item

Change Item Title: Disability Waiver Rate Setting Clarification

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	0	0	0
FTEs	0	0	0	0

Request:

Effective July 1, 2016, the Governor recommends clarifying the rate exception process used in the Disability Waiver Rate Setting (DWRS) System. This proposal also makes technical changes to the DWRS rate formulas in Minnesota law. This proposal has no fiscal impact.

Proposal:

In 2013, the Minnesota legislature authorized the Department of Human Services to implement a statewide rate setting methodology for disability waiver services. The new system (Disability Waiver Rate Setting or DWRS) established a consistent formula for setting rates for disability waiver programs (Brain Injury, Community Alternative Care, Community Access for Disability Inclusion, and Developmental Disability waivers) in statute. The authorizing legislation required rates to be "banded" for 5 years after initial implementation. "Banding" means that a provider's rates cannot go up or down by greater than 0.5% for the first three years and by greater than 1.0% for last two years. The exceptions process allows a provider to request a different rate for a person whose current banded rate is insufficient.

The proposal:

- Changes rate exception language to clarify that applications for exceptions for individuals who receive services with weighted averaged banded rates are allowable.
- Makes a technical change to banding language in M.S. §256B.4913 to mirror language passed in 2013. Currently, the statute does not include authority to establish historic county weighted averages for day services. This is assumed to be an omission that occurred during the plain language conversion effort. The Department currently uses weighted averages for day services.
- Makes technical change to align, county, tribe and lead agency terminology in sections 256B.4913 and 256B.4914.

Rationale/Background:

This proposal clarifies DWRS to make the statute more understandable and easier to implement.

Statutory Change(s):

M.S. §256B.4913, subds. 4 & 5; §256B.4914, subds. 10, 11, 14, 15

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 16	FY 17	FY 16-17	FY 18	FY 19	FY 18-19
General Fund								
HCAF								
Federal TANF								
Other Fund								
Total All Funds			$0	$0	$0	$0	$0	$0
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**

Department of Human Services
FY16-17 Supplemental Budget Change Item

Change Item Title: US Dept. of Labor Ruling & Workforce Study

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	0	18,183	20,111	20,260
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	18,183	20,111	20,260
FTEs	0	0	2.5	3.0

Request:

Effective July 1, 2016 the Governor recommends a 2.72% rate increase to the personal care assistance (PCA), Consumer Directed Community Supports (CDCS), and Consumer Support Grant (CSG) programs as well as the services of companion, personal support, chore, respite and homemaker/cleaning in the Home and Community-Based Services (HCBS) waiver programs. This rate increase is to assist providers to accommodate pressures, including changes to the Department of Labor home care rule. The Department of Labor home care rule requires that agencies pay certain workers the federal minimum wage, overtime and travel time. This proposal also requires HCBS providers to submit data to the Department on their workforce, including rate of pay and benefits, staff turnover, and other labor measures, in order to analyze workforce pressures in the HCBS system. An analysis on workforce pressures in the HCBS service system will be completed in 2018.

Proposal:

The U.S. Department of Labor issued a Final Rule in October 2013 that requires all home care workers to be paid overtime for more than 40 hours worked in a week and compensation for travel time between two work sites. Since these workers were previously exempt from federal Fair Labor Standards Act (FLSA) requirements, compliance with these regulations will be an additional cost for agencies with personal care workers. Compensating agencies for these increased costs would require a 2.72% rate increase for PCA, CSG, and CDCS Programs. Additional services such as companion, personal support, chore, respite, and homemaker within the Home and Community-Based Services (HCBS) waiver programs will also be impacted. This rate increase is also applied to these services effective July 1, 2016.

Effective no earlier than January 1, 2017, HCBS providers will be required to report data to the department on worker wages, benefits, overtime, travel costs and staff retention on an annual or semi-annual basis. Data will be used to monitor and analyze worker impacts to the HCBS service system. A study analyzing workforce issues in the HCBS service system as well as its impact on access will be completed in 2018.

This rate increase will be implemented in the provider billing system used by DHS (MMIS). Additional systems changes and administrative resources are needed to implement a provider reporting structure for HCBS providers.

This change will impact over 25,000 workers in Minnesota who support people on PCA and other similar waiver programs, including self-directed services.

Rationale/Background:

The US Department of Labor issued a Home Care Final rule in 2013 that requires payment of minimum wage and overtime compensation to most home care workers. This includes workers employed by home care agencies, providers of other home-based services and other third parties. Under the Rule, more domestic service workers will be protected by the Fair Labor Standards Act (FLSA) minimum wage, travel time, and overtime provisions. Because Medicaid (Medical Assistance) is a primary payer of home and community-based services, this final rule impacts several services within the Medical Assistance program. The current rate paid to providers of these services may not accommodate the additional costs of complying with the Rule. Frequently Asked Questions as well as fact sheets are available on the Dept. of Labor's website. The Department of Labor began enforcement of the rule November 12, 2015.

The new labor regulations have illuminated the lack of information available on the HCBS workforce. This includes information such as what workers in this field earn, benefits, overtime, and staff retention pressures faced by businesses, among other issues. A stable workforce is critical to ensuring quality HCBS services. Lack of workers can create service shortages. The Department is interested in

collecting this information from HCBS providers on an annual or semi-annual basis to be better able to analyze, monitor and respond to workforce issues.

Fiscal Impact:

In addition to program funding related to the rate increase, four (4.0) FTEs are included in this proposal: one (1.0) FTE for technical assistance to operationalize provider communications, training and troubleshooting and is only for FY 18, 2.0 FTEs for data collection, validation, and follow-up, and 1.0 FTE for data analysis and reporting. Three (3.0) of the FTEs are ongoing permanent positions. In addition, funding is allocated for administrative assistance for the Health Care Administration to cover increased demand at the provider call center, actuarial costs in FY17 and coordination with a trainer to distribute communication to providers. Also, $180,000 is for contracting with a vendor for administer the critical workforce availability study. Additional monies are included to conduct the study.

IT Related Proposals:

The rate change will be implemented using the Medicaid Management Information System (MMIS). MMIS or a different system will be utilized to collect information from providers on their worker wages, benefits, etc.

Results:

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quality	Percent of people with disabilities served in their own homes.	71.4%	73.5%	2008 to 2013
Quality	Percent of seniors served in their own homes.	77.0%	76.7%	2008 to 2013

Source: DHS Dashboard. Measure: The percentage of seniors and people with disabilities who receive long-term services and supports at home through waivers or state plan home care programs. The services may include personal care, homemaker, home-delivered meals, supplies and equipment, or home health services.

Statutory Change(s):

Uncodified rate increase, study rider. M.S. §256B.4912.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
General Fund			$0	$18,183	$18,183	$20,111	$20,260	$40,371
HCAF								
Federal TANF								
Other Fund								
Total All Funds			$0	$18,183	$18,183	$20,111	$20,260	$40,371
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	33	MA Grants – LW		17,349	17,349	19,113	19,746	38,859
GF	14	CC Admin		534	534	981	360	1,341
GF	13	HCA Admin		402	402	308	308	616
GF	11	Systems – Other		225	225	160	80	240
GF	REV1	Admin FFP @ 35%		(327)	(327)	(451)	(234)	(685)
Requested FTE's								
GF	14	CC Admin		0		2.5	3.0	
GF	13	HC Admin		0		0	0	

Change Item Title: Special Populations Chemical Dependency Rate Correction

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	0	105	142	145
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	0	0	0
FTEs	0	105	142	145

Request:
Effective July 1, 2016, the Governor recommends continuing current payment rate enhancements for chemical dependency treatment providers who serve special populations and meet specific criteria. This proposal would require appropriations above the current budget forecast of $105,000 in FY 2017 and $287,000 in the 2018-2019 biennium.

Proposal:
This proposal makes a technical correction to Minnesota statute to allow payment rate enhancements to continue for chemical dependency treatment programs that are designed to serve “special populations”. A recent legal review of statute governing payment rate enhancements for chemical dependency treatment discovered that current Minnesota law does not support paying enhanced rates for providers serving special populations. As a result, 8 programs that have historically received this payment rate enhancement will no longer receive this rate beginning July 1, 2016. This proposal seeks to clarify statute to ensure these providers can continue receiving this rate enhancement, which supports their ability to provide treatment that is tailored to the populations they serve.

Rationale/Background:
Since 2011, Minnesota has provided enhanced payment rates for chemical dependency treatment providers who serve particular populations of clients and who meet certain requirements specified in state statute and rule. The rate enhancements range from less than a dollar ($.78) to $9 per patient service per day depending on the type and intensity of the service being provided. The 2014 legislature approved statutory changes to clarify the definition of “culturally-specific” chemical dependency providers for the purposes of this payment rate enhancements. An internal review by the DHS Compliance Office has determined that our interpretation of what constitutes a “culturally specific program” is out of compliance with current state law. As a result, the programs targeting groups defined by sexual orientation, specific disabilities, or age, which have been receiving the enhanced rates, will no longer be considered eligible without further clarification to the law. Maintaining these enhanced rates will help to ensure that these providers can continue providing specialized treatment to their unique clientele.

Fiscal Impact:
This proposal assumes continuation of enhanced payment rates to providers serving special populations for substance use disorder treatment services. Without this proposal, these payments will be discontinued on July 1, 2016 according to current law and the February budget forecast. The result of continuing these payment rate enhancements is an increase in general fund costs of $105,000 in FY 2017 and $287,000 in the 2018-2019 biennium.

Statutory Change(s):
254B.05, subdivision 5

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 16	FY 17	FY 16-17	FY 18	FY 19	FY 18-19
General Fund			$0	$105	$105	$142	$145	$287
HCAF								
Federal TANF								
Other Fund								
Total All Funds			$0	$105	$105	$142	$145	$287
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
GF	35	CCDTF – Restore Special Populations	0	105	105	142	145	287

Department of Human Services
FY16-17 Supplemental Budget Change Item

Change Item Title: 245D Licensing Fee Structure Change (16-OP42)

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	0	(935)	(935)	(935)
Revenues	0	0	0	0
Special Revenue Fund				
Expenditures	0	6,437	6,521	6,607
Revenues	0	(6,728)	(6,412)	(6,498)
State Govt Special Revenue Fund				
Expenditures	0	4,000	3,600	3,600
Revenues	0	(3,709)	(3,709)	(3,709)
Net Fiscal Impact = (Expenditures – Revenues)	0	(935)	(935)	(935)
FTEs (net new)	0	8.0	8.0	8.0

Request:
Effective July 1, 2016, the Governor recommends that the Department of Human Services (DHS) implement a new licensing fee structure for Home & Community Based Services (HCBS) providers that adequately funds the cost of licensing and maltreatment-related activities. The fee program impacts providers licensed under Chapter 245A and providing services governed by standards under Chapter 245D. In addition, the Governor recommends transferring financing for all DHS licensing operations to the Special Revenue account from the State Government Special Revenue (SGSR) Fund.

Rationale/Background:
In 2012 and 2013 the Legislature enacted new and comprehensive home and community-based services licensing standards that combined 19 services, some of which were previously unlicensed, under one statewide license in Chapter 245D, and shifted responsibility for certain licensing and maltreatment investigative functions from the counties to the State. In 2013, the Legislature also adopted a license fee schedule for providers that takes effect in fiscal year 2017 to cover the projected costs of the new activities. During the transition period to the new fee schedule, some existing providers temporarily continue to pay fees under the previous licensing standards to which they were subject under Chapter 245B. The temporary fees during the transition period generate less revenue than the new fee schedule. This temporary fee is supplemented by a general fund appropriation which sunsets on June 30, 2016, when the new fee schedule takes effect.

It has been determined that the fee schedule established in 2013 and set to take effect on July 1, 2016, will not adequately fund the DHS work related to HCBS licensing and maltreatment investigations under Chapter 245D. There are approximately 32,000 people with a disability served by 1,256 providers delivering home and community-based services licensed under Minnesota Laws, Chapter 245D. Prior to January 1, 2014, nearly half of these providers were not required to be licensed by DHS. Chapter 245D expanded the scope and complexity of licensing. After more than 18 months of providing technical assistance to license holders , DHS has learned that many of the previously unlicensed providers, and some previously licensed providers, require significantly more technical assistance than originally thought, including on-going technical assistance, to comply with the new Chapter 245D HCBS standards. An additional 8 staff are needed to ensure that all programs are reviewed for compliance with the new rule at least every two years and licensing violations that are reported to DHS can be promptly investigated and corrective action ordered if warranted. DHS needs Legislative approval in 2016 for a new fee structure so that it can begin billing providers at the proposed fee level in late 2016 with little interruption in funding.

Proposal:
A new fee schedule will be established for licensing and maltreatment investigation activities for providers licensed under 245A and who provide Home and Community Based Services (HCBS) governed by 245D. The new schedule is based on a flat licensing fee for all HCBS providers plus a percent of each provider's revenue generated from Medical Assistance reimbursement. for the Chapter 245D licensed services.

This model charges all license holders a base rate of $450 per license – to recognize the minimum cost to DHS for maltreatment and licensing-related work – plus an additional one-half of one percent of a provider's Chapter 245D payment over $100,000 (meaning all providers would be allowed to subtract the first $100,000 in revenues before paying the one-half of one percent of revenue).

The new fee schedule is designed to keep fees low for small providers—not significantly different than the fees they had been paying under the previous schedule. Fees increase in the middle and upper range groups, but not unreasonably, based on total revenues.

This proposal will provide a stable source of funding that enables the Licensing Division to adequately staff its Home and Community-Based Services unit and respond in a timely manner to maltreatment complaints, licensing violations and ongoing monitoring, in addition to provider requests for technical assistance. In order to meet the growing demands of licensing HCBS providers, the new fee structure will allow DHS to hire an additional eight full-time-equivalent staff. These staff will complete inspections of license holders at least once every two years, and more often as needed in response to complaints of licensing violations, and monitor for compliance with Chapter 245D standards. Staff will also provide technical assistance to HCBS providers, develop and revise sample policies and procedures as needed to assist providers in adhering to Chapter 245D standards and reduce the potential for maltreatment by HCBS staff or providers.

This proposal also shifts the licensing fees from being paid into and then distributed out of the SGSR to the Special Revenue fund. This will allow the department to manage its budget based on the fees it collects according to statute.

Fiscal Impact:

DHS currently receives a $2 million appropriation from the SGSR, based on fee revenue, and a General Fund appropriation of approximately $1.4 million per year to cover the costs of licensing and maltreatment investigation activities under Chapter 245D. The General Fund appropriation sunsets on June 30, 2016. This proposal requests an additional $2.7 million to replace the lost General Fund support and cover increased costs to the department of providing technical assistance to providers and an additional 8.0 FTEs needed to meet a once-every-two-year inspection cycle as required in Statute. The anticipated costs of Chapter 245D activities is about $4.7 million annually.

Since 2011, funding for most of DHS' licensing's activities have been shifted from the General Fund to license holders through fees, which are deposited into the SGSR. Funding to cover the cost of licensing activities are appropriated from the SGSR by the Legislature. This proposal ends the SGSR appropriation ($3.709M) for all DHS licensing activities and shifts the current fees paid for all DHS licensing programs to the Special Revenue Account from which it will be available to cover licensing costs. This will enable the department to finance licensing activities based on the fee revenue it collects for that purpose.

Results:

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Licensed Waiver Providers	594	1,286	2013-2016
Quality	Number of Technical Assistance Visits Completed	N/A	604	2012/2013-2014/2015
Results	People Served by Licensed Waiver Providers	12,000	32,0000	2013-2016

Statutory Change(s):

Minnesota Statutes, section 245A.10 and appropriation rider

Fiscal Detail: 16-OP42

Net Impact by Fund (dollars in thousands)			FY 16	FY 17	FY 16-17	FY 18	FY 19	FY 18-19
General Fund			$0	$(935)	$(935)	$(935)	$(935)	$(1,871)
Other Fund, SR			$0	$(291)	$(291)	$109	$109	$218
Other Fund, SGSR			$0	$291	$291	$(109)	$(109)	$(218)
Total All Funds			$0	$(935)	$(935)	$(935)	$(935)	$(1,871)
Fund	BACT#	Description	FY 16	FY 17	FY 16-17	FY 18	FY 19	FY 18-19
GF	11	End GF support of 245D Licensing activities		(1,439)	(1,439)	(1,439)	(1,439)	(2,878)
GF	REV1	Administrative FFP @ 35%		504	504	504	504	1,007
DED	Exp	245D Licensing Fees Replace GF		1,439	1,439	1,439	1,439	2,878
DED	Exp	245D New Licensing Fees		1,289	1,289	1,373	1,459	2,832
DED	REV	245D Licensing Fees Replace GF		(1,439)	(1,439)	(1,439)	(1,439)	(2,878)
DED	REV	245D New Licensing Fees		(1,289)	(1,289)	(1,373)	(1,459)	(2,832)
SGSR	REV2	Transfer to SR		4,000	4,000	3,600	3,600	7,200
DED	REV	Transfer from SGSR		(4,000)	(4,000)	(3,600)	(3,600)	(7,200)
SGSR	11	Transfer to SR		(3,709)	(3,709)	(3,709)	(3,709)	(7,418)
DED	Exp	Transfer from SGSR		3,709	3,709	3,709	3,709	7,418
Requested FTE's								
Fund	BACT#	Description	FY 16	FY 17	FY 16-17	FY 18	FY 19	FY 18-19
DED	Exp	245D Licensing Fees Replace GF		12.0		12.0	12.0	
DED	Exp	Transfer from SGSR		33.7		33.7	33.7	
DED	Exp	245D New Licensing Fees		8.0		8.0	8.0	
SGSR	11	Transfer to SR		(33.7)		(33.7)	(33.7)	
GF	11	End GF support of 245D Licensing activities		(12.0)		(12.0)	(12.0)	

Change Item Title: Expanding Eligibility for the Crisis Housing Assistance Program

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	0	0	0
FTEs	0	0	0	0

Request:

Effective July 1, 2016 the Governor recommends expanding eligibility for the Crisis Housing Assistance Program in order to help more individuals maintain their housing while they are receiving inpatient or residential mental health care and to maximize the use of available grant funds. This proposal has no fiscal impact.

Proposal:

The Crisis Housing Assistance Program is a state-funded grant program that helps individuals age 18 and older maintain their housing while they are receiving inpatient or residential mental health care. The program helps people pay for rent, a mortgage, and/or utilities so that they do not lose their housing while accessing extended mental health treatment away from home.

Currently, the Crisis Housing Assistance Program is only available to persons with serious and persistent mental illness (SPMI), which is a narrowly defined group of people receiving mental health services. This narrow eligibility criteria does not reflect the actual need for the program, and excludes people who would benefit.

This proposal would expand eligibility to include persons with “serious mental illness (SMI)”, effective July 1, 2016. This change would also align the eligibility for the Crisis Housing Assistance Program with the eligibility for residential or inpatient mental health treatment.

This change will remove a barrier to some people accessing needed mental health treatment by allowing them to keep their housing and preventing homelessness while receiving treatment. It is anticipated that this change would double the number of potentially eligible participants, making the program available for an additional 250 people each year.

Since the Crisis Housing Assistance Program started in 1996 it has helped 6,210 individuals retain their housing while getting needed mental health treatment, an average of 310 each year. Utilization of the program peaked in FY 2007 at 491 and since that time the number of applications for the program has decreased each year. In FY 2015 there were only 242 persons served and only half of the available program funds were utilized.

The underutilization of this service is not due to a lack of need. Not having housing is consistently identified as a key barrier that prevents people who have successfully completed residential or inpatient mental health care from returning to the community. The Crisis Housing Assistance Program helps ensure people do not lose their housing while receiving intensive mental health treatment. Given the current pressure on Minnesota’s inpatient and residential mental health services, it is critical that we fully utilize available resources that could support people in both accessing care and returning to the community once their care is complete. However, current eligibility rules limit who can access the program.

Fiscal Impact:

This proposal is budget neutral. The program is currently under-utilizing the available grant funds and the projected increase in utilization can be served using the available funds. Additionally, the statute governing this program identifies that the program is not an entitlement and provides direction to impose statewide restrictions on the use of the funds or utilize other available mental health grant funds in the event that demand for the program exceeds the available appropriation.

Results:

The success of this proposal will be measured by monitoring the number of new and returning individuals who apply for the Crisis Housing Assistance Program in comparison to historical and recent program utilization. The program currently maintains data on funding utilization, the number of new or returning persons who apply, the costs related to the program, and the type of assistance provided.

Expanding the eligibility for the Crisis Housing Assistance Program will allow more people to access this resource and maintain their housing while receiving mental health treatment. This change is anticipated to double the number of potentially eligible participants, making the program available to an additional 250 people each year.

Statutory Change(s):

Minn. Statute 245.99, subd. 2

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
General Fund								
HCAF								
Federal TANF								
Other Fund								
Total All Funds			$0	$0	$0	$0	$0	$0
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**

Department of Human Services
FY16-17 Supplemental Budget Change Item

Change Item Title: Nursing Facility Value-Based Reimbursement System Implementation

Fiscal Impact ($000s)	FY 2016	FY 2017	FY 2018	FY 2019
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	0	0	0
FTEs	0	0	0	0

Request:

Effective retroactive to January 1, 2016, the Governor recommends inserting the words "other care related costs" to the total nursing facility payment rate computation in Minnesota Statute, section 256B.441, subd. 30, paragraph (b). This change corrects an inadvertent omission to match legislative intent.

Rationale/Background:

During the 2015 session, legislation was enacted that establishes a new value-based reimbursement (VBR) system for nursing facilities. Under the VBR system, beginning on January 1, 2016, Medicaid payment rates will be based on the actual annual costs reported by the providers. The new Reimbursement system will be used to establish the payment rates for 372 nursing facilities that provide over 9.5 million resident days of service annually. As work on the implementation of this payment reform began earlier this year, an issue was discovered that requires legislative intervention to resolve.

There was an inadvertent omission of the words "other care related costs" in the total payment rate computation in Laws of 2015, chapter 71, article 6, section 18, paragraph (b). "Other care related costs" include includes costs for nursing administration, activities, social services, raw food, therapy costs, and other direct care costs.

Excluding these costs when determining the total payment rates for facilities contradicts the legislature's intent and is inconsistent with other provisions in 256B.441. Implementing this provision as currently written would likely result in many receiverships, bankruptcies and facility closures. The Chairs of the Health & Human Services Finance committees submitted a letter to the commissioner, asking DHS to implement the VBR law the way it was intended and to pursue 2016 legislation to correct the NF payment reform statute error that this proposal addresses. DHS has proceeded with implementation of nursing facility rates as it believes the Legislature intended, consistent with principles of legislative intent and statutory construction under Minn. Stat. Ch. 645.

Proposal:

This proposal corrects an error in the law that determines how nursing facilities are to be paid under Medicaid. The words "other care related costs" were inadvertently omitted from the final law that was enacted by the 2015 legislature. This proposal corrects this error by adding these words into the formula described in the law. This change is being made retroactive to January 1, 2016 when the new nursing facility payment method (value-based reimbursement, or VBR system) began. Because the legislation matches current practice reflected in the Medical Assistance forecast, there is no fiscal impact.

This provision will need to be approved by the federal government as an amendment to the Medicaid State Plan.

Results:

This proposal will result in clear direction and consistency that is needed to move forward with the implementation and administration of VBR. Intended results include the avoidance of provider appeals related to how DHS treated other care-related costs when establishing payment rates for nursing facilities.

Statutory Change(s):

MN Statute 256B.441, subdivision 30.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 16	FY 17	FY 16-17	FY 18	FY 19	FY 18-19
General Fund			$0	$0	$0	$0	$0	$0
HCAF								
Federal TANF								
Other Fund								
Total All Funds			$0	$0	$0	$0	$0	$0
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**
			0	0	0	0	0	0
Requested FTE's								
Fund	**BACT#**	**Description**	**FY 16**	**FY 17**	**FY 16-17**	**FY 18**	**FY 19**	**FY 18-19**