A bill for an act

relating to corrections; providing for discharge plans for offenders with serious and persistent mental illness who are released from county jails or county regional jails; appropriating money; amending Minnesota Statutes 2004, section 244.054; proposing coding for new law in Minnesota Statutes, chapter 641.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 244.054, is amended to read:

244.054 [DISCHARGE PLANS; PHOTO IDENTIFICATION; OFFENDERS WITH SERIOUS AND PERSISTENT MENTAL ILLNESS.]

Subdivision 1. [OFFER TO DEVELOP PLAN.] The commissioner of human services, in collaboration with the commissioner of corrections, shall offer to develop a discharge plan for community-based services for every offender with serious and persistent mental illness, as defined in section 245.462, subdivision 20, paragraph (c), who (1) is being released from a correctional facility, or (2) has been incarcerated for more than three months and is being released from a county jail under section 641.01 or a county regional jail under section 641.261. If an offender is being released pursuant to section 244.05, the commissioner may offer the offender ~~may choose~~ the option to have the discharge plan made one of the conditions of the offender's supervised release and shall follow the conditions to the extent that services are available and offered to the

offender.

Subd. 2. [CONTENT OF PLAN.] If an offender chooses to have a discharge plan developed, the commissioner of human services shall develop and implement a discharge plan, which must include at least the following:

(1) at least 90 days before the offender is due to be discharged, the commissioner of human services shall designate an agent of the Department of Human Services with mental health training to serve as the primary person responsible for carrying out discharge planning activities;

(2) at least 75 days before the offender is due to be discharged, the offender's designated agent shall:

(i) obtain informed consent and releases of information from the offender that are needed for transition services;

(ii) contact the county human services department in the community where the offender expects to reside following discharge, and inform the department of the offender's impending discharge and the planned date of the offender's return to the community; determine whether the county or a designated contracted provider will provide case management services to the offender; refer the offender to the case management services provider; and confirm that the case management services provider will have opened the offender's case prior to the offender's discharge; and

(iii) refer the offender to appropriate staff in the county human services department in the community where the offender expects to reside following discharge, for enrollment of the offender, if eligible, in medical assistance or general assistance medical care, using special procedures established by process and Department of Human Services bulletin;

(3) at least ~~2-1/2-months~~ 75 days before discharge, the offender's designated agent shall secure timely appointments for the offender with a psychiatrist no later than 30 days following discharge, and with other program staff at a community mental health provider that is able to serve former offenders with serious and persistent mental illness;

(4) at least 30 days before discharge, the offender's designated agent shall convene a predischarge assessment and planning meeting of key staff from the programs in which the offender has participated while in the correctional facility, county jail, or county regional jail, the offender, the supervising agent, and the mental health case management services provider assigned to the offender. At the meeting, attendees shall provide background information and continuing care recommendations for the offender, including information on the offender's risk for relapse; current medications, including dosage and frequency; therapy and behavioral goals; diagnostic and assessment information, including results of a chemical dependency evaluation; confirmation of appointments with a psychiatrist and other program staff in the community; a relapse prevention plan; continuing care needs; needs for housing, employment, and finance support and assistance; and recommendations for successful community integration, including chemical dependency treatment or support if chemical dependency is a risk factor. Immediately following this meeting, the offender's designated agent shall summarize this background information and continuing care recommendations in a written report;

(5) immediately following the predischarge assessment and planning meeting, the provider of mental health case management services who will serve the offender following discharge shall offer to make arrangements and referrals for housing, financial support, benefits assistance, employment counseling, and other services required in sections 245.461 to 245.486;

(6) at least ten days before the offender's first scheduled postdischarge appointment with a mental health provider, the offender's designated agent shall transfer the following records to the offender's case management services provider and psychiatrist: the predischarge assessment and planning report, medical records, and pharmacy records. These records may be transferred only if the offender provides informed consent for their release;

(7) upon discharge, the offender's designated agent shall ensure that the offender leaves the correctional facility, county jail, or county regional jail with at least a ten-day supply of all necessary medications; and

(8) upon discharge, the prescribing authority at the offender's correctional facility, county jail, or county regional jail shall telephone in prescriptions for all necessary medications to a pharmacy in the community where the offender plans to reside. The prescriptions must provide at least a 30-day supply of all necessary medications, and must be able to be refilled once for one additional 30-day supply.

Subd. 3. [PHOTO IDENTIFICATION.] State correctional facilities, county jails, and county regional jails shall arrange for offenders with serious and persistent mental illness to have photo identification when they are released from incarceration. Correctional facilities, county jails, and county regional jails will ensure that offenders who lack photo identification are issued a photo identification card before or immediately upon release. The photo identification card must not disclose the offender's incarceration or criminal record. The photo identification card must list an address other than the address of a correctional facility, county jail, or county regional jail.

[EFFECTIVE DATE.] This section is effective January 1, 2006.

Sec. 2. [641.155] [DISCHARGE PLANS; OFFENDERS WITH SERIOUS AND PERSISTENT MENTAL ILLNESS.]

Pursuant to section 244.054, the commissioner of corrections, in collaboration with the commissioner of human services, shall offer to develop a discharge plan for community-based services for every offender with serious and persistent mental illness, as defined in section 245.462, subdivision 20, paragraph (c), who has been incarcerated for more than three months and is being released from a county jail or a county regional jail under this chapter.

[EFFECTIVE DATE.] This section is effective January 1, 2006.

Sec. 3. [APPROPRIATION.]

$..... is appropriated to the commissioner of corrections for fiscal year 2006 for the purpose of providing discharge plans under Minnesota Statutes, section 244.054, to offenders with serious and persistent mental illness who are released from county jails or county regional jails. This appropriation is in addition to any other appropriations to provide discharge plans under Minnesota Statutes, section 244.054.

Senate Counsel, Research, and Fiscal Analysis

G-17 STATE CAPITOL
75 REV. DR. MARTIN LUTHER KING, JR. BLVD.
ST. PAUL, MN 55155-1606
(651) 296-4791
FAX: (651) 296-7747
JO ANNE ZOFF SELLNER
DIRECTOR

Senate

State of Minnesota

S.F. No. 1028 - Offenders with Serious and Persistent Mental Illness Discharge Plans - Delete-Everything Amendment

Author: Senator Linda Berglin

Prepared by: Joan White, Senate Counsel (651/296-3814)

Date: April 13, 2005

The delete-everything amendment requires the Commissioner of Corrections to develop a model discharge planning process for every offender with a serious and persistent mental illness who has been convicted and sentenced to serve three or more months, and is being released from a county jail or regional jail.

The offender must be referred to the appropriate staff in the county human services department at least 60 days before being released. The county may carry out the provisions of the model discharge planning process, such as the provisions listed in this section.

JW:rdr

Preliminary

Consolidated Fiscal Note – 2005-06 Session

Bill #: S1028-1E **Complete Date:**

Chief Author: BERGLIN, LINDA

Title: CRIMINAL OFFENDERS W/ MENTAL ILLNESS

Fiscal Impact	Yes	No
State	X	
Local	X	
Fee/Departmental Earnings		X
Tax Revenue		X

Agencies: Corrections Dept (03/29/05) Human Services Dept (04/13/05)

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Net Expenditures					
General Fund		40	0	0	0
Corrections Dept		40	0	0	0
Revenues					
-- No Impact --					
Net Cost <Savings>					
General Fund		40	0	0	0
Corrections Dept		40	0	0	0
Total Cost <Savings> to the State		40	0	0	0

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
General Fund		0.50	0.00	0.00	0.00
Corrections Dept		0.50	0.00	0.00	0.00
Total FTE		0.50	0.00	0.00	0.00

Preliminary

Fiscal Note – 2005-06 Session

Bill #: S1028-1E **Complete Date:** 03/29/05

Chief Author: BERGLIN, LINDA

Title: CRIMINAL OFFENDERS W/ MENTAL ILLNESS

Fiscal Impact	Yes	No
State	X	
Local	X	
Fee/Departmental Earnings		X
Tax Revenue		X

Agency Name: Corrections Dept

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
General Fund		40	0	0	0
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund		40	0	0	0
Revenues					
-- No Impact --					
Net Cost <Savings>					
General Fund		40	0	0	0
Total Cost <Savings> to the State		40	0	0	0

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
General Fund		0.50	0.00	0.00	0.00
Total FTE		0.50	0.00	0.00	0.00

Preliminary

SF 1028-1E Criminal Offenders with Mental Illness

Bill Description

This bill provides discharge planning for offenders in county jails with a diagnosis of mental illness. This bill also requires state correctional facilities to arrange for photo identification for offenders with severe and persistent mental illness who are being released.

Assumptions

- The Department of Corrections (DOC) will develop and provide written instructions to jail personnel on the discharge planning process. The DOC will not provide actual discharge planning services to jail inmates.
- The process of completing written instructions will take approximately two months. It will then take another four months to distribute and train jail personnel on discharge planning.
- The annual cost for a discharge planner is $83,000 per year to cover the salary/benefits of $75,000 and operating expenses of $8,000. The annual cost for this position will be approximately $40,000.
- All offenders being released from prison are currently provided photo identification.
- This bill is effective 8/1/05.

Expenditure and/or Revenue Formula

Fiscal Year	2005	2006	2007	2008	2009
Discharge Planners	$0	$40	$0	$0	$0
Total DOC Cost (1=1,000)	**$0**	**$40**	**$0**	**$0**	**$0**
FTE	0	.5	0	0	0

Long-Term Fiscal Considerations

There are not any long-term fiscal considerations as this is a one-time cost for the Department of Corrections.

Local Government Costs

The impact on local correctional resources is likely to be significant with the provision requiring local jails and regional jails to provide photo identification for all offenders with serious and persistent mental illness upon release. County jails will also be responsible to provide discharge planning which will also have a fiscal impact.

References/Sources

Minnesota Department of Corrections staff.
Minnesota Department of Human Services staff.

FN Coord Signature: DENNY FONSECA
Date: 03/28/05 Phone: 642-0220

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: JIM KING
Date: 03/29/05 Phone: 296-7964

Preliminary

Fiscal Note – 2005-06 Session

Bill #: S1028-1E **Complete Date:** 04/13/05

Chief Author: BERGLIN, LINDA

Title: CRIMINAL OFFENDERS W/ MENTAL ILLNESS

Fiscal Impact	Yes	No
State		X
Local	X	
Fee/Departmental Earnings		X
Tax Revenue		X

Agency Name: Human Services Dept

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
-- No Impact --					
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
-- No Impact --					
Revenues					
-- No Impact --					
Net Cost <Savings>					
-- No Impact --					
Total Cost <Savings> to the State					

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

Narrative: SF 1028-1E

Bill Description

The first engrossment of SF1028 requires the commissioners of human services and corrections to develop discharge plans for offenders with serious and persistent mental illness who are being released from a county jails after a stay of more than 3 months.

Assumptions

Sec 1 directs DHS to offer discharge plans for people in county jails, but Sec 2 apparently requires DOC to do exactly the same thing. Sec. 3 appropriates an unspecified amount of money to DOC to develop those discharge plans. It is our understanding that DOC staff have talked with the bill's author and indicated that it would not be feasible for state agency staff to do discharge planning in local jails. The bill's author understands that the state agency's role will be primarily one of technical assistance to the counties. It appears that the cost of discharge planning under this bill would be borne by counties.

Expenditure and/or Revenue Formula

Despite checking with the state Department of Corrections and the Dept of Public Safety, DHS staff have not been able to find a definitive source of information regarding numbers and types of people in county jails. The best information we were able to find came from Anoka County Community Corrections, working with Association of MN Counties. According to Anoka County, there were 6,436 individuals in local correctional facilities on 12/31/04. Specific data is not available as to how many of those individuals had been in more than 3 months, but extrapolating from Anoka County's own population, it is reasonable to assume that about 40%, or about 2,600 people, were in jail longer than 3 months,

There is no county data regarding a percentage of serious and persistent mental illness (SPMI) in the county jails. Extrapolating from state prison data, it appears that about 25%, or about 650 of the above 2,600 have SPMI. Average length of stay for these individuals in county jails is probably about 6 months, meaning that the total per year is about 2 X 650 = 1,300 people with SPMI, staying longer than 3 months.

This bill implies that someone will have screened the entire jail population to determine who might have SPMI and be eligible for discharge planning. In any given year, that means about 5,200 people (2 x 2,600) would need to be screened. Based on experience with DHS MA programs, a reasonable cost estimate is $12.36 per screening, meaning that the annual cost for screening would be about $32,000. As is the case with discharge planning, it would not be feasible for state agencies to do these screenings, so it appears this would have to be expected of counties, without any reimbursement other than potential future savings in local costs due to reduced recidivism and other factors. With no county screening funds in the bill, this fiscal note assumes no mental health program fiscal impact.

This bill also requires state and county correctional facilities to arrange for offenders with SPMI to have photo ID cards when they are discharged. It is our understanding that the state facilities already provide this service. No information is available as to how many counties already do this, or what the cost would be.

Other than provision of technical assistance, it does not appear this bill requires DHS to either commit staff time or provide funding to counties. Therefore, a zero fiscal note is assumed for DHS.

Long-Term Fiscal Considerations

It is reasonable to assume that counties should see some long-term savings as a result of the services required under this bill. Those savings would probably include reduced recidivism, reduced crime, reduced social service costs, and probably others..

Local Government Costs

Counties would incur costs for screenings (estimated to be about $32,000 per year, as described above), plus an unspecified amount for discharge planning. Counties would probably also incur some costs for the photo ID requirement in Sec. 2. However, it is not known how many counties already provide this service.

References/Sources

Dan Ceynowa, Anoka Co Community Corrections; Nan Schroeder, Mn DOC

Agency Contact Name: John Zakelj 582-1825
FN Coord Signature: STEVE BARTA
Date: 04/13/05 Phone: 296-5685

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 04/13/05 Phone: 286-5618

A bill for an act

relating to human services; expanding children's therapeutic services and support; amending Minnesota Statutes 2004, section 256B.0943, subdivisions 1, 2.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 256B.0943, subdivision 1, is amended to read:

Subdivision 1. [DEFINITIONS.] For purposes of this section, the following terms have the meanings given them.

(a) "Care coordination" means activities that ensure:

(1) services are provided in the most appropriate manner to achieve maximum benefit to the client;

(2) nonduplication of services with county case managers;

(3) coordination of care with county social services, community corrections, and schools; and

(4) services are culturally competent, child-centered, and family-driven.

Care coordination may include activities that coordinate, for a particular client, any of the following:

(1) children's therapeutic services and supports covered service components, as provided in subdivision 2, paragraph (b), including psychotherapy, skills training, crisis assistance, mental health behavioral aide services, direction to a mental health behavioral aide, and family psychoeducation;

(2) other medical assistance reimbursable services that are

not covered components of children's therapeutic services and supports, including, but not limited to, outpatient treatment and home and community-based waivered services;

(3) other components of a therapeutic program not covered by medical assistance as part of children's therapeutic services and supports, including, but not limited to, a day treatment program, a preschool program, and other therapeutic activities included in the child's individual treatment plan;

(4) obtaining the client's history;

(5) diagnostic assessment, including functional assessment;

(6) development, review, and updating of the client's individual treatment plan;

(7) development, review, and updating of the client's individual behavioral plan;

(8) entry of a client's data into the performance measurement system;

(9) maintenance of clinical records;

(10) scheduling for the client;

(11) documentation required for billing;

(12) consultation with other providers;

(13) services that are the responsibility of a residential treatment provider, foster care provider, hospital, group home, regional treatment center, or other institutional group setting and the discharge planning from such settings; and

(14) adjunctive activities offered by a provider who does not provide children's therapeutic services and supports that are not covered by medical assistance, including, but not limited to, recreational services; social or educational services not expected to have a therapeutic outcome related to the client's emotional disturbance; consultation with other providers; and chemical dependency treatment.

(b) "Children's therapeutic services and supports" means the flexible package of mental health services for children who require varying therapeutic and rehabilitative levels of intervention. The services are time-limited interventions that are delivered using various treatment modalities and

combinations of services designed to reach treatment outcomes identified in the individual treatment plan.

~~(b)~~ (c) "Clinical supervision" means the overall responsibility of the mental health professional for the control and direction of individualized treatment planning, service delivery, and treatment review for each client. A mental health professional who is an enrolled Minnesota health care program provider accepts full professional responsibility for a supervisee's actions and decisions, instructs the supervisee in the supervisee's work, and oversees or directs the supervisee's work.

~~(c)~~ (d) "County board" means the county board of commissioners or board established under sections 402.01 to 402.10 or 471.59.

~~(d)~~ (e) "Crisis assistance" has the meaning given in section 245.4871, subdivision 9a.

~~(e)~~ (f) "Culturally competent provider" means a provider who understands and can utilize to a client's benefit the client's culture when providing services to the client. A provider may be culturally competent because the provider is of the same cultural or ethnic group as the client or the provider has developed the knowledge and skills through training and experience to provide services to culturally diverse clients.

~~(f)~~ (g) "Day treatment program" for children means a site-based structured program consisting of group psychotherapy for more than three individuals and other intensive therapeutic services provided by a multidisciplinary team, under the clinical supervision of a mental health professional.

~~(g)~~ (h) "Diagnostic assessment" has the meaning given in section 245.4871, subdivision 11.

~~(h)~~ (i) "Direct service time" means the time that a mental health professional, mental health practitioner, or mental health behavioral aide spends face-to-face with a client and the client's family. Direct service time includes time in which the provider obtains a client's history or provides service components of children's therapeutic services and supports.

Direct service time does not include time doing work before and after providing direct services, including scheduling, maintaining clinical records, consulting with others about the client's mental health status, preparing reports, receiving clinical supervision directly related to the client's psychotherapy session, and revising the client's individual treatment plan.

~~(i)~~ (j) "Direction of mental health behavioral aide" means the activities of a mental health professional or mental health practitioner in guiding the mental health behavioral aide in providing services to a client. The direction of a mental health behavioral aide must be based on the client's individualized treatment plan and meet the requirements in subdivision 6, paragraph (b), clause (5).

~~(j)~~ (k) "Emotional disturbance" has the meaning given in section 245.4871, subdivision 15. For persons at least age 18 but under age 21, mental illness has the meaning given in section 245.462, subdivision 20, paragraph (a).

~~(k)~~ (l) "Family psychoeducation services" means education provided under the supervision of a mental health professional to a parent, family member, foster parent, or guardian about the child's mental health condition.

(m) "Individual behavioral plan" means a plan of intervention, treatment, and services for a child written by a mental health professional or mental health practitioner, under the clinical supervision of a mental health professional, to guide the work of the mental health behavioral aide.

~~(l)~~ (n) "Individual treatment plan" has the meaning given in section 245.4871, subdivision 21.

~~(m)~~ (o) "Mental health professional" means an individual as defined in section 245.4871, subdivision 27, clauses (1) to (5), or tribal vendor as defined in section 256B.02, subdivision 7, paragraph (b).

~~(n)~~ (p) "Preschool program" means a day program licensed under Minnesota Rules, parts 9503.0005 to 9503.0175, and enrolled as a children's therapeutic services and supports

provider to provide a structured treatment program to a child who is at least 33 months old but who has not yet attended the first day of kindergarten.

~~(o)~~ (q) "Skills training" means individual, family, or group training designed to improve the basic functioning of the child with emotional disturbance and the child's family in the activities of daily living and community living, and to improve the social functioning of the child and the child's family in areas important to the child's maintaining or reestablishing residency in the community. Individual, family, and group skills training must:

(1) consist of activities designed to promote skill development of the child and the child's family in the use of age-appropriate daily living skills, interpersonal and family relationships, and leisure and recreational services;

(2) consist of activities that will assist the family's understanding of normal child development and to use parenting skills that will help the child with emotional disturbance achieve the goals outlined in the child's individual treatment plan; and

(3) promote family preservation and unification, promote the family's integration with the community, and reduce the use of unnecessary out-of-home placement or institutionalization of children with emotional disturbance.

Sec. 2. Minnesota Statutes 2004, section 256B.0943, subdivision 2, is amended to read:

Subd. 2. [COVERED SERVICE COMPONENTS OF CHILDREN'S THERAPEUTIC SERVICES AND SUPPORTS.] (a) Subject to federal approval, medical assistance covers medically necessary children's therapeutic services and supports as defined in this section that an eligible provider entity under subdivisions 4 and 5 provides to a client eligible under subdivision 3.

(b) The service components of children's therapeutic services and supports are:

(1) individual, family, and group psychotherapy;

(2) individual, family, or group skills training provided

by a mental health professional or mental health practitioner;

(3) crisis assistance;

(4) mental health behavioral aide services; ~~and~~

(5) direction of a mental health behavioral aide;

(6) care coordination services; and

(7) family psychoeducation services.

(c) Service components may be combined to constitute therapeutic programs, including day treatment programs and preschool programs. Although day treatment and preschool programs have specific client and provider eligibility requirements, medical assistance only pays for the service components listed in paragraph (b).

Sec. 3. [FEDERAL APPROVAL; EFFECTIVE DATE.]

If federal approval is required, the commissioner shall apply for federal approval, and sections 1 and 2 are effective upon federal approval. If federal approval is not necessary, sections 1 and 2 are effective July 1, 2006.

Senators Scheid, Hottinger, Pappas, Sparks and Kierlin introduced--
S.F. No. 1110: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; modifying the child care assistance income eligibility provisions; establishing a provider rate differential for accreditation; temporarily suspending child care license fees; modifying the child care assistance parent fee schedule; amending Minnesota Statutes 2004, sections 119B.09, subdivision 1; 119B.13, by adding a subdivision; 245A.10, by adding a subdivision; repealing Laws 2003, First Special Session chapter 14, article 9, section 36.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 119B.09, subdivision 1, is amended to read:

Subdivision 1. [GENERAL ELIGIBILITY REQUIREMENTS FOR ALL APPLICANTS FOR CHILD CARE ASSISTANCE.] (a) Child care services must be available to families who need child care to find or keep employment or to obtain the training or education necessary to find employment and who:

(1) meet the requirements of section 119B.05; receive MFIP assistance; and are participating in employment and training services under chapter 256J or 256K;

(2) have household income below the eligibility levels for MFIP; or

(3) have household income ~~less than or equal to 175 percent of the federal poverty guidelines, adjusted for family size, at program entry and~~ less than 250 percent of the federal poverty guidelines, adjusted for family size~~, at program exit~~.

(b) Child care services must be made available as in-kind services.

(c) All applicants for child care assistance and families currently receiving child care assistance must be assisted and required to cooperate in establishment of paternity and enforcement of child support obligations for all children in the family as a condition of program eligibility. For purposes of this section, a family is considered to meet the requirement for cooperation when the family complies with the requirements of section 256.741.

[EFFECTIVE DATE.] This section is effective July 1, 2005.

Sec. 2. Minnesota Statutes 2004, section 119B.13, is amended by adding a subdivision to read:

Subd. 3a. [PROVIDER RATE DIFFERENTIAL FOR ACCREDITATION.] A family child care provider or child care center shall be paid a 15 percent differential above the maximum rate established in subdivision 1, up to the actual provider rate, if the provider or center holds a current early childhood development credential or is accredited. For a family child care provider, early childhood development credential and accreditation includes an individual who has earned a child development associate degree, a diploma in child development from a Minnesota state technical college, or a bachelor's degree in early childhood education from an accredited college or university, or who is accredited by the National Association for Family Child Care or the Competency Based Training and Assessment Program. For a child care center, accreditation includes accreditation by the National Association for the Education of Young Children, the Council on Accreditation, the National Early Childhood Program Accreditation, the National School-Age Care Association, or the National Head Start Association Program of Excellence. For Montessori programs, accreditation includes the American Montessori Society, Association of Montessori International-USA, or the National Center for Montessori Education.

[EFFECTIVE DATE.] This section is effective July 1, 2005.

Sec. 3. Minnesota Statutes 2004, section 245A.10, is amended by adding a subdivision to read:

Subd. 7. [TEMPORARY SUSPENSION OF CHILD CARE LICENSE FEES.] County fees for background studies and licensing inspections in family and group family child care under subdivision 2 and annual child care center license fees under subdivision 4 are suspended. The commissioner shall use unallocated federal child care development fund money from the 2004-2005 biennium to reimburse the state and counties for the reduced child care licensure fee revenue due to the temporary suspension. The commissioner shall also set a standard statewide license and background study fee for family child care providers based on the average fees currently being charged. This subdivision expires on June 30, 2007.

[EFFECTIVE DATE.] This section is effective July 1, 2005.

Sec. 4. [PARENT FEE SCHEDULE.]

Notwithstanding Minnesota Rules, part 3400.0100, subpart 4, the parent fee schedule is as follows:

Income Range (as a percent of the federal poverty guidelines)	Co-payment (as a percentage of adjusted gross income)
0-74.99%	$0/month
75.00-99.99%	$5/month
100.00-104.99%	2.61%
105.00-109.99%	2.61%
110.00-114.99%	2.61%
115.00-119.99%	2.61%
120.00-124.99%	2.91%
125.00-129.99%	2.91%
130.00-134.99%	2.91%
135.00-139.99%	2.91%
140.00-144.99%	3.21%
145.00-149.99%	3.21%
150.00-154.99%	3.21%
155.00-159.99%	3.84%
160.00-164.99%	3.84%
165.00-169.99%	4.46%

170.00-174.99%	4.76%
175.00-179.99%	5.05%
180.00-184.99%	5.65%
185.00-189.99%	5.95%
190.00-194.99%	6.24%
195.00-199.99%	6.84%
200.00-204.99%	7.58%
205.00-209.99%	8.33%
210.00-214.99%	9.20%
215.00-219.99%	10.07%
220.00-224.99%	10.94%
225.00-229.99%	11.55%
230.00-234.99%	12.16%
235.00-239.99%	12.77%
240.00-244.99%	13.38%
245.00-249.99%	14.00%
250%	ineligible

A family's monthly co-payment fee is the fixed percentage established for the income range multiplied by the highest possible income within that income range.

[EFFECTIVE DATE.] This section is effective July 1, 2005.

Sec. 5. [REPEALER.]

Laws 2003, First Special Session chapter 14, article 9, section 36, is repealed.

Senate Counsel, Research, and Fiscal Analysis

G-17 STATE CAPITOL
75 REV. DR. MARTIN LUTHER KING, JR. BLVD.
ST. PAUL, MN 55155-1606
(651) 296-4791
FAX: (651) 296-7747
JO ANNE ZOFF SELLNER
DIRECTOR

Senate

State of Minnesota

S.F. No. 1110 - Modifying Child Care Assistance Income Eligibility Provisions

Author: Senator Linda Scheid

Prepared by: Joan White, Senate Counsel (651/296-3814)

Date: April 12, 2005

Section 1 modifies the income eligibility requirements for individuals applying for child care assistance by striking language that creates the income eligibility floor. The eligibility floor requires the applicant to have a household income less than or equal to 175 percent of the federal poverty guidelines. The eligibility floor was established in the 2003 session. This section is effective July 1, 2005.

Section 2 establishes the child care provider rate differential for accreditation. A child care provider or center must be paid a 15 percent differential above the maximum child care rate if the provider or center holds a current early childhood development credential or is accredited. The provider rate differential for accreditation was repealed in the 2003 session. This section is effective July 1, 2005.

Section 3 suspends fees for background studies, licensing inspections, and annual child care license fees. The commissioner is required to use unallocated federal child care development fund money from the 2004-2005 biennium to reimburse the county and state for reduced fees. The commissioner is also required to set standard statewide license and background study fees for family child care providers based on the average fees currently being charged. This subdivision expires on June 30, 2007.

Section 4 establishes a new parent fee schedule for the child care assistance co-payments. This section is effective July 1, 2005.

Section 5 repeals the parent fee schedule passed in the 2003 legislative session.

JW:rdr

Fiscal Note – 2005-06 Session

Bill #: S1110-0 **Complete Date:** 03/17/05

Chief Author: SCHEID, LINDA

Title: CHILD CARE INCOME ELIG & PARENT FEES

Fiscal Impact	Yes	No
State	X	
Local		X
Fee/Departmental Earnings	X	
Tax Revenue		X

Agency Name: Human Services Dept

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
General Fund	0	14,884	25,699	26,442	27,232
Federal Fund	0	3,250	3,250	0	0
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund	0	14,884	25,699	26,442	27,232
Federal Fund	0	3,250	3,250	0	0
Revenues					
General Fund	0	(873)	(873)	0	0
Net Cost <Savings>					
General Fund	0	15,757	26,572	26,442	27,232
Federal Fund	0	3,250	3,250	0	0
Total Cost <Savings> to the State	0	19,007	29,822	26,442	27,232

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

NARRATIVE: SF 1110/HF 1329

Bill Description
This bill would:

- Section 1 - Modify the child care assistance income eligibility provisions to change the income entry eligibility to 250% FPG (same as the current exit level),
- Section 2 - Pay a 15 percent differential above the maximum rate (up to the actual provider rate) reimbursed under the child care assistance program to family or center providers if the provider or center holds a current early childhood development credential or is accredited,
- Section 3 - Suspend county fees for background studies and licensing inspections in family and group family child care under subdivision 2 and annual child care center license fees under subdivision 4 until June 30, 2007 and pay the suspended fees with unallocated federal child care development funds,
- Section 3 - Require the Commissioner to set a standard statewide license and background study fee for family child care providers based on the average fees currently being charged, and
- Section 4 - Modify the childcare assistance parent fee schedule to reduce copayments. The current copayment schedule would be repealed.

Assumptions
Section 1 - See attached

Section 2 - See attached

Section 3. This section suspends annual license fees for child care centers from July 1, 2005 until June 30, 2007.

Child care center license fees are estimated to be $872,500 per year for CY 06 and CY07 based on child care center license fee billings for calendar year 2005. The license fees are billed in October and paid in November and December for the subsequent calendar year. This bill is effective from July 1, 2005, to June 30, 2007, so it will encompass the CY2006 and CY2007 billing cycles. For purposes of estimating the fiscal impact to the general fund related to child care center license fees, it is assumed that the number of programs and the licensed capacities of those centers will not change. However, actual billing information will be available during each billing cycle.

This section also suspends county fees for background studies and licensing inspections in family child care from July 1, 2005 until June 30, 2007 and reimburses counties for these costs with federal Child Care and Development Funds (CCDF).

DHS does not have comprehensive, up-to-date information on county charges for background studies and license inspections in family child care homes. At least 28 counties charge fees which generally range between $100 and $250 per year. Minnesota Statutes, section 245A.10, sets a cap of $250 per year (background studies cannot exceed $100; and licensing inspections cannot exceed $150 annually). It is assumed that if the county costs are reimbursed through unallocated federal child care development funds that all counties will seek reimbursement for their actual costs at the limit set forth in statutes, which is $250 per provider per year.

The reimbursement period is two years. Beginning on July 1, 2007, child care centers would resume responsibility for payment of annual license fees which would be deposited in the state general fund. Family child care centers would resume responsibility for payment to counties for background studies and license inspection fees.

Section 4 and repealer – See attached

Expenditure and/or Revenue Formula
Sections 1, 2 and 4 - See attached
Section 3 - Federal funds may be used to reimburse agencies for actual costs; they may not be used to reimburse the general fund for lost revenues. Therefore, federal reimbursement to the general fund for suspended license fees would not be allowed. The result is that this bill would result in an annual loss of state general fund revenues in FY 2006 and FY 2007 of $873,000.

On February 1, 2005, there were approximately 13,000 licensed family child care providers. Assuming counties complete annual background studies and licensing inspections for each provider, the reimbursable costs will be $3,250,000 annually (13,000 licensed family providers x $250 cost per year).

Long-term Fiscal Considerations

Local Government Costs

The bill proposes to reimburse counties for the cost to perform background studies and licensing inspections checks therefore there is no net fiscal impact on the counties.

References/Sources

Sections 1, 2 and 4
Shawn Welch,
Reports & Forecasts Division
MN Dept of Human Services
651.282.3932

Section 3
Jerry Kerber,
Licensing Division
MN Dept. of Human Services
651.296.4473

Minnesota
CHILD CARE ASSISTANCE PROGRAM
Fiscal Analysis of Senate File 1110

Section 1. General Eligibility Requirements for All Applicants.
This section establishes income eligibility for transition year (TY) child care for families up to 250% FPG (i.e. the income exit level for the BSF program). The effect of this change is to add eligibility for some families who exit MFIP with income above the current TY entry level of 175% FPG.

Based on department data, it is estimated that about 7% of MFIP exits in a given month result from income at or above 175% FPG. It is further estimated that about one-fourth of these exits had no prior subsidized child care usage (and would therefore need to satisfy the initial income test for TY) and would be denied TY eligibility under current law. Finally, we assume about 30% of these former MFIP cases would apply for subsidized child care, and that each case gaining TY eligibility uses an average of nine months of TY child care. This fiscal note assumes an effective date of July 1, 2005.

	FY2006	FY2007	FY2008	FY2009
Estimated average monthly MFIP/DWP exits	3,161	3,161	3,161	3,161
Estimated percent >=175% FPG	7%	7%	7%	7%
Estimated avg monthly MFIP exits >=175% FPG	217	217	217	217
Estimated % >=175% FPG with no prior child care	23%	23%	23%	23%
Avg monthly MFIP exits >=175% FPG with no prior child care	49	49	49	49
Percent applying for TY child care	30%	30%	30%	30%
Avg monthly MFIP exits denied TY child care under current law	15	15	15	15
Avg number of additional TY months per case	9	9	9	9
Average monthly TY child care expenditure	$929	$980	$1,034	$1,091
Phase-in effect	67%	100%	100%	100%
Total TY direct service cost	$985,822	$1,560,063	$1,645,866	$1,736,389
Administrative allowance	$49,291	$78,003	$82,293	$86,819
Total TY Cost	$1,035,113	$1,638,066	$1,728,160	$1,823,209

This section also eliminates the requirement that families have income less than 175% FPG to become eligible for the Basic Sliding Fee (BSF) program. Under current law, families must be below 175% FPG to enter the BSF program. However, once eligible, they can remain in the program until the family reaches 250% FPG. This policy change, then, would allow additional families to become eligible for the BSF program with application incomes between 175-250% FPG.

During FY2003, the BSF program operated under an entry and exit income threshold of 300% FPG. This fiscal analysis assumes a similar income distribution to the historical experience from FY2003,

recognizing that families with incomes above 250% FPG would remain ineligible for BSF under this language.

Based on sample data used in federal reporting, it is estimated that about 25% of the current average monthly BSF caseload has income between 175-250% FPG. It is further estimated that about 34% of the FY2003 average monthly BSF caseload had income between 175-250% FPG. This difference can be interpreted as the additional expected caseload with incomes between 175-250% FPG if the 175% FPG income requirement were removed from initial eligibility determination. Based on the projected average monthly BSF caseload in FY2006, this translates into an additional 1262 average monthly BSF cases. A similar logic is applied to the current BSF waiting list that results in an additional 644 average monthly BSF cases with incomes between 175-250% FPG.

Since these additional BSF families have average incomes higher than the overall BSF caseload, they will pay higher average copays. Thus, the average monthly CCAP payment for these cases will be lower than the overall projections under current law. Based on department BSF caseload data and the proposed copay schedule in section 4 of this bill, the average CCAP payment for these additional cases is projected to be about $115 per month less than the overall caseload average.

BSF is funded by a capped appropriation that is allocated to counties. If BSF funding is not adjusted to reflect the costs in this fiscal note or the actual demand for BSF eligibility among families with application incomes between 175-250% FPG exceeds these projections, it will result in a larger waiting list.

This fiscal note assumes an effective date of July 1, 2005. A twelve-month phase-in is assumed due to county allocation adjustments, initial eligibility determination, and billing lags.

	FY2006	FY2007	FY2008	FY2009
Additional average monthly BSF cases	1,906	1,906	1,906	1,906
Average monthly BSF payment	$640	$676	$711	$747
Phase-in effect	50%	100%	100%	100%
Total BSF direct service cost	$7,320,783	$15,455,425	$16,269,285	$17,083,144
Administrative allowance	$366,039	$772,771	$813,464	$854,157
Total BSF Cost	$7,686,822	$16,228,196	$17,082,749	$17,937,302

Section 2. Provider Rate Differential for Accreditation.
This section provides a rate differential up to 15% above the maximum rate, not to exceed the provider's charge, for any provider that meets the definition of "quality child care". This would allow higher CCAP payments for certain child care providers.

Based on Minnesota specific data in a study by the National Association of Child Care Referral and Resource Agencies, it is assumed that approximately 9% of MFIP and 12% of BSF children are using providers that would be eligible for this rate differential. It is also assumed that 50% of accredited providers charge above the maximum CCAP reimbursement rate and would therefore be eligible for this differential. This represents twice the expected rate of all providers given that maximum reimbursement rates are set at the 75th percentile under current law. For FY2006, a 15% differential above the maximum rate is estimated to be about $82 for MFIP/TY and about $71 for BSF.

This fiscal analysis uses a base forecast which assumes a declining caseload in the BSF program based on the projected average monthly number of children that can be served under base level funding. If BSF funding is not adjusted to reflect the costs in this fiscal note, it will result in fewer families being served in the program.

The effective date is July 1, 2005. This rate change will impact individual providers at redetermination, leading to a 6-month phase-in.

MFIP/TY Child Care	FY2006	FY2007	FY2008	FY2009
Average monthly MFIP/TY children	16,911	17,324	17,079	17,018
Percent using accredited child care providers	9%	9%	9%	9%
Avg monthly MFIP/TY children using accredited providers	1,528	1,565	1,543	1,538
Percent above maximum rate	50%	50%	50%	50%
Avg monthly MFIP/TY children at higher rate	764	783	772	769
Monthly rate differential	$82	$85	$89	$93
Phase-in	75%	100%	100%	100%
Total MFIP/TY direct service cost	$561,625	$801,626	$825,869	$859,927
County administrative allowance	$28,081	$40,081	$41,293	$42,996
Total MFIP/TY cost	$589,707	$841,707	$867,163	$902,923

BSF Child Care	FY2006	FY2007	FY2008	FY2009
Average monthly BSF children	17,021	15,630	14,958	14,340
Percent using accredited child care providers	12%	12%	12%	12%
Avg monthly BSF children using accredited providers	2,008	1,844	1,764	1,692
Percent above maximum rate	50%	50%	50%	50%
Avg monthly BSF children at higher rate	1004	922	882	846
Monthly rate differential	$71	$75	$78	$82
Phase-in	75%	100%	100%	100%
Total BSF direct service cost	$645,723	$826,185	$826,206	$827,761
County administrative allowance	$32,286	$41,309	$41,310	$41,388
Total BSF cost	$678,010	$867,494	$867,517	$869,149
Total Cost	$1,267,716	$1,709,201	$1,734,679	$1,772,072

Section 4. Parent Fee Schedule.
This section repeals the current law CCAP copayment schedule and replaces it with a new schedule. The current law schedule charges a) no copay for families with income under 75% of the federal poverty guidelines (FPG); b) a copay of $10/month for families with incomes between 75% and 100% FPG; and c) a sliding scale copay amount starting at 3.85% of income for families between 100-125% FPG and ending with 22% income for families between 245-250% FPG. The new copay schedule charges a) no copay for families with income under 75% FPG; b) a copay of $5/month for families with incomes between 75% and 100% FPG; and c) a sliding scale copay amount starting at 2.61% of income for families between 100-125% FPG and ending with 14% income for families between 245-250% FPG.

Based on department data and the published copayment tables for FY2005, it is estimated that the average monthly MFIP/TY copay would decrease by about $10/month (from $31/month to $21/month) and the average monthly BSF copay would decrease by about $47/month (from $137/month to $90/month) under the new schedule.

This fiscal analysis uses a base forecast which assumes a declining caseload in the BSF program based on the projected average monthly number of children that can be served under base level funding. If BSF funding is not adjusted to reflect the costs in this fiscal note, it will result in fewer families being served in the program.

The effective date is July 1, 2005. This copay change will impact individual CCAP cases as their income is redetermined, leading to a 6-month phase-in.

MFIP/TY Child Care	FY2006	FY2007	FY2008	FY2009
Average monthly MFIP/TY cases	9,320	9,548	9,413	9,379
Average monthly MFIP/TY copay reduction	$10	$10	$10	$10
Phase-in	75%	100%	100%	100%
Total MFIP/TY direct service cost	$878,334	$1,199,688	$1,182,746	$1,178,489
County administrative allowance	$43,917	$59,984	$59,137	$58,924
Total MFIP/TY cost	$922,250	$1,259,672	$1,241,883	$1,237,413

BSF Child Care	FY2006	FY2007	FY2008	FY2009
Average monthly BSF cases	8,963	8,231	7,877	7,552
Average monthly BSF copay reduction	$47	$47	$47	$47
Phase-in	75%	100%	100%	100%
Total BSF direct service cost	$3,783,301	$4,632,180	$4,432,823	$4,249,918
County administrative allowance	$189,165	$231,609	$221,641	$212,496
Total BSF cost	$3,972,466	$4,863,789	$4,654,465	$4,462,414
Total Cost	$4,894,717	$6,123,462	$5,896,348	$5,699,827

Fiscal Summary	FY2006	FY2007	FY2008	FY2009
	(in thousands)			
Increase entry level (TY)	$1,035	$1,638	$1,728	$1,823
Increase entry level (BSF)	$7,687	$16,228	$17,083	$17,937
Accreditation bonus	$1,268	$1,709	$1,735	$1,772
Decreased copays	$4,895	$6,124	$5,896	$5,700

Total Cost	$14,884	$25,699	$26,442	$27,232

Agency Contact Name: Jenny Ehrnst 282-2595
FN Coord Signature: STEVE BARTA
Date: 03/17/05 Phone: 296-5685

EBO Comments

EBO Signature: KATIE BURNS
Date: 03/17/05 Phone: 296-7289

CHILD CARE ACCESS BILL

SF 1110 (Scheid), HF 1329 (Slawik)

BACKGROUND

The Child Care Access bill offers solutions to a number of barriers affecting low-income families' access to quality child care in Minnesota.

ELIGIBILITY

Current Law: Families are eligible for CCAP assistance if they make less than 175 % of the Federal Poverty Guidelines (FPG); families are no longer eligible once they reach 250% of FPG. Under current law, families who need help paying for child care are asking for help, but are not eligible to receive assistance. At the same time, waiting lists statewide have shrunk to virtually nothing.

Section 1, Subd. 1(3) increases eligibility to enter the Child Care Assistance Program from the current level, which is just over $27,000 for a family of three, to 250% of FPG (about $39,000 for a family of three). Raising eligibility will increase access for low-income working families, enabling parents to stay in the workforce and their children to receive quality child care. The State can afford to serve more families under the current appropriation.

PARENT CO-PAYMENTS

Current Law: Co-pay scales ranges from $10 to 22% of a families' gross income. Anecdotal information suggests that many eligible families are dropping off CCAP because they are unable to afford their co-payments.

Section 4 lowers the parent co-pay structure to range from $5 for families between 75-100% of FPG (about $12,000) to 14% of a families' gross income at 250% of FPG. The new co-payment schedule also eases the incremental increase to avoid large jumps at any given increment.

HIGHER REIMBURSEMENT RATE FOR ACCREDITED PROGRAMS

Current Law: No differential rate for accredited providers.

Section 2, Subd. 3a allows accredited child care providers or family child care providers who meet educational criteria and care for Child Care Assistance children to be reimbursed at a rate up to 15% above the maximum reimbursement rate and up to the provider's actual rate charged to private-pay families.

TEMPORARY SUSPENSION OF CHILD CARE PROVIDER FEES

Current Law: Family child care providers may be charged up to $250 annually for background study and license fees. Individual counties determine the fees charged. Child care centers pay annual license fees based on capacity.

Section 3, Subd. 7 suspends license fees for child care centers and family child care providers as well as background study fees for family child care providers for FY 2006-07. Counties would be reimbursed for expected revenues. By 2007, a statewide standard rate would be put in place to replace the county-by-county charges that are now allowed.

CHILD CARE WORKS

April 14, 2005

Honorable Members of the Senate Health & Human Services Committee:

Child Care WORKS is a statewide coalition of parents and other child care advocates working towards quality, affordable, accessible child care for all children who need it in the state of Minnesota. As a statewide coalition, one of our roles is to coordinate efforts of organizations interested in child care public policy.

SF 1110, the Child Care Access bill, represents a broad joint effort of the many organizations you see represented. Public testimony for the bill is limited by time, but this letter is meant to indicate the broad level of statewide community support, and the deep concern felt in regards to the current state of the Child Care Assistance Program (CCAP). Minnesota's CCAP was once one of the flagship child care programs in the nation, with the 4th highest income eligibility, reasonable parent co-payments, and incentives for higher quality programs to care for CCAP children. Minnesota now ranks 33rd in income eligibility, imposes parent co-payments up to 22% of a family's gross income, and has made it nearly impossible for CCAP families to access higher quality accredited child care programs. Indeed, CCAP families are, in some areas, being driven away from licensed care entirely. In national reports today, Minnesota is often highlighted – not for its high quality, but for its retreat from what was once a high commitment to young children and families.

Child Care WORKS strongly supports this bill, and has coordinated this effort, because of the broad consensus in the child care community that CCAP no longer works for the low-income working families it is meant to serve. The Child Care Access bill increases access for families to child care assistance, allowing parents to work and children to be cared for in environments that will prepare them for kindergarten.

The statements attached speak for themselves, as do the witnesses you will hear from offering public testimony. **As a community, we urge you to support the economic stability of young families in Minnesota, and help their children be ready for kindergarten by passing SF 1110 and fighting for its ultimate passage into law.**

Sincerely,

Ann Kaner-Roth

Ann Kaner-Roth
Executive Director

212 2nd Street SE
Suite 116
Minneapolis, MN 55414
612-455-1055 phone
612-455-1056 fax

www.childcareworks.org

Organizational Statements of Support

Affirmative Options

The Affirmative Options Coalition, and our 55 member organizations from around Minnesota, supports the Child Care Access bill (SF 1110-Scheid, HF 1329-Slawik). We agree with the Minnesota Department of Human Services that "*State policy goals for promoting economic stability are supported most effectively when parents have access to affordable child care that supports their employment needs*" (January 2005 DHS *Cost of Child Care* study). Child care assistance is a good investment in Minnesota's working families and the Child Care Access bill will increase access to this needed work support.

Alliance for Early Childhood Professionals

The Alliance of Early Childhood Professionals supports the Child Care Access bill because quality care for children of working low-income families is important. Over and over again, low-income women say that the main barrier to working is quality affordable child care. The Child Care Access bill is a "beginning" for quality child care.

The child care providers in Minnesota make almost the lowest wage of any profession. Pay equity studies show that child care work is one of the most underpaid jobs in Minnesota and the United States. Studies also show that two of the most important factors for quality are the wage of the child care provider and the training. It is important that these are addressed in the Child Care Access bill – not only for the children, but for the people who are caring for our most precious resource.

Amherst H. Wilder Foundation

All young children need nurturing and guidance to develop the skills they need to succeed in school. Quality child care is an essential element, especially for families with working parents. The Amherst H. Wilder Foundation in Saint Paul believes that quality child care requires well trained caregivers, healthy and stimulating environments, and parents who are partners in their children's education. The Child Care Access Bill is important to ensuring that these standards can be met. Money invested in young children now will make our streets safer, reduce the need for corrections and public assistance, and ensure a community comprised of productive, taxpaying citizens. Please support the Child Care Access bill, invest in young children, and ensure a better future community. Thank you.

Children's Defense Fund Minnesota

Children's Defense Fund Minnesota supports the Child Care Access bill because it will increase access to quality, affordable child care for low-income working families. Child care assistance is important because it allows many families who are struggling to make ends meet remain in the workforce. Quality care also helps prepare children for kindergarten. Access to affordable, quality care was significantly limited for families in need of child care assistance as a result of the 2003 legislative changes. The Child Care Access bill would eliminate some of these barriers, allowing the program to serve more families with the fewest resources.

Congregations Concerned for Children- Child Advocacy Network

Because Congregations Concerned for Children Child Advocacy Network believes that every child is a precious gift from God, we believe that every child deserves the best possible early care and education, no matter what the economic status of their parents. The nurture and care of our children is a moral priority for every faith tradition. The deep state cuts to early care and education in the past few years in Minnesota have caused many of our children to go without the preparation they need to succeed and have put unhealthy stress on working parents and caused many child care providers unnecessary economic hardship. The Child Care Access Bill offers a solution. This bill would allow thousands of working parents and their children, as well as care providers, affected by these previous cuts to access the opportunities they need to thrive. And we know that when our children thrive, we all benefit. Investing in accessible quality child care for every Minnesota child is a building block for a stronger tomorrow for all of us. We heartily support the Child Care Access Bill (SF 1110, HF 1329).

Cozy Cottage Child Care

Please support a bill that makes all licensing fees uniform and reasonable among each county in Minnesota. There's no reason for one county to be able to charge $30 for a renewal and the next county to charge $150.

Greater Minnesota Day Care Association

The Child Care Assistance Program was a crucial factor in helping the state reduce welfare spending during the 1990's and it has allowed many children access to early education. Single parents are up to 32% more likely to be employed if they receive help with the cost of child care. To maintain the quality of life Minnesotans are so proud of, GMDCA believes the state must make investments that support the significant section of the workforce that are working poor. Children in these families make themselves known through their productive contribution to our state or they will make their presence known by the social and financial "drag" they place on our state. Continued reductions in the Child Care Assistance Program is irresponsible and will put more working poor families at risk for slipping into poverty. GMDCA supports the Child Care Assistance Bill because it will help working poor families maintain employment and insure the children in these families have a chance to access quality early education opportunities.

Joint Religious Legislative Coalition

The Joint Religious Legislative Coalition favors the Child Care Access bill (SF 1110-Scheid, HF 1329-Slawik) because every child deserves a consistent, loving environment while at home and also while parents work. Because the structure of our labor market and our public policies now require that low-income parents work full-time, childcare is a basic need for thousands of working families. We know that investing in quality child care pays very high dividends. Access to consistent, quality care is essential to improving children's health, school readiness, and their future standing as productive citizens. We limit a child's chances and violate their God-given dignity when we do not positively construct a quality child care system. We violate human dignity when families whose children are at risk of poor social and educational outcomes have to settle for whatever child care arrangements they can piece together because the cost of consistent care, or the co-payment, is unaffordable.

Minnesota Association for the Education of Young Children

The actions proposed in this bill will facilitate parents' access to child care, improve quality early learning opportunities for children, and increase the quality of programming offered by care providers. For these reasons, MnAEYC supports the Child Care Access bill being put forward this legislative session 2005.

Minnesota Association for Family and Early Education

The Minnesota Association for Family and Early Education (MNAFEE) is deeply committed to supporting the provision of high quality, early childhood programming and thus stands in support of the Child Care Access bill. Specifically, this bill will allow hard-working, lower income families to access high quality child care. This is important because high quality child care programs incorporate critical components into their programming that all children and families should have access to, including research-based best practices, parent support and education, highly trained staff, low child to teacher ratios as well as parent and community involvement. Research clearly indicates that high quality programs better prepare young children for school and result in a greater economic return on the dollars invested. The bill's proposal that accredited child care programs should receive a higher reimbursement rate than non-accredited programs serves as an incentive for programs to deliver high quality services. Ensuring families, access to early childhood programming – particularly high quality programming – is essential to the well-being of our community's children and families.

Minnesota Child Care Association

The Minnesota Child Care Association supports the Child Care Access bill because it will support working family's access to quality early childhood programs that have become out of reach for many families as a result of many changes made during the 2003 legislative session. This bill supports the mounting evidence nationally and locally that the best investment a state can make is in quality early childhood education. This bill will also provide some sorely needed financial relief to providers who have suffered huge financial hardship, and prevent many dedicated early childhood professionals from closing their doors.

Minnesota Child Care Resource and Referral Network

The Minnesota Child Care Resource and Referral Network supports the child care access bill because it addresses the goals of our system: supporting parents in their search for high quality and accessible child care options, and building a strong and diverse early care and education system to support these choices. Passage of this Bill would provide much needed support for Minnesota families and children with the fewest resources.

Minnesota School Age Care Alliance

The Minnesota School Age Care Alliance supports the Child Care Access bill because it will increase access to quality, affordable child care for working families. Child care assistance is important because it allows many families who are struggling to make ends meet remain in the workforce. Quality care provides children with caring people, quality places, and challenging opportunities during their out-of-school time. The Minnesota School Age Care Alliance serves children ages 5-14 during their non-school hours and believes the Child Care Access bill will broaden the opportunities for school age children/youth for quality care opportunities. Access to affordable, quality care was significantly limited for families in need of child care assistance as a result of the 2003 legislative changes. The Child Care Access bill would eliminate some of these barriers, allowing the program to serve more families with the fewest resources.

Ready4K

Ready4K strongly supports the Child Care Access bill because it will help low-income working families be able to afford quality child care. Ready4K believes that the child care subsidy program should be a two generation program – one that both helps parents remain or join the workforce, and that helps prepare children for kindergarten. The Child Care Access bill would provide an incentive to programs to deliver quality child care through the accreditation differential. Providing low-income parents with child care financial assistance gives them the ability to choose the child care setting that is right for them and for their children.

Resources for Child Caring

Resources for Child Caring supports the Child Care Access Bill. As an administrator of the Child Care Assistance Program for Ramsey County, we have first hand knowledge of how the recent cuts to this program impacted low-income families. Families no longer eligible have had to patch together care for their children while they work, a circumstance that stresses families and harms children. As the primary source of training for child care professionals in Anoka, Washington and Ramsey Counties, we have seen the effect of the loss of a higher reimbursement rate. Caregivers have lost a key incentive to accredit their programs, meaning fewer high quality programs are available to help children get ready for school.

YMCA

The YMCA supports the Child Care Access bill because it will allow more low-income families to place their children in quality child care programs. Many of the families we serve lost their eligibility for child care assistance as a result of the 2003 legislation, and many of those who remained eligible could not afford the increased co-pay. Even with YMCA financial assistance, a significant number of families could no longer afford to pay for child care. This has made it tougher for parents to remain in the workforce and has reduced the quality of care that their children receive. The Child Care Access bill will allow more families to have access to quality, affordable child care.

YWCA of Duluth

Children's health, wellbeing and education is our responsibility. We want to know that you, our elected representatives commit yourselves to ensuring that every child has the opportunity for quality, early childhood education. Our future depends on it.

Supporting Organizations

Affirmative Options
2314 University Avenue W., Suite 20
St. Paul, MN 55114
651-642-1904 x229
Karen Kingsley, Director
karen@affirmativeoptions.org

All Nations Education Center
1515 E 23rd St
Minneapolis, MN 55404
612-721-2508
Vicky Chavez-Peabody, Director
victorialchavez@qwest.net

Alliance for Early Childhood Professionals
2438 18th Avenue South
Minneapolis, MN 55404
612-721-4246
Margaret Boyer, Executive Director
allecp@aol.com

Amherst H. Wilder Foundation
919 Lafond Avenue
Saint Paul, MN 55104
651-642-4000
Mary Vanderwert, Director of Child Care Programs
Mav3@wilder.org

Anoka County Community Action
1201 89th Ave. NE
Blaine, MN 55432
763-783-4881
Patrick McFarland, Executive Director
patrick.mcfarland@accap.org

Brighter Beginnings Child Care Center
418 County Rd 49
Cold Spring, MN 56320
Doris Fiecke

Children's Defense Fund Minnesota
200 University Avenue, W., Suite 210
St. Paul, MN 55103
651-855-1188
Jim Koppel, Director
koppel@cdf-mn.org

Congregations Concerned for Children
122 W. Franklin Ave #315
Minneapolis, MN 55404
612-870-3670
Norma Bourland, Director
nbourland@ccccan.org

Cozy Cottage Child Care
23844 Lake Point Road
Pierz, MN 56364
320-468-2257
Annette Smieja, Owner
aksmieja@brainerd.net

Family and Children's Services
414 S 8th St.
Minneapolis, MN 55404
612-341-1615
Susie Brown, Public Policy Director
susie.brown@fcsmn.org

First Friends Child Care Center
4801 Veterans Dr
Saint Cloud, MN 56303
Teresa Voigt

First Unitarian Society Children's Issues Committee
8448 Little Rd
Bloomington, MN 55437
952-893-2383
Carol Koepp
ckoepp@mn.rr.com

Grasstops
176 Arundel Street, Suite 4
St. Paul, MN 55102
651-295-3774
Mary Nienow, MSW, Co-Director
mary@grasstops.org

Greater Minnesota Day Care Association
1628 Elliot Ave. S.
Minneapolis, MN 55404
612-341-1177
Sharon Henry-Blythe, Executive Director
Sharon.Henry-Blythe@GMDCA.org

JOBS NOW Coalition
400 Selby Avenue, Suite Q
St. Paul, MN 55102-4520.
651-290-0240
Carrie Thomas, Policy Director
cthomas@jobsnowcoalition.org

Joint Religious Legislative Coalition
122 West Franklin Avenue, Room 315
Minneapolis, MN 55404
612-870-3670
Brian Rusche, Executive Director
brusche@jrlc.org

Minnesota Association for the Education of Young Children
1821 University Avenue, Suite 298-S
St. Paul, MN 55104
651-646-8689
Deborah Fitzwater-Dewey, Executive Director
dfitzwater-dewey@mnaeyc.org

Minnesota Child Care Resources and Referral Network
380 Lafayette Road, Suite 103
St. Paul, MN 55107
(651) 290-9704 x115
Ann McCully, Executive Director
annm@mnchildcare.org

Minnesota Community Action Association
100 Empire Drive
St Paul, MN 55103
651-645-7425
Tarryl Clark, Executive Director
Tarrylclark@astound.net

Minnesota Licensed Family Child Care Association
1711 County Road B West, Suite 110 South
Roseville, MN 55113
651-636-1989
Michelle Thole, President
Michelle.thole@mlfcca.org

Minnesota Association for Family and Early Education
8014 Olson Memorial Highway
Minneapolis, Minnesota 55427
651-483-3784
Lois Engstrom, Board Co-Chair
mnafee@mnafee.org

Minnesota Child Care Association
306 Lake Hazeltine Drive
Chaska, MN 55318
Chad Dunkley, President
cdunkley@newhorizonchildcare.com

Minnesota School Age Care Alliance
1000 Westgate Drive Ste. 252
St. Paul, MN 55114-1067
612-709-7157
Brian Siverson-Hall, Executive Director
brians@mnsaca.org

Ready4K
2233 University Avenue, Suite 345
St Paul, MN 55114
651-644-8138
Todd Otis, President
toddotis@ready4k.org

Resources for Child Caring
10 Yorkton Court
St. Paul, MN 55117
651-641-6645
Carol Weber Rohde, Executive Director
crohde@resourcesforchildcare.org

Sheltering Arms Foundation
430 Oak Grove Street, Suite 214
Minneapolis, MN 55403
612-871-9210
Denise Mayotte, Executive Director
612-871-0041 (fax)
dmayotte@sheltering-arms.org

Voices for Children of Central Minnesota
640 54th Ave N
Saint Cloud, MN 56303
320-685-7700
Pamela Walz
hpwalz@earthlink.net

YMCA
400 River Road
Grand Rapids, MN 55744.
218-327-2418
Kathy Carroll, Minnesota YMCA Child Care Representative

YWCA Duluth
202 W 2nd St
Duluth, MN 55802
218-722-7425
Ellen O'Neill, Executive Director
ellen@ywcaduluth.org

YWCA of Minneapolis
1130 Nicollet Mall
Minneapolis, MN 55403
612-215-4169
Katie Williams, Director of Children's Programs
kwilliams@ywcampls.org

A bill for an act

relating to human services; modifying programs and services for persons with disabilities; amending Minnesota Statutes 2004, sections 256B.04, by adding a subdivision; 256B.056, subdivisions 3, 5c; 256B.057, subdivision 9; 256B.0575; 256B.0621, subdivisions 2, 3, 4, 5, 6, 7, by adding a subdivision; 256B.0622, subdivision 2; 256B.0625, subdivision 9; 256B.0916, by adding a subdivision; 256B.092, subdivision 4b; 256B.35, subdivision 1; 256B.49, subdivisions 13, 14, 16; 256B.5012, by adding a subdivision; 256B.69, subdivision 23; 256B.765; 256D.03, subdivision 4; 256L.03, subdivisions 1, 5.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 256B.04, is amended by adding a subdivision to read:

Subd. 20. [INCENTIVE FOR WELLNESS VISITS.] The commissioner of human services shall consult with private sector health plan companies and shall develop an incentive program to encourage medical assistance enrollees with disabilities to have regular wellness exams conducted by a primary care physician. The commissioner shall implement the incentive program beginning January 1, 2006.

Sec. 2. Minnesota Statutes 2004, section 256B.056, subdivision 3, is amended to read:

Subd. 3. [ASSET LIMITATIONS FOR ~~INDIVIDUALS AND FAMILIES~~ THE AGED, BLIND, OR DISABLED.] To be eligible for medical assistance, a person whose eligibility category is based on blindness, disability, or age of 65 or more years must not

individually own more than ~~$3,000~~ $10,000 in assets, or if a member of a household with two ~~family members, husband and wife, or parent and child~~ or more persons, the household must not own more than ~~$6,000~~ $18,000 in assets~~, plus $200 for each additional legal dependent~~. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The accumulation of the clothing and personal needs allowance according to section 256B.35 must also be reduced to the maximum at the time of the eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance is the value of those assets excluded under the supplemental security income program for aged, blind, and disabled persons, with the following exceptions:

(a) Household goods and personal effects are not considered.

(b) Capital and operating assets of a trade or business that the local agency determines are necessary to the person's ability to earn an income are not considered.

(c) Motor vehicles are excluded to the same extent excluded by the supplemental security income program.

(d) Assets designated as burial expenses are excluded to the same extent excluded by the supplemental security income program. Burial expenses funded by annuity contracts or life insurance policies must irrevocably designate the individual's estate as contingent beneficiary to the extent proceeds are not used for payment of selected burial expenses.

(e) Effective upon federal approval, for a person who no longer qualifies as an employed person with a disability due to loss of earnings, assets allowed while eligible for medical assistance under section 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility as an employed person with a disability, to the extent that the person's total assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph (b).

(f) Assets owned by children are not considered.

Sec. 3. Minnesota Statutes 2004, section 256B.056, subdivision 5c, is amended to read:

Subd. 5c. [EXCESS INCOME STANDARD.] (a) The excess income standard for families with children is the standard specified in subdivision 4.

(b) The excess income standard for a person whose eligibility is based on blindness, disability, or age of 65 or more years is ~~70~~ 100 percent of the federal poverty guidelines for the family size. ~~Effective July 1, 2002, the excess income standard for this paragraph shall equal 75 percent of the federal poverty guidelines.~~

Sec. 4. Minnesota Statutes 2004, section 256B.057, subdivision 9, is amended to read:

Subd. 9. [EMPLOYED PERSONS WITH DISABILITIES.] (a) Medical assistance may be paid for a person who is employed and who:

(1) meets the definition of disabled under the supplemental security income program;

(2) is at least 16 but less than 65 years of age;

(3) meets the asset limits in paragraph (b); and

(4) effective November 1, 2003, pays a premium and other obligations under paragraph (d).

Any spousal income or assets shall be disregarded for purposes of eligibility and premium determinations.

After the month of enrollment, a person enrolled in medical assistance under this subdivision who:

(1) is temporarily unable to work and without receipt of earned income due to a medical condition, as verified by a physician, may retain eligibility for up to four calendar months; or

(2) effective January 1, 2004, loses employment for reasons not attributable to the enrollee, may retain eligibility for up to four consecutive months after the month of job loss. To receive a four-month extension, enrollees must verify the medical condition or provide notification of job loss. All other eligibility requirements must be met and the enrollee must pay all calculated premium costs for continued eligibility.

(b) For purposes of determining eligibility under this subdivision, a person's assets must not exceed $20,000, excluding:

(1) all assets excluded under section 256B.056;

(2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans, Keogh plans, and pension plans; and

(3) medical expense accounts set up through the person's employer.

(c)(1) Effective January 1, 2004, for purposes of eligibility, there will be a $65 earned income disregard. To be eligible, a person applying for medical assistance under this subdivision must have earned income above the disregard level.

(2) Effective January 1, 2004, to be considered earned income, Medicare, Social Security, and applicable state and federal income taxes must be withheld. To be eligible, a person must document earned income tax withholding.

(d)(1) A person whose earned and unearned income is equal to or greater than 100 percent of federal poverty guidelines for the applicable family size must pay a premium to be eligible for medical assistance under this subdivision. The premium shall be based on the person's gross earned and unearned income and the applicable family size using a sliding fee scale established by the commissioner, which begins at one percent of income at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income for those with incomes at or above 300 percent of the federal poverty guidelines. Annual adjustments in the premium schedule based upon changes in the federal poverty guidelines shall be effective for premiums due in July of each year.

(2) Effective January 1, 2004, all enrollees must pay a premium to be eligible for medical assistance under this subdivision. An enrollee shall pay the greater of a $35 premium or the premium calculated in clause (1).

(3) Effective November 1, 2003, all enrollees who receive unearned income must pay one-half of one percent of unearned income in addition to the premium amount.

(4) Effective ~~November 1, 2003~~ July 1, 2005, for enrollees ~~whose income does not exceed 200 percent of the federal poverty guidelines and~~ who are also enrolled in Medicare, the commissioner must reimburse the enrollee for Medicare Part B premiums under section 256B.0625, subdivision 15, paragraph (a).

(5) Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year.

(e) A person's eligibility and premium shall be determined by the local county agency. Premiums must be paid to the commissioner. All premiums are dedicated to the commissioner.

(f) Any required premium shall be determined at application and redetermined at the enrollee's six-month income review or when a change in income or household size is reported. Enrollees must report any change in income or household size within ten days of when the change occurs. A decreased premium resulting from a reported change in income or household size shall be effective the first day of the next available billing month after the change is reported. Except for changes occurring from annual cost-of-living increases, a change resulting in an increased premium shall not affect the premium amount until the next six-month review.

(g) Premium payment is due upon notification from the commissioner of the premium amount required. Premiums may be paid in installments at the discretion of the commissioner.

(h) Nonpayment of the premium shall result in denial or termination of medical assistance unless the person demonstrates good cause for nonpayment. Good cause exists if the requirements specified in Minnesota Rules, part 9506.0040, subpart 7, items B to D, are met. Except when an installment agreement is accepted by the commissioner, all persons disenrolled for nonpayment of a premium must pay any past due premiums as well as current premiums due prior to being reenrolled. Nonpayment shall include payment with a returned, refused, or dishonored instrument. The commissioner may require

a guaranteed form of payment as the only means to replace a returned, refused, or dishonored instrument.

Sec. 5. Minnesota Statutes 2004, section 256B.0575, is amended to read:

256B.0575 [AVAILABILITY OF INCOME FOR INSTITUTIONALIZED PERSONS.]

When an institutionalized person is determined eligible for medical assistance, the income that exceeds the deductions in paragraphs (a) and (b) must be applied to the cost of institutional care.

(a) The following amounts must be deducted from the institutionalized person's income in the following order:

(1) the personal needs allowance under section 256B.35 or, for a veteran who does not have a spouse or child, or a surviving spouse of a veteran having no child, the amount of an improved pension received from the veteran's administration not exceeding $90 per month;

(2) the personal allowance for disabled individuals under section 256B.36;

(3) if the institutionalized person has a legally appointed guardian or conservator, five percent of the recipient's gross monthly income up to $100 as reimbursement for guardianship or conservatorship services;

(4) a monthly income allowance determined under section 256B.058, subdivision 2, but only to the extent income of the institutionalized spouse is made available to the community spouse;

(5) a monthly allowance for children under age 18 which, together with the net income of the children, would provide income equal to the medical assistance standard for families and children according to section 256B.056, subdivision 4, for a family size that includes only the minor children. This deduction applies only if the children do not live with the community spouse and only to the extent that the deduction is not included in the personal needs allowance under section 256B.35, subdivision 1, as child support garnished under a court

order;

(6) a monthly family allowance for other family members, equal to one-third of the difference between 122 percent of the federal poverty guidelines and the monthly income for that family member;

(7) reparations payments made by the Federal Republic of Germany and reparations payments made by the Netherlands for victims of Nazi persecution between 1940 and 1945;

(8) all other exclusions from income for institutionalized persons as mandated by federal law; and

(9) amounts for reasonable expenses incurred for necessary medical or remedial care for the institutionalized person that are not medical assistance covered expenses and that are not subject to payment by a third party.

For purposes of clause (6), "other family member" means a person who resides with the community spouse and who is a minor or dependent child, dependent parent, or dependent sibling of either spouse. "Dependent" means a person who could be claimed as a dependent for federal income tax purposes under the Internal Revenue Code.

(b) Income shall be allocated to an institutionalized person for a period of up to ~~three~~ six calendar months, in an amount equal to 100 percent of the ~~medical-assistance-standard~~ federal poverty guidelines for a family size of one if:

(1) a physician certifies that the person is expected to reside in the long-term care facility for ~~three~~ six calendar months or less;

(2) if the person has expenses of maintaining a residence in the community; and

(3) if one of the following circumstances apply:

(i) the person was not living together with a spouse or a family member as defined in paragraph (a) when the person entered a long-term care facility; or

(ii) the person and the person's spouse become institutionalized on the same date, in which case the allocation shall be applied to the income of one of the spouses.

For purposes of this paragraph, a person is determined to be residing in a licensed nursing home, regional treatment center, or medical institution if the person is expected to remain for a period of one full calendar month or more.

Sec. 6. Minnesota Statutes 2004, section 256B.0621, subdivision 2, is amended to read:

Subd. 2. [TARGETED CASE MANAGEMENT; DEFINITIONS.] For purposes of subdivisions 3 to 10, the following terms have the meanings given them:

(1) "home care service recipients" means those individuals receiving the following services under section 256B.0627: skilled nursing visits, home health aide visits, private duty nursing, personal care assistants, or therapies provided through a home health agency;

(2) "home care targeted case management" means the provision of targeted case management services for the purpose of assisting home care service recipients to gain access to needed services and supports so that they may remain in the community;

(3) "institutions" means hospitals, consistent with Code of Federal Regulations, title 42, section 440.10; regional treatment center inpatient services, consistent with section 245.474; nursing facilities; and intermediate care facilities for persons with mental retardation;

(4) "relocation targeted case management" ~~means~~ includes the provision of both county targeted case management and service coordination services for the purpose of assisting recipients to gain access to needed services and supports if they choose to move from an institution to the community. Relocation targeted case management may be provided during the last 180 consecutive days of an eligible recipient's institutional stay; and

(5) "targeted case management" means case management services provided to help recipients gain access to needed medical, social, educational, and other services and supports.

Sec. 7. Minnesota Statutes 2004, section 256B.0621,

subdivision 3, is amended to read:

Subd. 3. [ELIGIBILITY.] The following persons are eligible for relocation targeted case management or home ~~care-targeted~~ care targeted case management:

(1) medical assistance eligible persons residing in institutions who choose to move into the community are eligible for relocation targeted case management services; and

(2) medical assistance eligible persons receiving home care services, who are not eligible for any other medical assistance reimbursable case management service, are eligible for home ~~care-targeted~~ care targeted case management services beginning ~~January 1, 2003~~ July 1, 2005.

Sec. 8. Minnesota Statutes 2004, section 256B.0621, subdivision 4, is amended to read:

Subd. 4. [RELOCATION TARGETED COUNTY CASE MANAGEMENT PROVIDER QUALIFICATIONS.] (a) A relocation targeted county case management provider is an enrolled medical assistance provider who is determined by the commissioner to have all of the following characteristics:

(1) the legal authority to provide public welfare under sections 393.01, subdivision 7; and 393.07; or a federally recognized Indian tribe;

(2) the demonstrated capacity and experience to provide the components of case management to coordinate and link community resources needed by the eligible population;

(3) the administrative capacity and experience to serve the target population for whom it will provide services and ensure quality of services under state and federal requirements;

(4) the legal authority to provide complete investigative and protective services under section 626.556, subdivision 10; and child welfare and foster care services under section 393.07, subdivisions 1 and 2; or a federally recognized Indian tribe;

(5) a financial management system that provides accurate documentation of services and costs under state and federal requirements; and

(6) the capacity to document and maintain individual case

records under state and federal requirements.

(b) A provider of targeted case management under section 256B.0625, subdivision 20, may be deemed a certified provider of relocation targeted case management.

(c) A relocation targeted county case management provider may subcontract with another provider to deliver relocation targeted case management services. Subcontracted providers must demonstrate the ability to provide the services outlined in subdivision 6, and have a procedure in place that notifies the recipient and the recipient's legal representative of any conflict of interest if the contracted targeted case management provider also provides, or will provide, the recipient's services and supports. Counties must require that contracted providers must provide information on all conflicts of interest and obtain the recipient's informed consent or provide the recipient with alternatives.

Sec. 9. Minnesota Statutes 2004, section 256B.0621, subdivision 5, is amended to read:

Subd. 5. [HOME CARE TARGETED CASE MANAGEMENT AND RELOCATION SERVICE COORDINATION PROVIDER QUALIFICATIONS.] ~~The following qualifications and certification standards must be met by~~ Providers of home care targeted case management and relocation service coordination must meet the qualifications under subdivision 4 or the following qualifications and certification standards.

(a) The commissioner must certify each provider of home care targeted case management and relocation service coordination before enrollment. The certification process shall examine the provider's ability to meet the requirements in this subdivision and other state and federal requirements of this service.

(b) ~~A~~ Both home care targeted case management ~~provider is an~~ providers and relocation service coordination providers are enrolled medical assistance ~~provider~~ providers who ~~has~~ have a minimum of a bachelor's degree or a license in a health or human services field, or comparable training and two years of

experience in human services, and ~~is~~ have been determined by the commissioner to have all of the following characteristics:

(1) the demonstrated capacity and experience to provide the components of case management to coordinate and link community resources needed by the eligible population;

(2) the administrative capacity and experience to serve the target population for whom it will provide services and ensure quality of services under state and federal requirements;

(3) a financial management system that provides accurate documentation of services and costs under state and federal requirements;

(4) the capacity to document and maintain individual case records under state and federal requirements; ~~and~~

(5) the capacity to coordinate with county administrative functions;

(6) have no financial interest in the provision of out-of-home residential services to persons for whom targeted case management or relocation service coordination is provided; and

(7) if a provider has a financial interest in services other than out-of-home residential services provided to persons for whom targeted case management or relocation service coordination is also provided, the county must determine each year that:

(i) any possible conflict of interest is explained annually at a face-to-face meeting and in writing and the person provides written informed consent consistent with section 256B.77, subdivision 2, paragraph (p); and

(ii) information on a range of other feasible service provider options has been provided.

Sec. 10. Minnesota Statutes 2004, section 256B.0621, subdivision 6, is amended to read:

Subd. 6. [ELIGIBLE SERVICES.] (a) Services eligible for medical assistance reimbursement as targeted case management include:

(1) assessment of the recipient's need for targeted case

management services;

(2) development, completion, and regular review of a written individual service plan, which is based upon the assessment of the recipient's needs and choices, and which will ensure access to medical, social, educational, and other related services and supports;

(3) routine contact or communication with the recipient, recipient's family, primary caregiver, legal representative, substitute care provider, service providers, or other relevant persons identified as necessary to the development or implementation of the goals of the individual service plan;

(4) coordinating referrals for, and the provision of, case management services for the recipient with appropriate service providers, consistent with section 1902(a)(23) of the Social Security Act;

(5) coordinating and monitoring the overall service delivery and engaging in advocacy as needed to ensure quality of services, appropriateness, and continued need;

(6) completing and maintaining necessary documentation that supports and verifies the activities in this subdivision;

(7) ~~traveling~~ assisting individuals in order to access needed services, including travel to conduct a visit with the recipient or other relevant person necessary to develop or implement the goals of the individual service plan; and

(8) coordinating with the institution discharge planner in the 180-day period before the recipient's discharge.

(b) Relocation targeted county case management includes services under paragraph (a), clauses (2) and (4). Relocation service coordination includes services under paragraph (a), clauses (1), (3), and (5) to (8). Home care targeted case management includes services under paragraph (a), clauses (1) to (8).

Sec. 11. Minnesota Statutes 2004, section 256B.0621, subdivision 7, is amended to read:

Subd. 7. [TIME LINES.] The following time lines must be met for assigning a case manager:

(a) For relocation targeted case management, an eligible recipient must be assigned a county case manager who visits the person within 20 working days of requesting a case manager from their county of financial responsibility as determined under chapter 256G.

(1) If a county agency, its contractor, or federally recognized tribe does not provide case management services as required, the recipient may obtain ~~targeted relocation case management services~~ relocation service coordination from ~~an alternative~~ a provider ~~of targeted case management services enrolled by the commissioner~~ qualified under subdivision 5.

(2) The commissioner may waive the provider requirements in subdivision 4, paragraph (a), clauses (1) and (4), to ensure recipient access to the assistance necessary to move from an institution to the community. The recipient or the recipient's legal guardian shall provide written notice to the county or tribe of the decision to obtain services from an alternative provider.

(3) Providers of relocation targeted case management enrolled under this subdivision shall:

(i) meet the provider requirements under subdivision 4 that are not waived by the commissioner;

(ii) be qualified to provide the services specified in subdivision 6;

(iii) coordinate efforts with local social service agencies and tribes; and

(iv) comply with the conflict of interest provisions established under subdivision 4, paragraph (c).

(4) Local social service agencies and federally recognized tribes shall cooperate with providers certified by the commissioner under this subdivision to facilitate the recipient's successful relocation from an institution to the community.

(b) For home care targeted case management, an eligible recipient must be assigned a case manager within 20 working days of requesting a case manager from a home care targeted case

management provider, as defined in subdivision 5.

Sec. 12. Minnesota Statutes 2004, section 256B.0621, is amended by adding a subdivision to read:

Subd. 11. [DATA USE AGREEMENT AND NOTICE OF RELOCATION TARGETED CASE MANAGEMENT AVAILABILITY.] (a) The commissioner shall execute a data use agreement with the Center for Medicare and Medicaid Services to obtain the long-term care minimum data set data to assist residents of nursing facilities who have indicated a desire to live in the community. The commissioner shall in turn enter into agreements with the Centers for Independent Living and other disability advocacy organizations to assist persons who want help to move to the community.

(b) Upon admission and annually thereafter, the commissioner shall provide notification to medical assistance eligible persons who are residing in institutions of the availability of relocation targeted case management services, including contact information for the responsible county and senior and disability organizations that provide assistance to persons with disabilities.

Sec. 13. Minnesota Statutes 2004, section 256B.0622, subdivision 2, is amended to read:

Subd. 2. [DEFINITIONS.] For purposes of this section, the following terms have the meanings given them.

(a) "Intensive nonresidential rehabilitative mental health services" means adult rehabilitative mental health services as defined in section 256B.0623, subdivision 2, paragraph (a), except that these services are provided by a multidisciplinary staff using a total team approach consistent with assertive community treatment, the Fairweather Lodge treatment model, as defined by the standards established by the National Coalition for Community Living, and other evidence-based practices, and directed to recipients with a serious mental illness who require intensive services.

(b) "Intensive residential rehabilitative mental health services" means short-term, time-limited services provided in a residential setting to recipients who are in need of more

restrictive settings and are at risk of significant functional deterioration if they do not receive these services. Services are designed to develop and enhance psychiatric stability, personal and emotional adjustment, self-sufficiency, and skills to live in a more independent setting. Services must be directed toward a targeted discharge date with specified client outcomes and must be consistent with the Fairweather Lodge treatment model as defined in paragraph (a), and other evidence-based practices.

(c) "Evidence-based practices" are nationally recognized mental health services that are proven by substantial research to be effective in helping individuals with serious mental illness obtain specific treatment goals.

(d) "Overnight staff" means a member of the intensive residential rehabilitative mental health treatment team who is responsible during hours when recipients are typically asleep.

(e) "Treatment team" means all staff who provide services under this section to recipients. At a minimum, this includes the clinical supervisor, mental health professionals, mental health practitioners, and mental health rehabilitation workers.

Sec. 14. Minnesota Statutes 2004, section 256B.0625, subdivision 9, is amended to read:

Subd. 9. [DENTAL SERVICES.] ~~(a)~~ Medical assistance covers dental services. Dental services include, with prior authorization, fixed bridges that are cost-effective for persons who cannot use removable dentures because of their medical condition.

~~(b) Coverage of dental services for adults age 21 and over who are not pregnant is subject to a $500 annual benefit limit and covered services are limited to:~~

~~(1) diagnostic and preventative services;~~

~~(2) restorative services; and~~

~~(3) emergency services.~~

~~Emergency services, dentures, and extractions related to dentures are not included in the $500 annual benefit limit.~~

Sec. 15. Minnesota Statutes 2004, section 256B.0916, is

amended by adding a subdivision to read:

Subd. 10. [TRANSITIONAL SUPPORTS ALLOWANCE.] A transitional supports allowance shall be available to all persons under a home and community-based waiver who are moving from a licensed setting to a community setting. "Transitional supports allowance" means a onetime payment of up to $3,000, to cover the costs, not covered by other sources, associated with moving from a licensed setting to a community setting. Covered costs include:

(1) lease or rent deposits;

(2) security deposits;

(3) utilities set-up costs, including telephone;

(4) essential furnishings and supplies; and

(5) personal supports and transports needed to locate and transition to community settings.

[EFFECTIVE DATE.] This section is effective upon federal approval and to the extent approved as a federal waiver amendment.

Sec. 16. Minnesota Statutes 2004, section 256B.092, subdivision 4b, is amended to read:

Subd. 4b. [COUNTY CASE MANAGEMENT AND SERVICE COORDINATION FOR PERSONS RECEIVING HOME AND COMMUNITY-BASED SERVICES.] (a) Persons authorized for and receiving home and community-based services may select from public vendors of county case management which have provider agreements with the state to provide home and community-based case management service activities. ~~This subdivision becomes effective July 1, 1992, only if the state agency is unable to secure federal approval for limiting choice of case management vendors to the county of financial responsibility.~~

(b) The commissioner shall ensure that each eligible person is given a choice between county and private agency service coordination vendors consistent with the provisions of section 256B.49, subdivision 13.

[EFFECTIVE DATE.] This section is effective July 1, 2005, or, if a federal waiver is required, on the date the federal

waiver is granted.

Sec. 17. Minnesota Statutes 2004, section 256B.35, subdivision 1, is amended to read:

Subdivision 1. [PERSONAL NEEDS ALLOWANCE.] (a) Notwithstanding any law to the contrary, welfare allowances for clothing and personal needs for individuals receiving medical assistance while residing in any skilled nursing home, intermediate care facility, or medical institution including recipients of supplemental security income, in this state shall not be less than ~~$45~~ $150 per month from all sources. When benefit amounts for Social Security or supplemental security income recipients are increased pursuant to United States Code, title 42, sections 415(i) and 1382f, the commissioner shall, effective in the month in which the increase takes effect, increase by the same percentage to the nearest whole dollar the clothing and personal needs allowance for individuals receiving medical assistance while residing in any skilled nursing home, medical institution, or intermediate care facility. The commissioner shall provide timely notice to local agencies, providers, and recipients of increases under this provision.

(b) The personal needs allowance may be paid as part of the Minnesota supplemental aid program, notwithstanding the provisions of section 256D.37, subdivision 2, and payments to recipients of Minnesota supplemental aid may be made once each three months covering liabilities that accrued during the preceding three months.

(c) The personal needs allowance shall be increased to include income garnished for child support under a court order, up to a maximum of $250 per month but only to the extent that the amount garnished is not deducted as a monthly allowance for children under section 256B.0575, paragraph (a), clause (5).

Sec. 18. Minnesota Statutes 2004, section 256B.49, subdivision 13, is amended to read:

Subd. 13. [COUNTY CASE MANAGEMENT AND SERVICE COORDINATION SERVICES.] (a) Each recipient of a home and community-based waiver shall be provided county case management and service

coordination services by qualified vendors as described in the federally approved waiver application and offered a choice between county and private vendors for service coordination services. The county case management ~~service activities~~ services to be provided ~~will~~ include:

(1) assessing the needs of the individual within 20 working days of a recipient's request;

(2) developing the written individual service plan within ten working days after the assessment is completed, including a determination of resources needed to meet assessed needs;

(3) informing the recipient or the recipient's legal guardian or conservator of service options; and

(4) monitoring and evaluating the overall service plan implementation to assure the recipient's health, safety, welfare, and service outcomes.

(b) Each recipient shall be offered a choice of a service coordination vendor among qualified public and private vendors as described in the federally approved waiver application. The service coordination activities include:

(1) assisting the recipient to provide medical and other information to determine services needs;

(2) assisting the recipient in the identification of potential service providers;

~~(5)~~ (3) assisting the recipient to access services;

~~(6)~~ (4) coordinating, evaluating, and monitoring of the recipient and the services identified in the service plan to assure that the ongoing needs of the recipient are met or changes are made, if needed;

~~(7)~~ (5) assisting the recipient to obtain all information for completing the annual or other reviews described in subdivision 14 of the service plan with the case manager; ~~and~~

(6) participating in meetings and consultations and advocating for the recipient with recipient's service providers, medical providers, and county staff as needed;

(7) having no financial interest in out-of-home residential services for persons for whom service coordination is provided;

and

~~(8) informing the recipient or legal representative of the right to have assessments completed and service plans developed within specified time periods, and to appeal county action or inaction under section 256.045, subdivision 3~~ if a provider has a financial interest in services other than out-of-home residential services provided to persons for whom targeted case management or relocation service coordination is also provided, the county must determine each year that:

(i) any possible conflict of interest is explained annually at a face-to-face meeting and in writing and the person provides written informed consent consistent with section 256B.77, subdivision 2, paragraph (p); and

(ii) information on a range of other feasible service provider options has been provided.

~~(b)~~ (c) The ~~case manager~~ county may delegate certain aspects of the county case management or service coordination activities to another individual provided there is oversight by the case manager. The case manager may not delegate those aspects which require professional judgment including assessments, reassessments, and care plan development.

[EFFECTIVE DATE.] This section is effective July 1, 2005, or, if a federal waiver is required, on the date the federal waiver is granted.

Sec. 19. Minnesota Statutes 2004, section 256B.49, subdivision 14, is amended to read:

Subd. 14. [ASSESSMENT AND REASSESSMENT.] (a) Assessments of each recipient's strengths, informal support systems, and need for services shall be completed by the county case manager within 20 working days of the recipient's request. Reassessment of each recipient's strengths, support systems, and need for services shall be conducted by the county case manager at least every 12 months and at other times when there has been a significant change in the recipient's functioning.

(b) Persons with mental retardation or a related condition who apply for services under the nursing facility level waiver

programs shall be screened for the appropriate level of care according to section 256B.092.

(c) Recipients who are found eligible for home and community-based services under this section before their 65th birthday may remain eligible for these services after their 65th birthday if they continue to meet all other eligibility factors.

Sec. 20. Minnesota Statutes 2004, section 256B.49, subdivision 16, is amended to read:

Subd. 16. [SERVICES AND SUPPORTS.] (a) Services and supports included in the home and community-based waivers for persons with disabilities shall meet the requirements set out in United States Code, title 42, section 1396n. The services and supports, which are offered as alternatives to institutional care, shall promote consumer choice, community inclusion, self-sufficiency, and self-determination.

(b) Beginning January 1, 2003, the commissioner shall simplify and improve access to home and community-based waivered services, to the extent possible, through the establishment of a common service menu that is available to eligible recipients regardless of age, disability type, or waiver program.

(c) Consumer directed community support services shall be offered as an option to all persons eligible for services under subdivision 11, by January 1, 2002.

(d) Services and supports shall be arranged and provided consistent with individualized written plans of care for eligible waiver recipients.

(e) A transitional supports allowance shall be available to all persons under a home and community-based waiver who are moving from a licensed setting to a community setting. "Transitional supports allowance" means a onetime payment of up to $3,000, to cover the costs, not covered by other sources, associated with moving from a licensed setting to a community setting. Covered costs include:

(1) lease or rent deposits;

(2) security deposits;

(3) utilities set-up costs, including telephone;

(4) essential furnishings and supplies; and

(5) personal supports and transports needed to locate and transition to community settings.

(f) The state of Minnesota and county agencies that administer home and community-based waivered services for persons with disabilities, shall not be liable for damages, injuries, or liabilities sustained through the purchase of supports by the individual, the individual's family, legal representative, or the authorized representative with funds received through the consumer-directed community support service under this section. Liabilities include but are not limited to: workers' compensation liability, the Federal Insurance Contributions Act (FICA), or the Federal Unemployment Tax Act (FUTA).

[EFFECTIVE DATE.] This section is effective upon federal approval and to the extent approved as a federal waiver amendment.

Sec. 21. Minnesota Statutes 2004, section 256B.5012, is amended by adding a subdivision to read:

Subd. 6. [ICF/MR RATE INCREASES BEGINNING JANUARY 1, 2006, AND JANUARY 1, 2007.] For the rate years beginning January 1, 2006, and January 1, 2007, the commissioner shall provide facilities reimbursed under this section an adjustment to the total operating payment rate of ..... percent. At least two-thirds of each year's adjustment must be used for increased costs of employee salaries and benefits and associated costs for FICA, the Medicare tax, workers' compensation premiums, and federal and state unemployment insurance. Each facility receiving an adjustment shall report to the commissioner, in the form and manner specified by the commissioner, on how the additional funding was used.

Sec. 22. Minnesota Statutes 2004, section 256B.69, subdivision 23, is amended to read:

Subd. 23. [ALTERNATIVE INTEGRATED LONG-TERM CARE SERVICES; ELDERLY AND DISABLED PERSONS.] (a) The commissioner may implement demonstration projects to create alternative

integrated delivery systems for acute and long-term care services to elderly persons and persons with disabilities as defined in section 256B.77, subdivision 7a, that provide increased coordination, improve access to quality services, and mitigate future cost increases. The commissioner may seek federal authority to combine Medicare and Medicaid capitation payments for the purpose of such demonstrations. Medicare funds and services shall be administered according to the terms and conditions of the federal waiver and demonstration provisions. For the purpose of administering medical assistance funds, demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations, with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1, items B and C, which do not apply to persons enrolling in demonstrations under this section. An initial open enrollment period may be provided. Persons who disenroll from demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and the health plan's participation is subsequently terminated for any reason, the person shall be provided an opportunity to select a new health plan and shall have the right to change health plans within the first 60 days of enrollment in the second health plan. Persons required to participate in health plans under this section who fail to make a choice of health plan shall not be randomly assigned to health plans under these demonstrations. Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220, subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision, the commissioner may contract with managed care organizations, including counties, to serve only elderly persons eligible for medical assistance, elderly and disabled persons, or disabled persons only. For persons with primary diagnoses of mental retardation or a related condition, serious and persistent mental illness, or serious emotional disturbance, the

commissioner must ensure that the county authority has approved the demonstration and contracting design. Enrollment in these projects for persons with disabilities shall be voluntary. The commissioner shall not implement any demonstration project under this subdivision for persons with primary diagnoses of mental retardation or a related condition, serious and persistent mental illness, or serious emotional disturbance, without approval of the county board of the county in which the demonstration is being implemented.

(b) Notwithstanding chapter 245B, sections 252.40 to 252.46, 256B.092, 256B.501 to 256B.5015, and Minnesota Rules, parts 9525.0004 to 9525.0036, 9525.1200 to 9525.1330, 9525.1580, and 9525.1800 to 9525.1930, the commissioner may implement under this section projects for persons with developmental disabilities. The commissioner may capitate payments for ICF/MR services, waivered services for mental retardation or related conditions, including case management services, day training and habilitation and alternative active treatment services, and other services as approved by the state and by the federal government. Case management and active treatment must be individualized and developed in accordance with a person-centered plan. Costs under these projects may not exceed costs that would have been incurred under fee-for-service. Beginning July 1, 2003, and until two years after the pilot project implementation date, subcontractor participation in the long-term care developmental disability pilot is limited to a nonprofit long-term care system providing ICF/MR services, home and community-based waiver services, and in-home services to no more than 120 consumers with developmental disabilities in Carver, Hennepin, and Scott Counties. The commissioner shall report to the legislature prior to expansion of the developmental disability pilot project. This paragraph expires two years after the implementation date of the pilot project.

(c) Before implementation of a demonstration project for disabled persons, the commissioner must provide information to appropriate committees of the house of representatives and

senate and must involve representatives of affected disability groups in the design of the demonstration projects.

(d) A nursing facility reimbursed under the alternative reimbursement methodology in section 256B.434 may, in collaboration with a hospital, clinic, or other health care entity provide services under paragraph (a). The commissioner shall amend the state plan and seek any federal waivers necessary to implement this paragraph.

(e) The commissioner shall seek federal approval to expand the Minnesota disability health options (MnDHO) program established under this subdivision in stages, first to regional population centers outside the seven-county metro area and then to all areas of the state.

Sec. 23. Minnesota Statutes 2004, section 256B.765, is amended to read:

256B.765 [PROVIDER RATE INCREASES.]

Subdivision 1. [ANNUAL INFLATION ADJUSTMENTS.] (a) Effective July 1, 2001, within the limits of appropriations specifically for this purpose, the commissioner shall provide an annual inflation adjustment for the providers listed in ~~paragraph (c)~~ subdivision 2. The index for the inflation adjustment must be based on the change in the Employment Cost Index for Private Industry Workers - Total Compensation forecasted by Data Resources, Inc., as forecasted in the fourth quarter of the calendar year preceding the fiscal year. The commissioner shall increase reimbursement or allocation rates by the percentage of this adjustment, and county boards shall adjust provider contracts as needed.

(b) The commissioner of finance shall include an annual inflationary adjustment in reimbursement rates for the providers listed in ~~paragraph (c)~~ subdivision 2 using the inflation factor specified in paragraph (a) as a budget change request in each biennial detailed expenditure budget submitted to the legislature under section 16A.11.

~~(c)~~ Subd. 2. [ELIGIBLE PROVIDERS.] The annual adjustment under subdivision 1, paragraph (a), shall be provided for home

and community-based waiver services for persons with mental retardation or related conditions under section 256B.501; home and community-based waiver services for the elderly under section 256B.0915; waivered services under community alternatives for disabled individuals under section 256B.49; community alternative care waivered services under section 256B.49; traumatic brain injury waivered services under section 256B.49; nursing services and home health services under section 256B.0625, subdivision 6a; personal care services and nursing supervision of personal care services under section 256B.0625, subdivision 19a; private duty nursing services under section 256B.0625, subdivision 7; day training and habilitation services for adults with mental retardation or related conditions under sections 252.40 to 252.46; physical therapy services under sections 256B.0625, subdivision 8, and 256D.03, subdivision 4; occupational therapy services under sections 256B.0625, subdivision 8a, and 256D.03, subdivision 4; speech-language therapy services under section 256D.03, subdivision 4, and Minnesota Rules, part 9505.0390; respiratory therapy services under section 256D.03, subdivision 4, and Minnesota Rules, part 9505.0295; alternative care services under section 256B.0913; adult residential program grants under Minnesota Rules, parts 9535.2000 to 9535.3000; adult and family community support grants under Minnesota Rules, parts 9535.1700 to 9535.1760; semi-independent living services under section 252.275 including SILS funding under county social services grants formerly funded under chapter 256I; and community support services for deaf and hard-of-hearing adults with mental illness who use or wish to use sign language as their primary means of communication.

Subd. 3. [RATE INCREASE FOR BIENNIUM BEGINNING JULY 1, 2005.] For the fiscal years beginning July 1, 2005, and July 1, 2006, the commissioner shall increase reimbursement rates for the providers listed in subdivision 2 by ..... percent. At least two-thirds of each year's adjustment must be used for increased costs of employee salaries and benefits and associated costs for FICA, the Medicare tax, workers' compensation

premiums, and federal and state unemployment insurance. Each provider receiving an adjustment shall report to the commissioner, in the form and manner specified by the commissioner, on how the additional funding was used.

Sec. 24. Minnesota Statutes 2004, section 256D.03, subdivision 4, is amended to read:

Subd. 4. [GENERAL ASSISTANCE MEDICAL CARE; SERVICES.] (a)(i) For a person who is eligible under subdivision 3, paragraph (a), clause (2), item (i), general assistance medical care covers, except as provided in paragraph (c):

(1) inpatient hospital services;

(2) outpatient hospital services;

(3) services provided by Medicare certified rehabilitation agencies;

(4) prescription drugs and other products recommended through the process established in section 256B.0625, subdivision 13;

(5) equipment necessary to administer insulin and diagnostic supplies and equipment for diabetics to monitor blood sugar level;

(6) eyeglasses and eye examinations provided by a physician or optometrist;

(7) hearing aids;

(8) prosthetic devices;

(9) laboratory and X-ray services;

(10) physician's services;

(11) medical transportation except special transportation;

(12) chiropractic services as covered under the medical assistance program;

(13) podiatric services;

(14) dental services ~~and dentures, subject to the limitations specified in section 256B.0625, subdivision 9~~ as covered under the medical assistance program;

(15) outpatient services provided by a mental health center or clinic that is under contract with the county board and is established under section 245.62;

(16) day treatment services for mental illness provided under contract with the county board;

(17) prescribed medications for persons who have been diagnosed as mentally ill as necessary to prevent more restrictive institutionalization;

(18) psychological services, medical supplies and equipment, and Medicare premiums, coinsurance and deductible payments;

(19) medical equipment not specifically listed in this paragraph when the use of the equipment will prevent the need for costlier services that are reimbursable under this subdivision;

(20) services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if (1) the service is otherwise covered under this chapter as a physician service, (2) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the operating payment rate, and (3) the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171;

(21) services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic that is a department of, or that operates under the direct authority of, a unit of government, if the service is within the scope of practice of the public health nurse's license as a registered nurse, as defined in section 148.171; and

(22) telemedicine consultations, to the extent they are covered under section 256B.0625, subdivision 3b.

(ii) Effective October 1, 2003, for a person who is eligible under subdivision 3, paragraph (a), clause (2), item (ii), general assistance medical care coverage is limited to inpatient hospital services, including physician services

provided during the inpatient hospital stay. A $1,000 deductible is required for each inpatient hospitalization.

(b) Gender reassignment surgery and related services are not covered services under this subdivision unless the individual began receiving gender reassignment services prior to July 1, 1995.

(c) In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall where possible contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for prepaid health plans, competitive bidding programs, block grants, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. Before implementing prepaid programs in counties with a county operated or affiliated public teaching hospital or a hospital or clinic operated by the University of Minnesota, the commissioner shall consider the risks the prepaid program creates for the hospital and allow the county or hospital the opportunity to participate in the program in a manner that reflects the risk of adverse selection and the nature of the patients served by the hospital, provided the terms of participation in the program are competitive with the terms of other participants considering the nature of the population served. Payment for services provided pursuant to this subdivision shall be as provided to medical assistance vendors of these services under sections 256B.02, subdivision 8, and 256B.0625. For payments made during fiscal year 1990 and later years, the commissioner shall consult with an independent actuary in establishing prepayment rates, but shall retain final control over the rate methodology.

(d) Recipients eligible under subdivision 3, paragraph (a), clause (2), item (i), shall pay the following co-payments for services provided on or after October 1, 2003:

(1) $3 per nonpreventive visit. For purposes of this

subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(2) $25 for eyeglasses;

(3) $25 for nonemergency visits to a hospital-based emergency room; and

(4) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $20 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness~~;-and~~

~~(5)-50-percent-coinsurance-on-restorative-dental-services~~.

(e) Co-payments shall be limited to one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital-based emergency room. Recipients of general assistance medical care are responsible for all co-payments in this subdivision. The general assistance medical care reimbursement to the provider shall be reduced by the amount of the co-payment, except that reimbursement for prescription drugs shall not be reduced once a recipient has reached the $20 per month maximum for prescription drug co-payments. The provider collects the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment, except as provided in paragraph (f).

(f) If it is the routine business practice of a provider to refuse service to an individual with uncollected debt, the provider may include uncollected co-payments under this section. A provider must give advance notice to a recipient with uncollected debt before services can be denied.

(g) Any county may, from its own resources, provide medical payments for which state payments are not made.

(h) Chemical dependency services that are reimbursed under

chapter 254B must not be reimbursed under general assistance medical care.

(i) The maximum payment for new vendors enrolled in the general assistance medical care program after the base year shall be determined from the average usual and customary charge of the same vendor type enrolled in the base year.

(j) The conditions of payment for services under this subdivision are the same as the conditions specified in rules adopted under chapter 256B governing the medical assistance program, unless otherwise provided by statute or rule.

(k) Inpatient and outpatient payments shall be reduced by five percent, effective July 1, 2003. This reduction is in addition to the five percent reduction effective July 1, 2003, and incorporated by reference in paragraph (i).

(l) Payments for all other health services except inpatient, outpatient, and pharmacy services shall be reduced by five percent, effective July 1, 2003.

(m) Payments to managed care plans shall be reduced by five percent for services provided on or after October 1, 2003.

(n) A hospital receiving a reduced payment as a result of this section may apply the unpaid balance toward satisfaction of the hospital's bad debts.

Sec. 25. Minnesota Statutes 2004, section 256L.03, subdivision 1, is amended to read:

Subdivision 1. [COVERED HEALTH SERVICES.] For individuals under section 256L.04, subdivision 7, with income no greater than 75 percent of the federal poverty guidelines or for families with children under section 256L.04, subdivision 1, all subdivisions of this section apply. "Covered health services" means the health services reimbursed under chapter 256B, with the exception of inpatient hospital services, special education services, private duty nursing services, adult dental care services ~~other than services~~ except as covered under section 256B.0625, subdivision 9, ~~paragraph (b), orthodontic services,~~ nonemergency medical transportation services, personal care assistant and case management services, nursing home or

intermediate care facilities services, inpatient mental health services, and chemical dependency services. Outpatient mental health services covered under the MinnesotaCare program are limited to diagnostic assessments, psychological testing, explanation of findings, medication management by a physician, day treatment, partial hospitalization, and individual, family, and group psychotherapy.

No public funds shall be used for coverage of abortion under MinnesotaCare except where the life of the female would be endangered or substantial and irreversible impairment of a major bodily function would result if the fetus were carried to term; or where the pregnancy is the result of rape or incest.

Covered health services shall be expanded as provided in this section.

Sec. 26. Minnesota Statutes 2004, section 256L.03, subdivision 5, is amended to read:

Subd. 5. [CO-PAYMENTS AND COINSURANCE.] (a) Except as provided in paragraphs (b) and (c), the MinnesotaCare benefit plan shall include the following co-payments and coinsurance requirements for all enrollees:

(1) ten percent of the paid charges for inpatient hospital services for adult enrollees, subject to an annual inpatient out-of-pocket maximum of $1,000 per individual and $3,000 per family;

(2) $3 per prescription for adult enrollees; and

(3) $25 for eyeglasses for adult enrollees~~;-and~~

~~(4)-50-percent-of-the-fee-for-service-rate-for-adult-dental care-services-other-than-preventive-care-services-for-persons eligible-under-section-256L.04,-subdivisions-1-to-7,-with-income equal-to-or-less-than-175-percent-of-the-federal-poverty guidelines~~.

(b) Paragraph (a), clause (1), does not apply to parents and relative caretakers of children under the age of 21 in households with family income equal to or less than 175 percent of the federal poverty guidelines. Paragraph (a), clause (1), does not apply to parents and relative caretakers of children

under the age of 21 in households with family income greater than 175 percent of the federal poverty guidelines for inpatient hospital admissions occurring on or after January 1, 2001.

(c) Paragraph (a), clauses (1) to (4), do not apply to pregnant women and children under the age of 21.

(d) Adult enrollees with family gross income that exceeds 175 percent of the federal poverty guidelines and who are not pregnant shall be financially responsible for the coinsurance amount, if applicable, and amounts which exceed the $10,000 inpatient hospital benefit limit.

(e) When a MinnesotaCare enrollee becomes a member of a prepaid health plan, or changes from one prepaid health plan to another during a calendar year, any charges submitted towards the $10,000 annual inpatient benefit limit, and any out-of-pocket expenses incurred by the enrollee for inpatient services, that were submitted or incurred prior to enrollment, or prior to the change in health plans, shall be disregarded.

Sec. 27. [FEDERAL APPROVAL.]

By August 1, 2005, the commissioner of human services shall request any federal approval and plan amendments necessary to implement (1) the transitional supports allowance under Minnesota Statutes, sections 256B.0916, subdivision 10; and 256B.49, subdivision 16; and (2) the choice of case management service coordination provisions under Minnesota Statutes, sections 256B.0621, subdivision 4; 256B.092, subdivisions 2a and 4b; and 256B.49, subdivision 13.

Sec. 28. [DENTAL ACCESS FOR PERSONS WITH DISABILITIES.]

The commissioner of human services shall study access to dental services for persons with disabilities, and shall present recommendations for improving access to dental services to the legislature by January 15, 2006. The study must examine physical and geographic access, the willingness of dentists to serve persons with disabilities enrolled in state health care programs, reimbursement rates for dental service providers, and other factors identified by the commissioner as potential barriers to accessing dental services.

Sec. 29. [DISABILITY SERVICES INTERAGENCY WORK GROUP.]

Subdivision 1. [ESTABLISHMENT.] The commissioners of human services and housing finance and the Minnesota State Council on Disability shall convene an interagency work group of interested stakeholders, including other state agencies, counties, public housing authorities, the Metropolitan Council, disability service providers, and representatives from disability advocacy organizations to identify barriers, strengthen coordination, recommend policy and funding changes, and pursue federal financing that will assist Minnesotans with disabilities who are attempting to relocate from or avoid placement in institutional settings.

Subd. 2. [WORK GROUP ACTIVITIES.] The work group shall make recommendations to the state agencies and the legislature related to:

(1) coordinating the availability of housing, transportation, and support services needed to discharge persons with disabilities from institutions;

(2) improving information and assistance needed to make an informed choice about relocating from an institutional placement to community-based services;

(3) identifying gaps in human services, transportation, and housing access that are barriers to moving to community services;

(4) identifying strategies that would result in earlier identification of persons most at risk of institutional placement in order to promote diversion to community services or reduce lengths of stay in an institutional facility;

(5) identifying funding mechanisms and financial strategies to assure a financially sustainable community support system that diverts and relocates individuals from institutional placement; and

(6) identifying state actions needed to address any federal changes affecting policies, benefits, or funding used to support persons with disabilities in avoiding institutional placement.

Subd. 3. [RECOMMENDATIONS.] Recommendations of the work

group must be submitted to each state agency and to the chairs of the health and human services policy and finance committees of the senate and house of representatives by October 15, 2006.

Senate Counsel, Research, and Fiscal Analysis

G-17 STATE CAPITOL
75 REV. DR. MARTIN LUTHER KING, JR. BLVD.
ST. PAUL, MN 55155-1606
(651) 296-4791
FAX: (651) 296-7747
JO ANNE ZOFF SELLNER
DIRECTOR

Senate

State of Minnesota

S.F. No. 984 - Services for Persons With Disabilities (The First Engrossment)

Author: Senator Becky Lourey

Prepared by: Joan White, Senate Counsel (651/296-3814)
Katie Cavanor, Senate Counsel (651/296-3801)
David Giel, Senate Research (651/296-7178)

Date: April 13, 2005

S.F. No. 984 modifies a variety of programs affecting persons with disabilities. It increases MA asset limits for recipients who are aged, blind, or disabled. It modifies various case management provisions. It restores MA, GAMC, and MinnesotaCare dental benefits for adults. It authorizes a onetime payment of $3,000 to assist waivered services clients moving from a licensed facility to a community setting. It increases the MA personal needs allowance. It provides an unspecified rate increase for intermediate care facilities for persons with mental retardation and for a variety of community-based providers.

Section 1 (256B.04, subdivision 20) requires the Department of Human Services (DHS) to consult with private sector health plan companies and develop an incentive program to encourage MA recipients with disabilities to have regular wellness exams.

Section 2 (256B.056, subdivision 3) increases the asset limits for MA eligibility for the aged, blind, or disabled from $3,000 to $10,000 for an individual and from $6,000 to $18,000 for a family.

Section 3 (256B.056, subdivision 5c) sets the excess income standard for the aged, blind or disabled at 100 percent of the federal poverty guidelines (FPG).

Section 4 (256B.057, subdivision 9) states that in the MA employed persons with disabilities program for enrollees who are also enrolled in Medicare, the commissioner will reimburse the enrollee for Medicare part B premiums regardless of income. This section also states that increases

in benefits under Title II of the Social Security Act shall not be counted as income until July 1 of each year.

Section 5 (256B.0575) lengthens the period of time for allocating income to an MA recipient who is institutionalized but expected to return home eventually. Under current law, income is allocated to the person rather than to the cost of institutional care for up to three months. Under this bill, the allocation would be for up to six months. This section also changes terminology.

Sections 6 to 12 modify MA targeted case management services.

Section 6 (256B.0621, subdivision 2) broadens the definition of "relocation targeted case management" to include both targeted case management, which the bill renames county targeted case management, and service coordination services.

Section 7 (256B.0621, subdivision 3) postpones eligibility for home care targeted case management services for certain recipients of home care services from January 1, 2003, until July 1, 2005.

Section 8 (256B.0621, subdivision 4) assigns to counties the duty to require contracted providers of relocation targeted case management services to disclose to the recipient all conflicts of interest and obtain the recipient's informed consent or provide the recipient with alternatives.

Section 9 (256B.0621, subdivision 5) modifies provider qualifications for the broadened relocation targeted case management service. Providers must meet the standards in subdivision 4 or the qualifications in this subdivision. Qualifications are added regarding financial conflicts of interest.

Section 10 (256B.0621, subdivision 6) requires the county to provide service coordinator provider options to persons choosing to relocate at the first contact and upon request. It also lists the services included in relocation targeted county case management and in relocation service coordination.

Section 11 (256B.0621, subdivision 7) requires relocation targeted case management recipients to be assigned a county case manager. Current law refers only to case manager. If the county, its contractor, or a tribe does not provide case management services as required, the recipient may obtain relocation service coordination from a qualified provider. The option to receive targeted case management services from an alternative qualified provider is stricken.

Section 12 (256B.0621, subdivision 11) adds a new subdivision, which requires the commissioner to execute an agreement with the federal government to obtain the minimum data set in order to assist residents who want to leave nursing homes. The commissioner must enter into agreements with community organizations to help persons move into the community. Upon admission and annually thereafter, the commissioner must provide notification to MA-eligible persons who are residing in institutions of the availability of relocation targeted case management services.

Section 13 (256B.0622, subdivision 2) modifies the definition section governing intensive rehabilitation mental health services to clarify language related to the Fairweather Lodge treatment

model, by adding "as defined by the standards established by the National Coalition for Community Living."

Section 14 (256B.0625, subdivision 9) removes the $500 annual benefit limit on dental services for adults in the MA program and restores the benefits to what they were prior to 2003.

Section 15 (256B.0916, subdivision 10) authorizes a transitional supports allowance for persons receiving waiver services for persons with mental retardation and related conditions who are moving from a licensed setting to a community setting. The allowance is a one-time payment of up to $3,000 to pay for items not covered by other sources, including rent and security deposits, utility set-up costs, essential furnishings and supplies, and personal supports and transportation needed to locate and transition to community settings.

Section 16 (256B.092, subdivision 4b) requires recipients of waiver services for persons with developmental disabilities to select from public vendors of county case management services but requires DHS to ensure them a choice between county and private service coordination vendors. This section is effective July 1, 2005, or upon federal approval if required.

Section 17 (256B.35, subdivision 1) increases the MA personal needs allowance to $150.

Section 18 (256B.49, subdivision 13) amends the home and community-based waiver for chronically ill children and disabled persons (CADI, CAC, and TBI waivers) by requiring the recipient of services to be provided county case management and service coordination. The client must be allowed to choose a county or private services coordination provider. This section also modifies the description of case management services and adds a description of service coordination activities. This section is effective July 1, 2005, or, if a federal waiver is required, on the date the federal waiver is granted.

Section 19 (256B.49, subdivision 14) specifies that recipient assessments and reassessments are the duty of the county case manager.

Section 20 (256B.49, subdivision 16) authorizes a transitional supports allowance for persons receiving waiver services under one of three waiver programs (Community Alternatives for Disabled Individuals (CADI); Community Alternative Care (CAC); and the Traumatic Brain Injury (TBI) waiver), who are moving from a licensed setting to a community setting. The allowance is a onetime payment of up to $3,000 to pay for items not covered by other sources, including rent and security deposits, utility set-up costs, essential furnishings and supplies, and personal supports and transportation needed to locate and transition to community settings.

Section 21 (256B.5012, subdivision 6) provides an unspecified rate increase for intermediate care facilities for persons with mental retardation (ICFs/MR) effective January 1, 2006, and January 1, 2007. At least two-thirds of the increase must be used to increase employee salaries and benefits and pay related costs. Facilities must report to DHS on how the additional funding was used.

Section 22 (256B.69, subdivision 23) requires DHS to seek federal approval to expand the Minnesota Disability Health Options (MnDHO) Program in stages, beginning with population centers outside the seven-county metro area and then expanding to all areas of the state.

Section 23 (256B.765) provides an unspecified rate increase each year of the upcoming biennium for a variety of community-based providers. At least two-thirds of the increase must be used to increase employee salaries and benefits and pay related costs. Providers must report to DHS on how the additional funding was used.

Section 24 (256D.03, subdivision 4) removes the $500 annual benefit limit on dental services and the 50 percent co-payment on restorative dental services for individuals in the general assistance medical care program, restoring the benefits to what they were prior to 2003.

Sections 25 and 26 (256L.03) restore the adult dental benefits in MinnesotaCare so that for adult enrollees, dental coverage is the same as in the MA program. For pregnant women and children, dental services are the same as in the MA program. Removes the co-payment for adult restorative dental services.

Section 27 requires DHS to request any federal approvals and plan amendments necessary to implement the transitional supports allowance and the case management service coordination choices authorized under this bill.

Section 28 requires DHS to study access to dental services for persons with disabilities and present recommendations to the legislature by January 15, 2006.

Section 29 requires the establishment of an interagency work group to study issues surrounding efforts by persons with disabilities to relocate from or avoid placement in an institution. A report is due by October 15, 2006.

JW/KC/DG:rdr

Consolidated Fiscal Note – 2005-06 Session

Bill #: S0984-1E (R) **Complete Date:** 04/08/05

Chief Author: LOUREY, BECKY

Title: HUMAN SERVICES PRGMS FOR DISABLED

Fiscal Impact	Yes	No
State	X	
Local	X	
Fee/Departmental Earnings	X	
Tax Revenue		X

Agencies: Human Services Dept (04/07/05)
Housing Finance Agency (03/17/05)
Disability Council (04/07/05)

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Net Expenditures					
General Fund	0	60,241	65,668	80,464	101,416
Human Services Dept	0	60,241	65,668	80,464	101,416
Disability Council		0	0		
Health Care Access Fund	0	1,178	2,026	1,760	1,952
Human Services Dept	0	1,178	2,026	1,760	1,952
Revenues					
General Fund	0	140	112	84	84
Human Services Dept	0	140	112	84	84
Net Cost <Savings>					
General Fund	0	60,101	65,556	80,380	101,332
Human Services Dept	0	60,101	65,556	80,380	101,332
Disability Council		0	0		
Health Care Access Fund	0	1,178	2,026	1,760	1,952
Human Services Dept	0	1,178	2,026	1,760	1,952
Total Cost <Savings> to the State	0	61,279	67,582	82,140	103,284

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
General Fund	0.00	3.45	3.13	3.00	3.00
Human Services Dept	0.00	3.00	3.00	3.00	3.00
Disability Council		0.45	0.13		
Total FTE	0.00	3.45	3.13	3.00	3.00

Consolidated EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 04/08/05 Phone: 286-5618

Fiscal Note – 2005-06 Session

Bill #: S0984-1E (R) **Complete Date:** 04/07/05

Chief Author: LOUREY, BECKY

Title: HUMAN SERVICES PRGMS FOR DISABLED

Agency Name: Human Services Dept

Fiscal Impact	Yes	No
State	X	
Local	X	
Fee/Departmental Earnings	X	
Tax Revenue		X

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
General Fund	0	60,241	65,668	80,464	101,416
Health Care Access Fund	0	1,178	2,026	1,760	1,952
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund	0	60,241	65,668	80,464	101,416
Health Care Access Fund	0	1,178	2,026	1,760	1,952
Revenues					
General Fund	0	140	112	84	84
Net Cost <Savings>					
General Fund	0	60,101	65,556	80,380	101,332
Health Care Access Fund	0	1,178	2,026	1,760	1,952
Total Cost <Savings> to the State	0	61,279	67,582	82,140	103,284

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
General Fund	0.00	3.00	3.00	3.00	3.00
Total FTE	0.00	3.00	3.00	3.00	3.00

NARRATIVE: SF 984-1E

Bill Description
This bill includes proposals for increased assistance to persons with disabilities in several areas, including the areas of Medical Assistance (MA) eligibility provisions, incentives for wellness visits, case management services, transitional supports, Minnesota disability health options (MnDHO) expansion, ICF and LTC provider rate increases, alignment of GAMC and Minnesota Care dental coverage with MA for certain groups, and formation of a interagency work group. This bill analysis will address health care program eligibility issues related to this bill. All changes to eligibility provisions go into effect July 1, 2005.

This bill provides a cost of living adjustment for ICFs/MR and a number of continuing care providers. Because the bill does not specify the percentage increase to be granted, there are no COLA costs included in the totals for this fiscal note. However, the cost of a COLA at 1% is provided as an advisory within the narrative of this fiscal note.

Section 1: Incentives for Wellness Visits
Requires the commissioner to develop (includes consultation with health plan companies) and implement incentive programs to encourage medical assistance enrollees with disabilities to seek regular wellness exams from a primary care physician. The commissioner must implement the incentive programs by January 1, 2006.

Section 2: Asset Limitation
Amends Minn. Stat.§256B.056, Subd.3 to increase the medical assistance (MA) asset limits for the aged, blind, and disabled population from $3,000/$6,000 to $10,000/$18,000.

Section 3: MA Spend down Standard
Amends Minn. Stat. §256B.056, Subd. 5c: to increase the medically needy income standard for the aged, blind, and disabled population from 75% of the federal poverty guidelines (FPG) to 100% FPG.

Section 4: MA-EPD
Amends Minn. Stat. §256B.057, Subd. 9 (d) (4): to eliminate the 200% FPG income limit for payment of Medicare Part B premiums for MA-EPD enrollees.

Amends Minn. Stat. §256B.057, Subd. 9 (d)(5): to disregard the annual cost of living adjustment (COLA) for Social Security benefits from January 1 through June 30 when determining income for premium and unearned income obligation amounts for MA-EPD enrollees.

Section 5: Availability of Income for Institutionalized Persons
Amends Minn. Stat. §256B.0575 (b) to increase the period of time, from 3 calendar months to 6 calendar months, that an income allocation to an institutionalized person can be allowed for purposes of maintaining a residence in the community. This provision also clarifies that the income allowance is calculated based on an amount equal to 100% FPG for a family size of one. Current language refers to the "medical assistance standard".

Sections 6-12; 16; 18-19: Case Management
This bill proposes the following changes:

1) Case management administrative and service coordination activities are redefined for Relocation Service Coordination and CADI, CAC and TBI Waiver case management.

2) Expansion of the case management provider system to private providers of service coordination in the following disability programs:
   - Relocation Service Coordination (RSC) and Home Care TCM.
   - MRRC Waiver case management, and
   - CADI, CAC, and TBI Waiver case management

3) Requires the execution of a data use agreement between CMS and DHS relating obtaining data on nursing facility residents and the notification to all persons in institutions of the availability of RSC at the time of placement and annually thereafter. (Section 12)

Section 13: Definitions

Clarifies the treatment model used for evidenced based practices for treatment of persons with mental illness.

Section 14: MA Dental Services
Subd 9: Eliminates the $500 dental cap from MA

Sections 15 and 20: Transitional Support Allowance
This bill will allow for a one-time payment of up to $3,000 for transitional supports.

Section 17: Personal Needs Allowance
Amends Minn. Stat. §256B.35, Subd.1: to increase the state minimum per month amount for a personal needs allowance (PNA) for persons residing in a skilled nursing home, intermediate care facility, or medical institution from the $45 to $150. Under current law the PNA is increased each January 1 by the Social Security or SSI COLA; the current PNA is $76/month

Section 21: ICF Rate Increase
This bill will give Intermediate Care Facilities for the mentally retarded (ICF/MR) a reimbursement rate increase. Each facility receiving an adjustment shall report to the commissioner, in the form and manner specified by the commissioner, on how the additional funding was used.

Section 22: MnDHO Expansion Expansion of Minnesota Disability Health Options (MnDHO) program statewide

Section 23: LTC Provider Increase
This bill will give LTC providers and home and community-based service providers a rate increase. Each provider receiving an adjustment shall report to the commissioner, in the form and manner specified by the commissioner, on how the additional funding was used.

Section 24: GAMC Dental Services
Subd. 4: (a) (i) (14) Eliminates the $500 dental cap for GAMC
(d) (5) Eliminates the 50% co-pay for restorative services in GAMC

Section 25: MNCare Dental Services
Subd.1: References new subd.3b which spells out MNCare adult dental coverage. Changes all MnCare dental to the same coverage as MA – includes orthodontia. Removes the annual calendar year dental cap.

Section 26: MNCare Dental Co-payment
Subd. 5 (4): Eliminates the 50% copayment from MinnesotaCare.

Section 27: Federal Approval
Federal approval and plan amendments necessary to implement transitional supports allowance and choice of case management service coordination.

Section 28: Dental Access for Persons with Disabilities
Requires the commissioner to study access to dental services for persons with disabilities and present recommendations to the legislature by January 15, 2006.

Section 29: Disability Services Interagency Work Group
Establishes an interagency work group, defines its membership and activities, and requires recommendations to be submitted to each participating agency and the chairs of the health and human service finance committees of the legislature by October 15, 2006.

Assumptions
A section by section cost summary is provided below. The assumptions and explanatory notes have been provided in the attachment to this fiscal note.

Expenditure and/or Revenue Formula
A section by section cost summary is provided below. The expenditure and revenue formulas have been provided in the attachment to this fiscal note.

			SFY 2006	SFY 2007	SFY 2008	SFY 2009
Section 1	Wellness Visits					
	Language needs to be clarified					
	to determine cost impact					
Section 2	Asset Changes	Expenditures	13,650	13,650	13,650	13,650
	Increases MA Asset Standard	Revenues	0	0	0	0
		Net State				
	for Elderly & Disabled from 3,000	Cost	13,650	13,650	13,650	13,650
	/6,000 to 10,000/18,000	FTE'S	0	0	0	0
Section 3	Income Standard	Expenditures	18,164	17,619	18,469	19,368
	Raises the Medically Needy	Revenues	0	0	0	0
		Net State				
	Income Standard from 75% -	Cost	18,164	17,619	18,469	19,368
	100% FPG	FTE'S	0	0	0	0
Section 4	MA-EPD	Expenditures	437	426	426	426
	Removes income limit for	Revenues	0	0	0	0
	reimbursement of Medicare	Net State				
	premiums,	Cost	437	426	426	426
	and adds recipients to MA-EPD	FTE'S	0	0	0	0
Section 5	Income Allocation	Expenditures	59	59	59	59
	Extends time of home	Revenues	0	0	0	0
		Net State				
	maintenance allowance from 3	Cost	59	59	59	59
	to 6 months	FTE'S	0	0	0	0
	Relocation Service					
Section 6	Coordination	Expenditures	35	-161	-573	-965
7,8,10,11	Eligible Service RSC	Revenues	14	14	14	14
		Net State				
	Allows use of private vendors;	Cost	21	(175)	(587)	(979)
	Increases RSC costs, and	FTE'S	0.5	0.5	0.5	0.5
	NF Relocations for both elderly					
	and disabled					
Section 9	Home Care TCM	Expenditures	0	0	0	0
	Current law already allows private	Revenues	0	0	0	0
		Net State				
	Vendors of case management	Cost	-	-	-	-
		FTE'S	0	0	0	0
Section 12	Notification of RSC	Expenditures	35	35	35	35
	Requires recipient notification of	Revenues	14	14	14	14
		Net State				
	RSC for elderly and disabled	Cost	21	21	21	21
	and agreement with CMS and	FTE'S	0.5	0.5	0.5	0.5
	advocacy organizations.					
Section 13	Mental Health	Expenditures	0	0	0	0

	No cost	Revenues	0	0	0	0
		Net State Cost	-	-	-	-
		FTE'S	0	0	0	0
Section 14	MA Dental Services	Expenditures	574	1,366	1,504	1,623
	Removes 500 Dental Cap	Revenues	0	0	0	0
		Net State Cost	574	1,366	1,504	1,623
		FTE'S	0	0	0	0
Section 15	Transitional Allowance	Similar waiver amendments already submitted: no additional cost				
Section 16	Waiver DD CM	Expenditures	70	2,395	10,112	21,108
	Allows use of Private vendors,	Revenues	28	28	28	28
	Increases use of DD waiver CM	Net State Cost	42	2,367	10,084	21,080
	Increases waiver costs	FTE'S	1	1	1	1
Section 17	Personal Needs Allowance	Expenditures	25,275	26,057	26,925	27,794
	Increased to 150/month	Revenues	0	0	0	0
		Net State Cost	25,275	26,057	26,925	27,794
		FTE'S	0	0	0	0
Section 18,19	Disability Waivers CM	Expenditures	70	1,272	6,531	14,731
	Allows use of private vendors;	Revenues	28	28	28	28
	Increases use of waiver CM	Net State Cost	42	1,244	6,503	14,703
	Increases waiver costs	FTE'S	1	1	1	1
Section 20	Transitional Allowance	Similar waiver amendments already submitted: no additional cost				
Section 21	ICF/MR Rate Increases @1%	Expenditures	250	811	1,077	1,010
	January 1 implementation	Revenues	0	0	0	0
	Advisory	Net State Cost	250	811	1,077	1,010
		FTE'S	0	0	0	0
Section 22	MNDHO Expansion		0	0	0	0
	Federal Medicare approval for expansion not likely at this time.					
Section 23	CC Provider Increases@1%	Expenditures	8,319	20,179	23,706	25,505
	July 1 implementation	Revenues	28	28	28	0
	Advisory	Net State Cost	8,291	20,151	23,678	25,505
		FTE'S	1	1	1	0
Section 24	GAMC Dental Expansion:	Expenditures	18	52	59	63
	No Co-pay on restorative	Expenditures	956	2,830	3,266	3,524

	Removes 500 Dental Cap	Revenues	0	0	0	0
		Net State Cost	974	2,882	3,325	3,587
		FTE'S	0	0	0	0
Section 25	MnCare Dental Services	Expenditures	10	21	20	22
	Removes 500 Dental Cap	Revenues	0	0	0	0
		Net State Cost	10	21	20	22
		FTE'S	0	0	0	0
Section 26	MnCare Co-Payments	Expenditures	1,168	2,005	1,740	1,930
		Revenues	0	0	0	0
		Net State Cost	1,168	2,005	1,740	1,930
		FTE'S	0	0	0	0
Section 27	Federal Approval	Expenditures	-	-	-	-
		Revenues	0	0	0	0
		Net State Cost	-	-	-	-
		FTE'S	0	0	0	0
Section 28	Dental Access Study	Expenditures	-	-	-	-
	Will be completed using existing	Revenues	0	0	0	0
	dental access advisory	Net State Cost	-	-	-	-
	committee per section 256B.55	FTE'S	0	0	0	0
Section 29	Interagency Workgroup	Expenditures	140	70	-	-
	Report due by October 2006	Revenues	56	28	-	-
	Group sunsets after report	Net State Cost	84	42	-	-
	Administrative Costs	FTE'S	0	0	0	0
	Systems Cost of SF 984	Expenditures	758			
	Includes MMIS, MAXIS, and	Revenues	0	0	0	0
	Health Match	Net State Cost	758	-	-	-
		FTE'S	0	0	0	0

SF 984 with 1% Cola		**State Dollars in Thousands**			
All Funds		**SFY 2006**	**SFY 2007**	**SFY 2008**	**SFY 2009**
	Expenditures	69,988	88,685	107,006	129,883
	Revenues	168	140	112	84
	Net State Cost	69,820	88,545	106,894	129,799
	FTE'S	4	4	4	3
Net Cost by Fund		**SFY 2006**	**SFY 2007**	**SFY 2008**	**SFY 2009**
MA-General Fund		66,798	83,497	101,641	124,133
GAMC-General Fund		974	2,882	3,325	3,587

MNCARE-HCAF	1,178	2,026	1,760	1,952
DHS Admin-General Fund	280	280	280	210
DHS Admin-Fund 200	758			
Revenues-General Fund	168	140	112	84
Net Impact	69,820	88,545	106,894	129,799

SF 984 without 1% Cola		State Dollars in Thousands			
All Funds		**SFY 2006**	**SFY 2007**	**SFY 2008**	**SFY 2009**
	Expenditures	61,419	67,695	82,223	103,368
	Revenues	140	112	84	84
	Net State Cost	61,279	67,583	82,139	103,284
	FTE'S	3	3	3	3
Net Cost by Fund		**SFY 2006**	**SFY 2007**	**SFY 2008**	**SFY 2009**
MA-General Fund		58,299	62,577	76,928	97,619
GAMC-General Fund		974	2,882	3,325	3,587
MNCARE-HCAF		1,178	2,026	1,760	1,952
DHS Admin-General Fund		210	210	210	210
DHS Admin-Fund 200		758			
Revenues-General Fund		140	112	84	84
Net Impact		61,279	67,583	82,139	103,284

Long-Term Fiscal Considerations

Without cost of living increases, this bill will increase state spending of $185.4 million in SFY 2008 and SFY 2009 across all accounts.

Local Government Costs

Without the cost of living increases, this bill will reduce revenues to county agencies for case management as recipients choose private service coordination vendors.

References/Sources

February 2005 Forecast
Matrix of Services
Continuing Care Research and Analysis

Minnesota
MEDICAL ASSISTANCE
Fiscal Analysis of a Proposal to
Increase MA Asset Standard for Elderly & Disabled
To $10,000 for One / $18,000 For Two
Senate File 984: Section 2

The current MA asset standard for elderly and disabled is $3000 for one and $6,000 for two. This section increases that standard to $10,000 / $18,000, which is the current standard for the Medicare supplement programs.

The main impact of this change comes from its effect on elderly MA enrollees, who tend to have significant assets. Each year several thousand new elderly individuals reach MA eligibility while they are in a nursing facility or other form on long-term care. Those who reach eligibility in a long-term care setting generally do so by spending down assets until they reach MA eligibility. The effect of the increase in the asset standard is to permit the individual to retain more assets and spend less on the cost of their care, resulting in MA paying more and sooner for their care.

Because potential MA recipients have other options for spending down assets, we assume that 75% of the difference in the asset standard will turn into added MA costs.

	FY 2006	FY 2007	FY 2008	FY 2009
Current asset standard for one	$3,000	$3,000	$3,000	$3,000
Proposed asset standard for one	$10,000	$10,000	$10,000	$10,000
Difference	$7,000	$7,000	$7,000	$7,000
Annual number of new elderly NF recipients spending down assets	5,000	5,000	5,000	5,000
75% of difference in asset standard	$5,250	$5,250	$5,250	$5,250
Annual MA cost	$26,250,000	$26,250,000	$26,250,000	$26,250,000
Federal share	13,125,000	13,125,000	13,125,000	13,125,000
State share	13,125,000	13,125,000	13,125,000	13,125,000

We project the same effect for 200 MA disabled recipients per year:

	FY 2006	FY 2007	FY 2008	FY 2009
Annual number of new disabled MA recipients spending down assets	200	200	200	200
75% of difference in asset standard	$5,250	$5,250	$5,250	$5,250
Annual MA cost	$1,050,000	$1,050,000	$1,050,000	$1,050,000
Federal share	525,000	525,000	525,000	525,000
State share	525,000	525,000	525,000	525,000

	FY 2006	FY 2007	FY 2008	FY 2009
		(Thousands of Dollars)		
MA LTC Facilities	13,125	13,125	13,125	13,125
MA Eld. & Disabled Basic	525	525	525	525
Total General Fund	13,650	13,650	13,650	13,650

Section 3

Minnesota
MEDICAL ASSISTANCE
Fiscal Analysis of a Proposal to
Raise the Medically Needy Income Standard
for the Elderly, Blind, and Disabled to 100% FPG
Senate File 984: Section 3

Currently the medically needy standard is equal to 75% FPG, while the categorically needy standard is equal to 100% FPG. This requires those who have income over 100% FPG to spend down to the 75% FPG standard to reach MA eligibility. The categorically needy standard for one person is currently $776 per month; the medically needy standard for one person is currently $582 per month. The difference between the two monthly standards is $194.

The cost associated with raising the medically needy standard results from

recipients paying less in spenddown and MA consequently paying more. For current MA recipients with sepnddowns, we assume that MA costs increase by the dollar amount of the spenddown reductions.

In theory all those who benefit from this change would experience a $194 per month spenddown reduction. But Group Residential Housing recipients have some GRH care costs applied to their spenddowns, resulting in a benefit less than $194 for these individuals. (The $194 benefit is projected to increase by 2% per year through inflation of the federal poverty guidelines.)

For individuals who are currently eligible only for the Medicare savings programs as QMB-Only or SLMB-Only enrollees, the spenddown barrier to full MA eligibility will be reduced by $194 per month. We assume that this will result in 75% of current QMB-Only enrollees and 50% of current SLMB-Only enrollees becoming fully eligible for MA. For those affected in this way, the average benefit will be the difference between the monthly value of their current benefit and full MA eligibility. The QMB benefit is coverage of Medicare premiums, copays, and deductibles. The SLMB benefit is coverage of Medicare premiums only, so the benefit increase is larger for the SLMB group.

MA Elderly	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**
Current recipients with partial benefit	367	367	367	367
Average monthly benefit	$112.87	$115.13	$117.43	$119.78
Annual MA cost	$497,088	$507,030	$517,170	$527,514
Current recipients with $194 benefit	1,858	1,858	1,858	1,858
Average monthly benefit	$194.00	$197.88	$201.84	$205.87
Annual MA cost	$4,325,424	$4,411,932	$4,500,171	$4,590,175
MA Elderly, Continued	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**
Current QMB-Only gain MA eligibility	1,200	1,200	1,200	1,200
Average monthly benefit	$265.73	$112.10	$117.71	$123.60
Annual MA cost	$3,826,466	$1,614,303	$1,695,019	$1,779,770
Current SLMB-Only gain MA eligibility	2,000	2,000	2,000	2,000
Average monthly benefit	$364.95	$216.29	$227.11	$238.46
Annual MA cost	$8,758,844	$5,190,976	$5,450,525	$5,723,051
Total MA Cost for Elderly	17,407,822	11,724,241	12,162,885	12,620,509
Federal share	8,703,911	5,862,121	6,081,442	6,310,254
State share	8,703,911	5,862,121	6,081,442	6,310,254

MA Disabled	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**

Current recipients with partial benefit	657	657	657	657
Average monthly benefit	$114.32	$116.61	$118.94	$121.32
Annual MA cost	$901,308	$919,334	$937,721	$956,475
Current recipients with $194 benefit	3,265	3,265	3,265	3,265
Average monthly benefit	$194.00	$197.88	$201.84	$205.87
Annual MA cost	$7,600,920	$7,752,938	$7,907,997	$8,066,157
Current QMB-Only gain MA eligibility	225	225	225	225
Average monthly benefit	$280.03	$76.04	$79.85	$83.84
Annual MA cost	$756,081	$205,320	$215,586	$226,365
Current SLMB-Only gain MA eligibility	600	600	600	600
Average monthly benefit	$583.22	$394.39	$414.11	$434.82
Annual MA cost	$4,199,166	$2,839,617	$2,981,598	$3,130,678
Total MA Cost for Disabled	13,457,475	11,717,209	12,042,902	12,379,675
Federal share	6,728,737	5,858,605	6,021,451	6,189,838
State share	6,728,737	5,858,605	6,021,451	6,189,838

	FY 2006	FY 2007	FY 2008	FY 2009
Total MA Cost for Elderly & Disabled	30,865,297	23,441,451	24,205,786	25,000,184
Federal share	15,432,648	11,720,725	12,102,893	12,500,092
State share	15,432,648	11,720,725	12,102,893	12,500,092

Medicare Part D Clawback Cost

The implementation of Medicare Part D pharmacy coverage makes the cost of covering added MA eligibles less beginning in January 2006. But enrollment of added dual eligibles in MA (Medicare and MA together) will raise the payback which Minnesota has to make to the federal government, based on the monthly number of dual eligibles.

In effect, Minnesota pays through the clawback for the pharmacy savings implicit in the lower projected cost of covering additional MA dual eligibles.

	FY 2006	FY 2007	FY 2008	FY 2009
Avg. added dual eligible enrollees	2,013	4,025	4,025	4,025
Rx per person per month	$314.20	$345.62	$380.18	$418.20
Gross annual Part D savings	$7,587,947	$16,693,483	$18,362,832	$20,199,115
Apply clawback factors:				
Rebate factor	80.00%	80.00%	80.00%	80.00%

State share factor	50.00%	50.00%	50.00%	50.00%
Phase-down factor	90.00%	88.33%	86.67%	85.00%
Projected clawback cost to state	$2,731,661	$5,898,342	$6,365,733	$6,867,618

Fiscal Summary	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**
		(Thousands of Dollars)		
MA program cost	15,433	11,721	12,103	12,500
MA clawback cost	2,732	5,898	6,366	6,868
Total MA cost	18,164	17,619	18,469	19,368

MA Eld. & Disabled Basic

Section 4

Minnesota
MEDICAL ASSISTANCE
Fiscal Analysis of a Proposal to
Modify Policies Affecting MA-EPD Eligibles
Senate File 984: Section 4

Currently MA payments of Medicare premiums is limited to MA-EPD eligibles with income under 200% FPG. This section removes that limit. This change is projected to result in MA paying Medicare part B premiums for about 910 additional recipients on a monthly basis.

This section also delays recognition of annual cost of living adjustments to Social Security payments from January 1 to July 1. This is projected to have a one-time cost of $23,000 resulting from later recognition of income increases in determining MA-EPD premiums.

	FY 2006	**FY 2007**	**FY 2008**	**FY 2009**
Added recipients with Medicare premium covered	910	910	910	910
Monthly Medicare Part B premium	$78.00	$78.00	$78.00	$78.00
Annual cost of premiums	$851,760	$851,760	$851,760	$851,760
Cost for delay of COLA adjustments	$23,000	$0	$0	$0
Total MA Cost	$874,760	$851,760	$851,760	$851,760
Federal share	437,380	425,880	425,880	425,880
State share	437,380	425,880	425,880	425,880

Section 5

Minnesota
MEDICAL ASSISTANCE
Fiscal Analysis of a Proposal to
Extend the Availability of the Home Maintenance Allowance
from Three Months to Six Months
Senate File 984: Section 5

Currently the home maintenance allowance of $776 per month is allowed to approximately 190 MA recipients each month. Because income is sometimes less than $776, the average benefit to the recipient and the average cost to MA is approximately $616 per month.

We assume that increasing the period for which this allowance is available from three months to six months will result in an additional 190 average monthly recipients with an average monthly cost of $616.

	FY 2006	FY 2007	FY 2008	FY 2009
Additional average recipients	190	190	190	190
Avg. monthly cost	$616	$616	$616	$616
Total MA Cost	$117,040	$117,040	$117,040	$117,040
Federal share	58,520	58,520	58,520	58,520
State share	58,520	58,520	58,520	58,520

Section 6 - 11

Senate File 984, Sections 6-11

Subject: Allows Private Vendors to Provide Relocation Service Coordination

1. Current Forecast-Relocation Service Coordination.

		Actual SFY 2004	Estimated SFY 2005	SFY 2006	Projected SFY 2007	SFY 2008	SFY 2009
Number of Recipients		1,491	1,500	1,500	1,500	1,500	1,500
Average Cost Per Recipient		$ 603	$ 603	$ 603	$ 603	$ 603	$ 603
Total Costs		$898,532	$ 903,960	$903,960	$903,960	$ 903,960	$903,960
	Federal	$449,266	$ 451,980	$451,980	$451,980	$451,980	$451,980
	State	$ 449,266	$ 451,980	$451,980	$451,980	$ 451,980	$451,980
	Local	$ -	$ -	$ -	$ -	$ -	$ -

2. Increase Use due to Expansion to Private Vendors		SFY 2007	SFY 2008	SFY 2009
Percent Change in Use		10%	10%	10%
Additional Recipients		150	150	150
Average Cost Per Recipient		$ 603	$ 603	$ 603
Total Costs		$90,396	$90,396	$90,396
	Federal	$45,198	$45,198	$ 45,198
	State	$45,198	$45,198	$45,198
	Local	$ -	$ -	$ -

3. Increased placements from Nursing Facilities-Disabled		SFY 2007	SFY 2008	SFY 2009
Additional Recipients Per Year		-50	-50	-50
Additional Recipients Over Time		-50	-100	-150
Average Daily Cost Per Recipient	$ 132.90	$ 140.23	$ 142.68	$ 145.13
Average Days Per Year		183	244	256
Total Costs		(1,283,063)	(3,476,564)	(5,568,491)
	Federal	$(641,532)	$(1,738,282)	$(2,784,245)
	State	$(513,225)	$(1,390,626)	$(2,227,396)
	Local	$(128,306)	$(347,656)	$(556,849)

4. Increase Movement to Waivers-Disabled		SFY 2007	SFY 2008	SFY 2009
Additional Recipients Per Year		50	50	50
Additional Recipients/slots Over time		50	100	150
Average Cost Per Recipient (CADI Conversion)	$ 94.25	$ 99.56	$ 101.30	$ 103.04
Percent of Nursing Home Costs				
Average Days Per Year		183	244	256
Total Costs		910,975	2,468,361	3,953,628
Federal		$455,487	$1,234,180	$1,976,814
State		$ 455,487	$1,234,180	$1,976,814
Local		$ -	$ -	$ -

5. Increased placements from Nursing Facilities-Elderly		SFY 2007	SFY 2008	SFY 2009
Additional Recipients Per Year		-25	-25	-25
Additional Recipients Over Time		-25	-50	-75
Average Daily Cost Per Recipient	$ 114.49	$120.80	$122.92	$125.03
Average Days Per Year		183	244	256
Total Costs		(552,678)	(1,497,525)	(2,398,619)
Federal		$(276,339)	$(748,762)	$(1,199,309)
State		$(276,339)	$(748,762)	$(1,199,309)
Local		$ -	$ -	$ -

6. Increase Movement to Waivers-Elderly		SFY 2007	SFY 2008	SFY 2009
Additional Recipients Per Year		25	25	25
Additional Recipients/slots Over time		25	50	75
Average Cost Per Recipient (EW Conversion)	$38.60	$40.73	$41.44	$ 42.15
Percent of Nursing Home Costs				
Average Days Per Year		183	244	256
Total Costs		186,332	504,881	808,679
Federal		$93,166	$252,441	$404,340
State		$93,166	$252,441	$404,340
Local		$ -	$ -	$ -
MA Elderly and Disabled		**45**	**45**	**45**
MA LTC Facilities		**(790)**	**(2,139)**	**(3,427)**
MA Waivers and Home Care		**549**	**1,487**	**2,381**
Total		**(196)**	**(608)**	**(1,000)**

Assumptions

1. The federal share of Medical Assistance is 50% of the total costs. The remaining 50% will be paid by the state.
2. It will require one year of preparation before the state pays for private relocation service coordination. This includes development of standards, requesting and securing federal approval, doing needed systems work, enrollment of and training of providers. As a result, program payments are not affected until July 1, 2006.
3. Federal approval of the necessary state plan and waiver amendment will be granted.

4. The increase in relocation service coordination costs will increase by 10% due to improved access to relocation service coordination. With existing residential providers and day program providers becoming potential relocation service coordination providers as well, recipients can quickly access private CM vendors, and may be encourage to do so by existing providers.
5. The state will reduce payments to county agencies for relocation service coordination as private vendors provide relocation service coordination.
6. Improved access to relocation service coordination will result in additional relocations from nursing facilities of 50 recipients per year. These recipients will go to the disability waiver programs where their services will cost 71% of their cost in a nursing facility. For the elderly, improved access to relocation service coordination will result in additional relocations from nursing facilities of 25 recipients per year. These recipients will go to the elderly waiver program where their services will cost about 34% of their cost in a nursing facility.
7. The entitlement to relocation service coordination remains unchanged, that is, up to 180 days of RSC for each stay in an institutional.
8. The per recipient cost for private relocation service coordination services will be no different than the public relocation service coordination cost. While the rate may be lower for private case management, this will be offset by an increase use of case management.
9. Under current law, targeted case managment for home care recipients is to be offered to recipients in SFY 2006. This casemanagement option will already use private and public vendors, as a result, there is no additional fiscal impact with this bill.

Calculations

1. Estimates for relocation service coordination were based on SFY 2004 actual cost and use.. Since relocation service coordination tends to happen once per recipient SFY 2004 is the estimated base cost for this activity.
2. Estimates for nursing facility costs for persons under 65 were based on SFY 2003 actual cost and use., and were trended forward based on the change in cost per day for nursing facilities in the February 2005 Forecast.
3. Estimates for home and community based service costs were based on the SFY 2004 CADI daily costs for a new conversion(71% of the nursing home rate). Future home and community based services costs were estimated to be 71% of the nursing home rate for person under 65.

February 2005 Forecast for NF's

	Paid Days	Average Recipients	Total Payments	Average Cost Per Day	
SFY 2003	8,333,583	23,772	895,486,149	107.46	
SFY 2004	7,973,240	22,848	912,866,198	114.49	

NF Under 65(From Olivia

	Paid Days	Average Recipients	Total Payments	Average Cost Per Day	
SFY 2003	898,932	2,630	112,124,419	124.73	
SFY 2004	878,961	2,593	113,961,389	129.65	incomplete

Proportion of NF Under 65

	Paid Days	Average Recipients	Total Payments	Average Cost Per Day	
SFY 2003	11%	11%	13%	116%	
SFY 2004	0.11	0.11	0.12	1.13	incomplete

CADI New Conversions SFY 2004						Daily Rate SFY 2004 Waiver and Homecare	Homecare Only	
Conversion	260	42,654	4,020,320			810,931		$94.25
With Res. Services	137	22,495	$2,695,024	$19,671.71	$119.81	$31,686		
Without Res. Services	123	20,159	$1,325,296	$10,774.76	$65.74	$779,245		

Section 14, 24, 25

Medical Assistance and General Assistance Medical Care
Senate File 984 Sections 14, 24 and 25
A Fiscal Analysis of a Proposal to
Eliminate the $500 Dental Cap

Based on actuarial estimates, current managed care rates include a reduction for the $500 cap. For MA and GAMC that reduction is .143% and .018%.

Based on a revised definition of emergency dental that was implemented with the $500 cap, the FFS estimates are based on 50% of the 2003 session estimates applied to the November forecast.

Assumes an October 1, 2005 implementation date for FFS; January 1, 2006 for HMO.

	HMO	FFS Dental
MA Fam	0.143%	1.30%
MA E&D	0.143%	3.25%
GAMC HMO	0.018%	0.70%
MnCare parents	0.020%	NA
MnCare Adults under 75%	0.010%	NA

	FY 2006	FY 2007	FY 2008	FY 2009
February 2005 Forecast (in 000s)				
HMO				
MA elderly and disabled	$352,453	$313,667	$345,744	$379,025
MA families and children	$875,146	$1,054,894	$1,173,657	$1,271,325
GAMC	$187,847	$251,760	$292,833	$317,003
MnCare Parents	$191,591	$168,447	$169,655	$186,494
MnCare Adults Under 75%	$71,576	$35,637	$22,259	$23,606
FFS Dental				
MA Elderly and Disabled	$17,648	$19,118	$20,644	$22,141
MA families and children	$10,772	$11,762	$12,644	$12,870
GAMC	$901	$926	$919	$841
Impact of elimination of $500 Cap (in 000s)				
MA Elderly and Disabled HMO	$210	$449	$494	$542
MA Elderly and Disabled FFS	$335	$621	$671	$720
Total	$545	$1,070	$1,165	$1,262
Federal Share	$272	$535	$583	$631
State Share	**$272**	**$535**	**$583**	**$631**
MA Families and Children HMO	$521	$1,508	$1,678	$1,818
MA Families and Children FFS	$82	$153	$164	$167
Total	$603	$1,661	$1,843	$1,985
Federal Share	$302	$831	$921	$993
State Share	**$302**	**$831**	**$921**	**$993**
GAMC HMO	$14	$45	$53	$57
GAMC FFS	$4	$6	$6	$6
GAMC Total	**$18**	**$52**	**$59**	**$63**
Total GF	**$592**	**$1,417**	**$1,563**	**$1,686**

Minnesota Care				
Caretakers	$16	$34	$34	$37
FFP rate	54.46%	48.66%	47.77%	46.43%
Federal Share	$9	$16	$16	$17
State Share	**$7**	**$17**	**$18**	**$20**
Adults w/o children	**$3**	**$4**	**$2**	**$2**
Minnesota Care Total	**$10**	**$21**	**$20**	**$22**
All Funds Total	**$602**	**$1,438**	**$1,583**	**$1,709**

Assumes a one month lag for HMO and 2 month lag for FFS

Section 16

Senate File 984, Section 16

Subject: Allows Private Vendors to Provide Waiver Casemanagement to Persons with Developmental Disabilities.

1. Current Estimates for DD Casemanagement

	SFY 2004	SFY 2005	SF 2006	SFY 2007	SFY 2008	SFY 2009
a. VA/DD Targeted Casemanagement	0	0	0	0	0	0
Federal	0	0	0	0	0	0
State						
Local	0	0	0	0	0	0
b. DD CWTCM	-	-	-	-	-	-
Federal	0	0	0	0	0	0
State						
Local	0	0	0	0	0	0
c. DD Waiver Case managment	$25,852,082	$26,118,924	$26,652,610	$27,453,137	$28,253,665	$29,054,193
Federal	13,688,677	13,059,462	13,326,305	13,726,569	14,126,833	14,527,096
State	12,163,404	13,059,462	13,326,305	13,726,569	14,126,833	14,527,096
Local						
Total State Costs				**$13,726,569**	**$14,126,833**	**$14,527,096**

2. HF 980 Estimates for DD Casemanagement

	SFY 2004	SFY 2005	SF 2006	SFY 2007	SFY 2008	SFY 2009
a. VA/DD Targeted Casemanagement				0	0	0
Federal				0	0	0
State				-	-	-
Local				0	0	0
% moving to private Casemanagement						
b. DD CWTCM				0	0	0
Federal				0	0	0
State				-	-	-
Local				0	0	0
% moving to private Casemanagement				0.00	0.00	0.00
c. DD Waiver Case management				$28,372,817	$32,039,656	$35,478,075
Federal				$14,186,409	$16,019,828	$17,739,038

State		$14,186,409	$16,019,828	$17,739,038
Local				
% moving to private Casemanagement		5.0%	20.0%	33.0%
Reduction in County Casemanagement	-0.33	-1.7%	-6.6%	-10.9%
Net Difference		3.4%	13.4%	22.1%
Total State Costs		**14,186,409**	**16,019,828**	**17,739,038**

3. State Cost(000's)Difference (2-1) Casemanagement Increase	460	1,893	3,212
4. Increased State Costs(000,s) to Waivers Due to Service Plan Changes			
DD Waiver	$1,865	$8,149	$17,826

	SF 2006	SFY 2007	SFY 2008	SFY 2009
4. State Budget (000's)				
MA Waivers and Homecare		2,325	10,042	21,038
MA Elderly and Disabled		0	0	0
Total State Costs		**2,325**	**10,042**	**21,038**

Assumptions

1. It will require one year of preparation before the state pays for private case management. This includes development of standards, requesting and securing federal approval, doing needed systems work, enrollment of and training of providers. As a result, program payments are not affected until July 1, 2006.
2. Federal approval of the necessary state plan and waiver amendment will be granted.
3. The number of recipients using to private vendors will be 5% in SFY 2007, 20% in SFY 2008, and 33% in SFY 2009. With existing providers providers becoming potential service coordination providers as well, recipients can quickly access private CM vendors, and may be encourage to do so by existing providers and advocates.
4. County agencies will reduce their spending on case management at one third of the rate of the movement to private vendors. Counties will increase their case management time for recipients continuing to choose them, will avoid staff lay-offs, increase their time on administrative case management functions, and continue to provide basic case management services to all recipients.
5. The service plan determines the service entitlement for waivered services. Currently, county agencies are responsible for service planning and managing waiver budgets. Service plans are based on service assessment activity. When service assessment activity moves to private providers, many of whom may be providing the person's other services and will advocate for additional services, an increase in service costs is expected. The incremental increases to waiver costs are estimated at .5% in SFY 2007, 1.5% in SFY 2008, and 2% in SFY 2009 of total waiver costs.
6. County waiver allocations will need to be adjusted to accommodate the additional case management and waiver costs of this section.
7. The per recipient cost for private case management services will be no different than the public case managment cost. While the rate may be lower for private case management, this will be offset by an increase use of case management.

Calculations

1. Estimates for DD waiver case management were based on SFY 2004 actuals multiplied by the year to year change in the DD waiver caseload as projected in the February 2005 Forecast.
2. Estimates for increases in waiver costs were calculated using the rate change table methodology in section 23.

Section 17

Minnesota
MEDICAL ASSISTANCE
Fiscal Analysis of a Proposal to
Increase the Personal Needs Allowance to $150
House File 980: Section 17

The personal needs allowance is considered in the need budgets for MA recipients living in nursing facilities and in ICF/MRs. It also affects the need budgets of recipients of the Group Residential Housing (GRH) program. The personal needs allowance is indexed to increase in SSI payment standards. The 2005 personal needs allowance is $76. This analysis assumes a 2% increase, rounded to even dollars, every January 1st.

Personal Needs Allowance	**CY 2005**	**CY 2006**	**CY 2007**	**CY 2008**	**CY 2009**
Current law	$76.00	$78.00	$80.00	$82.00	$84.00
Proposed	**Eff. July 2005** $150.00	$153.00	$156.00	$159.00	$162.00

Personal Needs Allowance: Average by FY	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**
Current law	$77.00	$79.00	$81.00	$83.00
Proposed	$151.50	$154.50	$157.50	$160.50
Difference	$74.50	$75.50	$76.50	$77.50

Institutional MA Recipients	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**
MA NF Recipients	20,984	20,576	20,312	20,024
MA ICF/MR recipients	1,844	1,693	1,545	1,392
Total MA facility residents	22,828	22,268	21,857	21,417
Subset with current MSA PNA payment	1,042	959	882	812
Subset added to MSA PNA payment	1,430	1,513	1,590	1,661
Remaining subset	20,356	19,796	19,385	18,944
Subset with Current MSA PNA payment				
MSA avg. monthly cost	$74.50	$75.50	$76.50	$77.50
MSA annual cost	$931,756	$868,722	$809,810	$754,764
Subset added to MSA PNA payment				
MSA avg. monthly cost	$37.25	$37.75	$38.25	$38.75
MSA annual cost	$639,210	$685,561	$729,850	$772,206
MA avg. monthly cost	$37.25	$37.75	$38.25	$38.75
MA annual cost	$639,210	$685,561	$729,850	$772,206
Federal share	$319,605	$342,780	$364,925	$386,103
State share	$319,605	$342,780	$364,925	$386,103

Remaining subset				
MA avg. monthly cost	$74.50	$75.50	$76.50	$77.50
MA annual cost	$18,198,008	$17,935,288	$17,795,014	$17,618,245
Federal share	$9,099,004	$8,967,644	$8,897,507	$8,809,122
State share	$9,099,004	$8,967,644	$8,897,507	$8,809,122

GRH Recipients	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**

The higher personal needs allowance increases GRH payments for MSA-type GRH recipients and increases GA costs for GA-GRH recipients.

MSA-GRH recipients	13,358	14,022	14,665	15,308
GRH avg. monthly cost	$74.50	$75.50	$76.50	$77.50
GRH annual cost	$11,941,788	$12,703,897	$13,462,610	$14,236,789
GA-GRH recipients	2,622	2,747	2,898	3,049
GA avg. monthly cost	$74.50	$75.50	$76.50	$77.50
GA annual cost	$2,343,770	$2,488,536	$2,660,779	$2,835,146

Fiscal Summary	**FY 2006**	**FY 2007**	**FY 2008**	**FY 2009**
		(Thousands of Dollars)		
MA LTC Facilities	9,419	9,310	9,262	9,195
MSA	1,571	1,554	1,540	1,527
GRH	11,942	12,704	13,463	14,237
General Assistance	2,344	2,489	2,661	2,835
Gen. Fund Total	25,275	26,057	26,925	27,794

	FY 2006	**FY 2007**	**FY 2008**	**FY 2009**
Total GAMC Cost	$0	$0	$0	$0

Section 18-19

Senate File 984, Section 18-19

Subject: Allow Private Vendors to Provide Casemanagement for Persons Receiving Services on Disability Waivers

1. Current Estimates for DD Casemanagement

		SFY 2004	**SFY 2005**	**SF 2006**	**SFY 2007**	**SFY 2008**	**SFY 2009**
a. CADI Waiver		14,308,224	16,453,814	21,973,480	27,179,852	29,811,154	32,278,033
	Federal	7,154,112	8,226,907	10,986,740	13,589,926	14,905,577	16,139,016
	State	7,154,112	8,226,907	10,986,740	13,589,926	14,905,577	16,139,016
	Local						
b. TBI Waiver		2,649,586	3,003,434	3,921,474	4,973,541	5,679,458	6,404,542
	Federal	1,324,793	1,501,717	1,960,737	2,486,771	2,839,729	3,202,271
	State	1,324,793	1,501,717	1,960,737	2,486,771	2,839,729	3,202,271
	Local						
c. CAC Waiver		507,555	596,592	673,021	753,382	833,710	914,040
	Federal	253,777	298,296	336,510	376,691	416,855	457,020

State	253,777	298,296	336,510	376,691	416,855	457,020
Local						
Total State Costs				**16,453,388**	**18,162,161**	**19,798,307**

2. HF 980 Estimates for Disability Casemanagement

	SFY 2004	SFY 2005	SF 2006	SFY 2007	SFY 2008	SFY 2009
a. CADI Waiver				28,090,377	33,805,848	39,414,706
Federal				14,045,189	16,902,924	19,707,353
State				14,045,189	16,902,924	19,707,353
Local				0	0	0
% moving to private Casemanagement				5%	20%	33%
Reduction in County Casemanagement				-2%	-7%	-11%
Net Difference				3%	13%	22%
b. TBI Waiver				5,140,155	6,440,506	7,820,586
Federal				2,570,077	3,220,253	3,910,293
State				2,570,077	3,220,253	3,910,293
Local				0	0	0
% moving to private Casemanagement				5%	20%	33%
Reduction in County Casemanagement				-2%	-7%	-11%
Net Difference				3%	13%	22%
c. CAC Waiver				389,310	472,714	558,067
Federal				194,655	236,357	279,033
State				194,655	236,357	279,033
Local						
% moving to private Casemanagement				5%	20%	33%
Reduction in County Casemanagement				-2%	-7%	-11%
Net Difference				3%	13%	22%
Total State Costs				**16,809,921**	**20,359,534**	**23,896,679**

3. State Cost(000's) Difference (2-1) Casemanagement Increase	357	2,197	4,098

4. Increased State Costs(000's) to Waivers Due to Service Plan Changes

CADI Waiver	$579	$2,930	$7,254
CAC Waiver	$27	$135	$338
TBI Waiver	$239	$1,199	$2,971

	SF 2006	SFY 2007	SFY 2008	SFY 2009
4. State Budget (000's)				
MA Waivers and Homecare		1,202	6,461	14,661
Total State Costs		**1,202**	**6,461**	**14,661**

Assumptions

1. It will require one year of preparation before the state pays for private case management. This includes development of standards, requesting and securing federal approval, doing needed systems work, enrollment of and training of providers. As a result, program payments are not affected until July 1, 2006.
2. Federal approval of the necessary state plan and waiver amendment will be granted.
3. The number of recipients using to private vendors will be 5% in SFY 2007, 20% in SFY 2008, and 33% in SFY 2009. With existing providers providers becoming potential service coordination providers as well, recipients can quickly access private CM vendors, and may be encourage to do so by existing providers and advocates.
4. County agencies will reduce their spending on case management at one third of the rate of the movement to private vendors. Counties will increase their case management time for recipients continuing to choose them, will avoid staff lay-offs, increase their time on administrative case management functions, and continue to provide basic case management services to all recipients.
5. The service plan determines the service entitlement for waivered services. Currently, county agencies are responsible for service planning and

managing waiver budgets. Service plans are based on service assessment activity. When service assessment activity moves to private providers, many of whom may be providing the person's other services and will advocate for additional services, an increase in service costs is expected. The incremental increases to waiver costs are estimated at .5% in SFY 2007, 1.5% in SFY 2008, and 2% in SFY 2009 of total waiver costs.

6. County waiver allocations will need to be adjusted to accommodate the additional case management and waiver costs of this section.
7. The per recipient cost for private case management services will be no different than the public casemanagment cost. While the rate may be lower for private case management, this will be offset by an increase use of case management.

Calculations

1. Estimates for disability waiver case management were based on SFY 2004 actuals multiplied by the year to year change in the respective waiver caseload, as projected in the February 2005 Forecast.
2. Estimates for increases in waiver costs were calculated using the rate change table methodology in section 23

Based on 02.05 Forecast

HF 980

Continuing Care Services

Summary by decision item:

(State dollars in thousands)

Updated as of 2/18/05	**FY2006**	**FY2007**	**FY2008**	**FY2009**
MA LTC Waivers and Home Care				
Devel. Disabilities Waiver	$0	$7,458	$28,993	$72,772
Elderly Waiver	$0	$0	$0	$0
CADI	$0	$2,318	$10,413	$29,639
CAC	$0	$107	$480	$1,381
TBI	$0	$956	$4,260	$12,138

(State dollars in thousands)

Summary by budget activity	**FY2006**	**FY2007**	**FY2008**	**FY20**
MA LTC Waivers and Home Care	$0	$10,839	$44,146	$115,930
Biennial Total		$10,839		$160,076
Grand Total	$0	$10,839	$44,146	$115,930

Level of Rate Change Based on Service Plan Changes

0.00%	SFY 2006
2.00%	SFY 2007
5.00%	SFY 2008
9.00%	SFY 2009

Section 21 & 23

Subject: Increases Rates for Certain Continuing Care Programs

HF 980 Summary by decision item:	Continuing Care Services (State dollars in thousands)				Level of Rate Change	
Updated as of 2/18/05	FY2006	FY2007	FY2008	FY2009	SFY 06	0.01
MA LTC Waivers and Home Care					SFY 07	0.01
Devel. Disabilities Waiver	3586	8212	9285	9637	1	
Elderly Waiver	570	1267	1312	1298	1	
CADI	839	2497	3283	3887	1	
CAC	43	116	151	181	1	
TBI	353	1031	1344	1592	1	
Home Health Agencies	140	321	364	380	1	
Personal Care & PDN	1365	3218	3767	4049	1	
MA LTC Waivers and Home Care Subtotal	6896	16662	19506	21024		
MA LTC Facilities						
DT&H for ICF-MR	112	235	241	222	1	
Nursing Facilities w/ APS inflation	0	0	0	0	0	Not in HF 980
ICF-MR	250.4545	810.6364	1077	1010	1	Jan. 1 Implmnt (Sec. 18)
MA LTC Facilities Subtotal	362.4545	1045.636	1318	1232		
MA Basic Elderly & Disabled - Transfer to MH Case Mgmt	0	0	0	0	0	Not in MH Grant Increase
MA Basic Elderly & Disabled - EW Managed Care	76.5	568	966	1298	1	Tied to EW Increase:1/1 Implemented
MA Basic F&C - Non-citizens w/out FFP	1	2	3	3	1	
MA Rehab (PT,OT,ST)	45.04699	107.123	125.4431	133.7869	1	From 02/05 Forecast-Rehab
GAMC Rehab (PT,OT,ST)	0.416667	0.920833	1.005	1.005	1	50,000/year base

MA Respiratory Therapy	44.07597	104.8139	122.7391	130.903	1	Based on first 6 mo. Of SFY 05
GAMC Respiratory Therapy	1.583333	3.499167	3.819	3.819	1	Based on first 6 mo. Of SFY 05
Alternative Care Grants	535	1185	1295	1297	1	
GRH supplemental service payments	0	0	0	0	0	Not included in HF 980
State share of CD Tier I	0	0	0	0	0	Not included in HF 980
State Share of CSG	74	183	217	236	1	Tied to homecare increase 256.476 subd.11(1)(iv)
Adult Mental Health Grants	374	823	897	897	1	
Children's Mental Health Grants	24	75	84	84	1	
DD Comm Supp Grants SILS	57	140	153	153	1	
Comm Soc Svc Grants, non-MA DT&H	0	0	0	0	0	County pays 100% for CSSA Recipients
Comm Soc Svc Grants, former GRH/SILS	2	5	6	6	1	
Deaf and Hard of Hearing Grants	6	15	15	15	1	
Aging and Adult Services Grants - Epilepsy	0	0	0	0	0	Not included in HF 980
TOTAL GENERAL FUND ABOVE	8499.078	20919.99	24713.01	26514.51		
Biennial totals		29419.07		51227.52		
Totals for Section 20 without ICFs	8248.623	20109.36	23636.01	25504.51		

(State dollars in thousands)

Summary by budget activity	FY2006	FY2007	FY2008	FY2009
MA LTC Waivers and Home Care	6896	16662	19506	21024
MA LTC Facilities	362.4545	1045.636	1318	1232
MA Basic Health Care E&D	165.623	779.9368	1214.182	1562.69
MA Basic Health Care F&C	1	2	3	3
GAMC Basic Health Care	2	4.42	4.824	4.824
Alternative Care Grants	535	1185	1295	1297

Group Residential Housing	0	0	0	0		
Adult Mental Health Grants	374	823	897	897		
Children's Mental Health Grants	24	75	84	84		
DD Comm Supp Grants	57	140	153	153		
Comm Soc Svc Grants	2	5	6	6		
Deaf and Hard of Hearing Grants	6	15	15	15		
Aging and Adult Services Grants	0	0	0	0		
State share of CD Tier I	0	0	0	0		
Consumer Support Grants	74	183	217	236		
TOTAL GENERAL FUND ABOVE	8499.078	20919.99	24713.01	26514.51		
Biennial Total		29419.07		51227.52		
Grand Total	8499.078	20919.99	24713.01	26514.51	0.01	SFY 2006
					0.01	SFY 2007

County Cost Impacts of Rate Changes(000's)

	FY2006	FY2007	FY2008	FY2009	Switch
County Costs(NF)	0	0	0	0	0
County Costs(ICF)	76.60196	153.4513	149.6192	140.3204	1
County Costs(DT&H)	15.62178	32.63346	33.4472	30.89661	1
County Costs(DT&H) CSSA	141.0978	346.4736	378.1422	378.1422	1
County Costs (CD Tier 1)	0	0	0	0	0
County Costs(SILS Grants)	14.25	35	38.25	38.25	1
County Costs(Other)					
Total County Costs	247.5716	567.5583	599.4586	587.6092	

Assumptions

1. Continuing care service rates/allocations would be increased by 1% on July 1, 2005 and 1% on July 1, 2006. The effects of the rate increase continue

2. Nursing facilities, Chemical health services, Epilepsy grants, and GRH supplemental service rates are not affected by this legislation.

3. The managed care capitation for elderly waiver services would increase at the same rate as the fee-for-service program. Consumer support grants would increase at the same rate as fee-for-service home care rates.

4. The cash effects of rate increase are phased-in based on the program and funding source. The cash estimates are based on the following phase-in for each rate increase.

- NFs and ICF/MR rates: 11/12th in the first year, and 1/12th in the second year
- Other MA funded programs including home and community based waivers, home care: 10/12th in the first year, and 2/12th in the second year
- State grants not appropriated as part of CCSA, such as adult mental health, SILS, etc : 9/12th in the first year, and 3/12th in the second year
- State grants appropriated as part of CCSA (including children's mental health, etc): 9/12th in the first year, and 3/12th in the second year
- Other state grants such as deaf and hard of hearing: no delay

5. The county social service share of the rate increase for day training and habilitation and SILS is not funded as part of this proposal

6. For state grant programs that have been folded into CCSA (children's mental health) the SFY 2004 grant base is used to calculate the effect of the rate increase.

7. Medical Assistance federal financial participation rates were estimated at 50% of the total costs with the state paying 100% of non-federal share.

The only exception is for payments to larger ICFs/MR (including day training costs), where the state pays 80% and the counties pay 20% of the non-federal share.

8. Rate increases to therapies will cost money in both the medical assistance and GAMC programs. GAMC is 100% state funded.

9. An additional staff person is required to implement the provisions of this bill, beyond the effort currently available in the Department.

This person would design provider reports, send the report format to providers, provide technical assistance to providers in completing the report, and summarize the results of the reports.

Expenditure and/or Revenue Formula

1) For continuing care programs, the proposed change to the rates is as follows: 1.0% increase on July 1, 2005 and 1.0% increase on July 1, 2006, except for ICF/MR rate changes which are implemented on January 1of each year.

2) The rate increases in SFY 2006 and SFY 2007 would have ongoing effects in SFY 2008 and 2009

3) The rate change for nursing homes and other CC programs was applied to the program projections of the February 2005 forecasts for those programs funded by the Medical Assistance Program or GAMC.

4) The rate change for CC state grant programs was applied to the respective state base to each year for those programs. For state grant programs that have been folded into CCSA (children's mental health, social service funded day training, etc) the SFY 2004 grant base was used to calculate the effect of the rate increase.

5) The additional position requested has been budgeted at a rate of 70,000 per year for 3 years. Revenues generated by the position were estimated at 40% of the total cost of the position.

Section 22

Senate File 984, Section 22

Subject: Expansion of Minnesota's Disability Health Options(MNDHO) Program

Expansion of the current MnDHO demonstration would require special CMS approval since MnDHO is a federal Medicare demonstration. DHS recently requested CMS approval to expand MnDHO beyond the current approved seven county metro service area. In December of 2004 CMS declined to approve this request. In addition there are new obstacles to expansion at this time. As part of the Medicare Modernization Act, CMS has set new deadlines for Medicare plans and demonstrations for any service area expansions. Application for new service areas must be submitted to CMS by March 23, 2005 in order to be considered for approval for operation in 2006. At this time, it is already too late for DHS to try to obtain federal approval again, conduct an RFP and submit the application and network for CMS approval by that date.

The MnDHO demonstration is currently approved by CMS through CY 2007. Therefore even if CMS approval was granted at a later date, the demonstration would be almost over by the time the State could implement the expansion. DHS typically does not project MA program costs in a fiscal note when the required CMS approval appears unlikely, so we are not projecting program costs in this fiscal note for this activity at this time. This implies that, should this waiver expansion meet with CMS approval, we would need to return to the Legislature for appropriations to cover expected program costs.

If we were to be able to expand MnDHO statewide, we would expect a slow enrollment growth since the program is voluntary and there are few providers ready to accommodate the program requirements. There would be fiscal impact in terms of additional administrative costs (actuarial, staff and systems changes for a risk adjustment system), cash flow costs for managed care prepayment, and potential impact on waiver slot caps.

Section 24

General Assistance Medical Care

House File 984, Section 24

A Fiscal Analysis of a Proposal to

Eliminate the 50% Restorative Dental Copayment

Based on Information from the actuary, current GAMC managed care rates include a .995% offset for restorative dental.

Based on actual GAMC restorative dental offsets from January 2004 to June 2004, it is estimated that eliminating GAMC restorative dental copayment would increase GAMC FFS costs by .33%

Assumes an October 1, 2005 implementation date for FFS; January 1, 2006 for HMO.

	HMO	FFS
GAMC HMO	0.995%	0.33%

	FY 2006	FY 2007	FY 2008	FY 2009
February 2005 Forecast (in 000s)				
HMO				
GAMC	$187,847	$251,760	$292,833	$317,003
FFS				
GAMC	$92,005	$98,415	$106,819	$112,153

Impact of elimination of restorative dental copay (in 000s)

GAMC HMO	$779	$2,505	$2,914	$3,154
GAMC FFS	$177	$325	$353	$370
GAMC Total	**$956**	**$2,830**	**$3,266**	**$3,524**
Total GF	**$956**	**$2,830**	**$3,266**	**$3,524**

Assumes a one month lag for HMO and two months for FFS.

Section 26

Minnesota

MINNESOTACARE

Fiscal Analysis of a Proposal to

Modify Dental Coverage

Senate File 984, Section 26

Effective January 2006

This section makes the coverage of dental services for adults in MinnesotaCare the same as in Medical Assistance. This change (1) eliminates the $500 annual cap on dental services, (2) eliminates the 50% copayment for restorative services for those currently subject to it, and (3) adds coverage of orthodontia.

The cost to eliminate the $500 cap is dealt with in a separate analysis that includes MA and GAMC effects of this change.

Elimination of the 50% copayment affects caretakers under 175% FPG (caretakers over 175% FPG do not have the copayment requirement in the current law) and adults with no kids with income under 75% FPG (those over 75% have the limited benefit set, which does not include dental coverage.)

The cost of adding adult orthodontia coverage is projected to have an inconsequential cost. Payments for orthodontic procedure codes account for only about 0.04% of MA adults dental payments and 0.07% of GAMC dental payments.

These changes are assumed to be effective with 2006 managed care contracts.

FAMILIES WITH CHILDREN

Caretakers Under 175% FPG

Eliminating the 50% copayment increases PMPM by 2%.

	FY 2006	FY 2007	FY 2008	FY 2009
Number of eligibles	14,363	27,396	25,270	25,544
Avg. monthly payment	$7.28	$7.66	$8.17	$8.88
Avg. monthly revenue				

Total payments	1,254,880	2,517,585	2,478,701	2,721,661
Federal share %	54.46%	48.66%	47.77%	46.43%
Federal share	683,409	1,224,933	1,184,138	1,263,800
State share	571,471	1,292,652	1,294,563	1,457,861
Total revenue	0	0	0	0
Federal share %	54.46%	48.66%	47.77%	46.43%
Federal share	0	0	0	0
State share	0	0	0	0
Net cost	1,254,880	2,517,585	2,478,701	2,721,661
Federal share	683,409	1,224,933	1,184,138	1,263,800
State share	571,471	1,292,652	1,294,563	1,457,861

ADULTS WITHOUT CHILDREN

Eliminating the 50% copayment increases PMPM by 2%.

Number of eligibles	6,050	6,430	3,892	3,868
Avg. monthly payment	$8.22	$9.24	$9.53	$10.17
Avg. monthly revenue				
Total payments	596,463	712,733	445,173	472,128
Total revenue	0	0	0	0
Net cost	596,463	712,733	445,173	472,128

Total MinnesotaCare Cost	1,851,342	3,230,318	2,923,874	3,193,789
Federal share	683,409	1,224,933	1,184,138	1,263,800
State share	1,167,933	2,005,385	1,739,736	1,929,989

Positions/Admin.

Senate File 984 as amended

Subject: Positions/Costs Requested to Implement Provisions

		Positions Requested	Cost Per Position	Total Costs	Revenues	Purpose	Amount of Time
Section 7-11	Relocation Service Coordination (RSC)	0.50	70,000	35,000	14,000	Develop request for state plan submission, submit request to feds, develop provider qualifications, provide training and assistance to consumers, counties, and providers, enrolls providers, sets rates.	On-going
Section 12	Notification of RSC	0.50	70,000	35,000	14,000	Sets up systems for notification for all disabled and elderly in nursing homes and other institutional settings; tracks notifications to recipients, assures notifications are appropriate for cultural background, provides consumer assistance, etc	On-going
Section 16	Waiver DD CM*	1.00	70,000	70,000	28,000	Develop request for state plan submission, submit request to feds, develop provider qualifications, provide training and assistance to consumers and providers, enrolls providers, sets rates.	On-going
Section 18-19	Disability Waiver CM*	1.00	70,000	70,000	28,000	Develop request for state plan submission, submit request to feds, develop provider qualifications, provide training and assistance to consumers and providers, enrolls providers, sets rates.	On-going
Section 21 and 23	CC Rate Increases	1.00	70,000	70,000	28,000	Develops provider reporting tools, provides provider assistance, collates and summarizes results, and responds to inquiries.	Three Years
Section 27	Interagency Work Group**	-		210,000	84,000	Respond to workgroup requests for information; assist in preparing recommendations and report; workgroup sunsets after report. Costs equivalent to 2.0 FTE's for 18 months.	18 Months
	Total	**4**	**350,000**	**490,000**	**196,000**		

*Casemanagement positions will be specialized focusing on policy research and development, rate setting and fiscal analysis, enrollment and provider assistance, consumer assistance and information.

**Time limited administration cost

System Cost

Senate File 984

Subject: Systems Cost

This proposal would cause a two month HealthMatch delay. The complex design of the innovative HealthMatch system is near completion and programming has begun. Due to the intricacies of programming a new system, any change to system completion requires substantial analysis and design rework, in addition to programming the actual changes. This effort delays the HealthMatch implementation date and results in costs of $889,000 per month of delay. Currently, for each month of delay to the project, the associated vendor cost for maintaining staff on the project is $600,000. Concurrent state staff costs per month are $289,000. (Numbers reflect 100% of the cost; state budget costs are less when adjusted for federal participation)

Once HealthMatch is completely built and implemented, the cost for making requested changes will be significantly lower. Legislation with effective dates on or after August 1, 2006, or upon HealthMatch implementation, whichever is later, will not incur the additional time for analysis and associated vendor costs caused by implementation delay.

SFY 2006

	Total	State	FFP Rate
MMIS	365,000	127,750	0.65
MAXIS	17,000	7,650	0.55
HealthMatch	1,778,000	622,300	0.65
Total	2,160,000	757,700	
State Budget(000's)		**758**	

Agency Contact Name: Robert F. Meyer 582-1935/George Hoffman 296-6154
FN Coord Signature: STEVE BARTA
Date: 04/07/05 Phone: 296-5685

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: DOUG GREEN
Date: 04/07/05 Phone: 286-5618

Fiscal Note – 2005-06 Session

Bill #: S0984-1E (R) **Complete Date:** 04/07/05

Chief Author: LOUREY, BECKY

Title: HUMAN SERVICES PRGMS FOR DISABLED

Fiscal Impact	Yes	No
State		X
Local		X
Fee/Departmental Earnings		X
Tax Revenue		X

Agency Name: Disability Council

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
General Fund		28	9		
Less Agency Can Absorb					
General Fund		28	9		
Net Expenditures					
General Fund		0	0		
Revenues					
-- No Impact --					
Net Cost <Savings>					
General Fund		0	0		
Total Cost <Savings> to the State					

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
General Fund		0.45	0.13		
Total FTE		0.45	0.13		

Bill Description

This fiscal note addresses only Section 29 of the bill. Section 29 establishes a Disability Services Interagency Work Group, convened jointly by the commissioners of human services and housing finance and the Minnesota State Council on Disability (MSCOD). The work group may also include other state agencies, counties, public housing authorities, the Metropolitan Council, disability service providers and representatives from various disability advocacy organizations. The work group's purpose is to identify barriers, strengthen coordination, recommend policy and funding changes, and where applicable, pursue federal funding that will assist Minnesotans with disabilities who are attempting to relocate from or avoid placement in an institutional setting.

Assumptions

The work group's duration is from July 1, 2005 through October 15, 2006, and as one of the three conveners, the MSCOD would be expected to assume a leadership role in the work group activities. Such a role would necessitate approximately a 10% time commitment from the Council's executive director and a similar (i.e., 10%) commitment from the Council staff's housing and transportation/education specialists. In addition, given the role of the Council, it is anticipated that a 15% time commitment from the administrative support staff person would be necessary (No extraordinary expenditures are anticipated for meetings, travel, printing, postage, and other miscellaneous expenses associated with the work group's functioning.)

Expenditure and/or Revenue Formula

N/A

Long-Term Fiscal Considerations

None

Local Government Costs

None

References/Sources

Sources: Prior Council Staff interagency work group experience.

Agency Contact Name: Joan Willshire
FN Coord Signature: DARYL SCHWIER
Date: 04/07/05 Phone: 296-1747

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: CRAIG WIEBER
Date: 04/07/05 Phone: 282-5065

Fiscal Note – 2005-06 Session

Bill #: S0984-1E (R) **Complete Date:** 03/17/05

Chief Author: LOUREY, BECKY

Title: HUMAN SERVICES PRGMS FOR DISABLED

Fiscal Impact	Yes	No
State		X
Local		X
Fee/Departmental Earnings		X
Tax Revenue		X

Agency Name: Housing Finance Agency

This table reflects fiscal impact to state government. Local government impact is reflected in the narrative only.

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
-- No Impact --					
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
-- No Impact --					
Revenues					
-- No Impact --					
Net Cost <Savings>					
-- No Impact --					
Total Cost <Savings> to the State					

	FY05	FY06	FY07	FY08	FY09
Full Time Equivalents					
-- No Impact --					
Total FTE					

Bill Description

SF 984 makes numerous changes to the Medical Assistance program aimed at promoting relocation of persons living in institutions to the community.

Section 29 of the bill is the only section that directly impacts the Housing Finance Agency. Section 29 establishes a disability services interagency work group to be convened by the commissioners of the Department of Human Services and the Minnesota Housing Finance Agency (MHFA) and the Minnesota Council on Disabilities. The work group is charged with recommending policy and funding changes that will assist individuals in moving out of an institution or in avoiding institutionalization, including recommendations relating to coordinating housing, transportation, and support services, identifying strategies to assure a financially sustainable community support system.

Assumptions

MHFA already has a staff person who serves as a liaison to the Department of Human Services and who specializes in issues related to housing for people with disabilities. It is assumed for purposes of this fiscal note that staffing the proposed work group is within the scope of the work plan of the existing MHFA staff person. For this reason there is no additional cost or savings to MHFA as a result of the creation of the work group.

Expenditure and/or Revenue Formula

Long-Term Fiscal Considerations

Local Government Costs

References/Sources

Agency Contact Name: TONJA M. ORR (651) 296-9820
FN Coord Signature: JULIE STAHL
Date: 03/17/05 Phone: 296-2291

EBO Comments

I have reviewed this Fiscal Note for accuracy and content.

EBO Signature: KEITH BOGUT
Date: 03/17/05 Phone: 296-7642

NATIONAL MULTIPLE SCLEROSIS SOCIETY
Minnesota Chapter

National Multiple Sclerosis Society
Minnesota Chapter
200 12th Ave. South
Minneapolis, MN 55415-1255

Tel 612 335 7900
1 800 FIGHT MS
Fax 612 335 7997
E-Mail: info@mssociety.org
www.mssociety.org

April 13, 2005

Senator Linda Berglin
309 Capitol
St. Paul, MN 55155

Dear Senator Berglin,

Thank you for your willingness to hear Senate File 984 in your committee on Thursday. I understand that you want to focus on the dental sections and cost-saving/no cost sections of the bill. We know the fiscal note of this bill is daunting and that many of the sections will need to dropped for this year.

Our goal in including the COLA, personal needs allowance increase, and the income standard and asset provisions was to educate members on these issues and get an updated fiscal note on the cost of these initiatives. These comprise the bulk of the proposal's cost, and the House has said they will not be funding the bulk of these provisions.

I want you to be aware that we are still negotiating the sections relating to waiver county case management and we may have an idea that could produce cost savings. (We meet with MACSSA, DHS, and Sen. Lourey this afternoon.) Our latest proposal is to give people choice of waiver case management but in order to that there would be a reduction of five or ten percent from the individual's waiver allocation similar to the consumer support grant and CDCS. We are hopeful that you will allow us to continue to work through these options with the department and counties.

I am asking you to include in the Senate omnibus bill the following sections **that have cost savings:**

- **Sections 6,7,8,10, 11, and 12** – Relocation Service Coordination providing for choice of conty or private agency for seniors or non-elderly disabled living in nursing homes. $175,000 in savings this biennium. $1.56 million in savings in the next

I am asking you to include in the Senate omnibus bill the following sections **that have no cost:**

- **Section 13** – your amendment relating to Mental Health Services
- **Sections 15, 20 and 27** – Asking DHS to seek a transitional needs allowance waiver request. We know they are in the process of submitting this but we want the language to ensure that they finish the job.
- **Section 28** – Dental Access study to examine challenges in serving people with disabilities

Two other sections we ask you to consider that have **very low costs** include:

- **Section 4** – There is two topic areas relating to MA-EPD. We are asking you to look at the low cost item in SF984 1st engrossment, lines 5.7-5.9. This is a technical change that relating to the annual Social Security COLA's. One time cost of $23,000 in FY06
- **Section 5** – Extending the home maintenance allowance from three months to six months for people in nursing homes who are very likely to be able to move home after rehabilitation. $59,000 per year
- **Section 29** – Creating an interagency work group to provide strategies to help people with disabilities to avoid institutional placements. $126,000 only in the first biennium.

Thank you for your continued support of people with disabilities.

Sincerely,

Joel Ulland
Public Policy Director

Cc: Anne Henry
John Tschida
Sen. Becky Lourey

Duluth
301 West First Street, #528
Duluth, MN 55802
218-722-5625
Fax: 218-722-7885

Grand Rapids
204 First Avenue NW, #4
Grand Rapids, MN 55744
218-326-7044
Fax: 218-326-5376

MINNESOTA DISABILITY LAW CENTER

THE PROTECTION & ADVOCACY
SYSTEM FOR MINNESOTA

430 FIRST AVENUE NORTH, SUITE 300
MINNEAPOLIS, MN 55401-1780
Phone: 612- 332-1441
Intake: 612-334-5970
TDD: 612-332-4668
Toll Free 1-800-292-4150
Facsimile: 612-334-5755

www.mndlc.org

Moorhead
P.O. Box 714
Moorhead, MN 56560
218-233-8585
Fax 218-233-8586

Willmar
P.O. Box 1866
Willmar, MN 56201-1866
320-235-9600
Fax 320-235-1030

TO: **Senator Linda Berglin**

FROM: **Anne L. Henry**

RE: **SF 984, Consortium for Citizens with Disabilities, Disability Bill**

DATE: **April 7, 2005**

As I am sure you have noted, there is one provision in the Consortium for Disabilities (CCD) Disability bill which has modest savings for this biennium ($154,000) increasing for the next ($1.57 million, '08/'09), attached. That section is relocation case management which divides the case management duties into county case management and county or private vendor service coordination duties. Persons (elderly and disabled) living in institutional settings, mostly nursing homes, would have a choice of service coordination vendor.

Also, I am working on some specific language regarding PCA changes or efforts which DHS has undertaken or has described for the near future. I will get that language to you by early next week. Thank you.

ALH:nb

Attachment

cc: David Godfrey

Part of Fiscal Note for SF 984 (HF 980) with modest savings

Assumptions
A section by section cost summary is provided below. The assumptions and explanatory notes have been provided in the attachment to this fiscal note.

Expenditure and/or Revenue Formula
A section by section cost summary is provided below. The expenditure and revenue formulas have been provided in the attachment to this fiscal note.

HF 980 as Amended

			State Dollars in Thousands			
			SFY 2006	SFY 2007	SFY 2008	SFY 2009
Section 1	Parental Fees	Expenditures	564	1,128	1,128	1,128
	Reduces fees and increases	Revenues	(951)	(897)	(897)	(897)
	caseloads	Net State Cost	1,515	2,025	2,025	2,025
		FTE'S	0	0	0	0
Section 2	Wellness Visits					
	Language needs to be clarified to determine cost impact					
Section 3	Asset Changes	Expenditures	13,650	13,650	13,650	13,650
	Increases MA Asset Standard	Revenues	0	0	0	0
	for Elderly & Disabled from 2,000	Net State Cost	13,650	13,650	13,650	13,650
	/6,000 to 10,000/18,000	FTE'S	0	0	0	0
Section 4	Income Standard	Expenditures	18,164	17,619	18,469	19,368
	Raises the Medically Needy	Revenues	0	0	0	0
	Income Standard from 75% -	Net State Cost	18,164	17,619	18,469	19,368
	100% FPG	FTE'S	0	0	0	0
Section 5	MA-EPD	Expenditures	437	426	426	426
	Removes income limit for	Revenues	0	0	0	0
	reimbursement of Medicare premiums,	Net State Cost	437	426	426	426
	and adds recipients to MA-EPD	FTE'S	0	0	0	0
Section 6	Income Allocation	Expenditures	59	59	59	59
	Extends time of home	Revenues	0	0	0	0
	maintenance allowance from 3	Net State Cost	59	59	59	59
	to 6 months	FTE'S	0	0	0	0
Section 7	Relocation Service Coordination	Expenditures	35	-161	-573	-965
Section 8	Eligible Service RSC	Revenues	14	14	14	14
		Net State Cost	21	(175)	(587)	(979)
	Allows use of private vendors;	FTE'S	0.5	0.5	0.5	0.5
	Increases RSC costs, and					
	NF Relocations for both elderly and disabled					
Section 9	Notification of RSC	Expenditures	35	35	35	35

ATTACHMENT "A"

04/13/05 [COUNSEL] JW SCS0984A10

Senator ..... moves to amend S.F. No. 984 as follows:

Page 8, line 26, after "and" insert "public or private vendor"

Page 10, line 24, after "4" insert "for county vendors"

Page 10, line 25, before the period, insert "for private vendors"

Page 11, after line 30, insert:

"(c) The State of Minnesota, a county board, or agency acting on behalf of a county board shall not be liable for damages, injuries, or liabilities sustained because of services provided to a client by a private service coordination vendor."

Page 12, line 1, after "services" insert "and for persons choosing to relocate, the county must provide service coordination provider options at the first contact and upon request"

Page 12, line 28, after "clauses" insert "(1)," and after "(2)" insert a comma

Page 12, line 30, delete "(1), (3)," and insert "(3)"

Page 14, line 11, delete everything after "Living"

Page 14, line 12, delete "assist" and insert "provide information about assistance for" and delete "help"

Page 32, line 28, after "services" insert ", in consultation with the Dental Access Advisory Committee established under Minnesota Statutes, section 256B.55,"

A bill for an act

relating to human services; expanding children's therapeutic services and support; amending Minnesota Statutes 2004, section 256B.0943, subdivisions 1, 2.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 256B.0943, subdivision 1, is amended to read:

Subdivision 1. [DEFINITIONS.] For purposes of this section, the following terms have the meanings given them.

(a) "Care coordination" means activities that ensure:

(1) services are provided in the most appropriate manner to achieve maximum benefit to the client;

(2) nonduplication of services with county case managers;

(3) coordination of care with county social services, community corrections, and schools; and

(4) services are culturally competent, child-centered, and family-driven.

Care coordination may include activities that coordinate, for a particular client, any of the following:

(1) children's therapeutic services and supports covered service components, as provided in subdivision 2, paragraph (b), including psychotherapy, skills training, crisis assistance, mental health behavioral aide services, direction to a mental health behavioral aide, and family psychoeducation;

(2) other medical assistance reimbursable services that are

not covered components of children's therapeutic services and supports, including, but not limited to, outpatient treatment and home and community-based waivered services;

(3) other components of a therapeutic program not covered by medical assistance as part of children's therapeutic services and supports, including, but not limited to, a day treatment program, a preschool program, and other therapeutic activities included in the child's individual treatment plan;

(4) obtaining the client's history;

(5) diagnostic assessment, including functional assessment;

(6) development, review, and updating of the client's individual treatment plan;

(7) development, review, and updating of the client's individual behavioral plan;

(8) entry of a client's data into the performance measurement system;

(9) maintenance of clinical records;

(10) scheduling for the client;

(11) documentation required for billing;

(12) consultation with other providers;

(13) services that are the responsibility of a residential treatment provider, foster care provider, hospital, group home, regional treatment center, or other institutional group setting and the discharge planning from such settings; and

(14) adjunctive activities offered by a provider who does not provide children's therapeutic services and supports that are not covered by medical assistance, including, but not limited to, recreational services; social or educational services not expected to have a therapeutic outcome related to the client's emotional disturbance; consultation with other providers; and chemical dependency treatment.

(b) "Children's therapeutic services and supports" means the flexible package of mental health services for children who require varying therapeutic and rehabilitative levels of intervention. The services are time-limited interventions that are delivered using various treatment modalities and

combinations of services designed to reach treatment outcomes identified in the individual treatment plan.

~~(b)~~ (c) "Clinical supervision" means the overall responsibility of the mental health professional for the control and direction of individualized treatment planning, service delivery, and treatment review for each client. A mental health professional who is an enrolled Minnesota health care program provider accepts full professional responsibility for a supervisee's actions and decisions, instructs the supervisee in the supervisee's work, and oversees or directs the supervisee's work.

~~(c)~~ (d) "County board" means the county board of commissioners or board established under sections 402.01 to 402.10 or 471.59.

~~(d)~~ (e) "Crisis assistance" has the meaning given in section 245.4871, subdivision 9a.

~~(e)~~ (f) "Culturally competent provider" means a provider who understands and can utilize to a client's benefit the client's culture when providing services to the client. A provider may be culturally competent because the provider is of the same cultural or ethnic group as the client or the provider has developed the knowledge and skills through training and experience to provide services to culturally diverse clients.

~~(f)~~ (g) "Day treatment program" for children means a site-based structured program consisting of group psychotherapy for more than three individuals and other intensive therapeutic services provided by a multidisciplinary team, under the clinical supervision of a mental health professional.

~~(g)~~ (h) "Diagnostic assessment" has the meaning given in section 245.4871, subdivision 11.

~~(h)~~ (i) "Direct service time" means the time that a mental health professional, mental health practitioner, or mental health behavioral aide spends face-to-face with a client and the client's family. Direct service time includes time in which the provider obtains a client's history or provides service components of children's therapeutic services and supports.

Direct service time does not include time doing work before and after providing direct services, including scheduling, maintaining clinical records, consulting with others about the client's mental health status, preparing reports, receiving clinical supervision directly related to the client's psychotherapy session, and revising the client's individual treatment plan.

~~(i)~~ (j) "Direction of mental health behavioral aide" means the activities of a mental health professional or mental health practitioner in guiding the mental health behavioral aide in providing services to a client. The direction of a mental health behavioral aide must be based on the client's individualized treatment plan and meet the requirements in subdivision 6, paragraph (b), clause (5).

~~(j)~~ (k) "Emotional disturbance" has the meaning given in section 245.4871, subdivision 15. For persons at least age 18 but under age 21, mental illness has the meaning given in section 245.462, subdivision 20, paragraph (a).

~~(k)~~ (l) "Family psychoeducation services" means education provided under the supervision of a mental health professional to a parent, family member, foster parent, or guardian about the child's mental health condition.

(m) "Individual behavioral plan" means a plan of intervention, treatment, and services for a child written by a mental health professional or mental health practitioner, under the clinical supervision of a mental health professional, to guide the work of the mental health behavioral aide.

~~(l)~~ (n) "Individual treatment plan" has the meaning given in section 245.4871, subdivision 21.

~~(m)~~ (o) "Mental health professional" means an individual as defined in section 245.4871, subdivision 27, clauses (1) to (5), or tribal vendor as defined in section 256B.02, subdivision 7, paragraph (b).

~~(n)~~ (p) "Preschool program" means a day program licensed under Minnesota Rules, parts 9503.0005 to 9503.0175, and enrolled as a children's therapeutic services and supports

provider to provide a structured treatment program to a child who is at least 33 months old but who has not yet attended the first day of kindergarten.

~~(o)~~ (q) "Skills training" means individual, family, or group training designed to improve the basic functioning of the child with emotional disturbance and the child's family in the activities of daily living and community living, and to improve the social functioning of the child and the child's family in areas important to the child's maintaining or reestablishing residency in the community. Individual, family, and group skills training must:

(1) consist of activities designed to promote skill development of the child and the child's family in the use of age-appropriate daily living skills, interpersonal and family relationships, and leisure and recreational services;

(2) consist of activities that will assist the family's understanding of normal child development and to use parenting skills that will help the child with emotional disturbance achieve the goals outlined in the child's individual treatment plan; and

(3) promote family preservation and unification, promote the family's integration with the community, and reduce the use of unnecessary out-of-home placement or institutionalization of children with emotional disturbance.

Sec. 2. Minnesota Statutes 2004, section 256B.0943, subdivision 2, is amended to read:

Subd. 2. [COVERED SERVICE COMPONENTS OF CHILDREN'S THERAPEUTIC SERVICES AND SUPPORTS.] (a) Subject to federal approval, medical assistance covers medically necessary children's therapeutic services and supports as defined in this section that an eligible provider entity under subdivisions 4 and 5 provides to a client eligible under subdivision 3.

(b) The service components of children's therapeutic services and supports are:

(1) individual, family, and group psychotherapy;

(2) individual, family, or group skills training provided

by a mental health professional or mental health practitioner;

(3) crisis assistance;

(4) mental health behavioral aide services; ~~and~~

(5) direction of a mental health behavioral aide;

(6) care coordination services; and

(7) family psychoeducation services.

(c) Service components may be combined to constitute therapeutic programs, including day treatment programs and preschool programs. Although day treatment and preschool programs have specific client and provider eligibility requirements, medical assistance only pays for the service components listed in paragraph (b).

Sec. 3. [FEDERAL APPROVAL; EFFECTIVE DATE.]

If federal approval is required, the commissioner shall apply for federal approval, and sections 1 and 2 are effective upon federal approval. If federal approval is not necessary, sections 1 and 2 are effective July 1, 2006.

Senate Counsel, Research, and Fiscal Analysis

G-17 STATE CAPITOL
75 REV. DR. MARTIN LUTHER KING, JR. BLVD.
ST. PAUL, MN 55155-1606
(651) 296-4791
FAX: (651) 296-7747
JO ANNE ZOFF SELLNER
DIRECTOR

Senate

State of Minnesota

S.F. No. 1818 - Children's Therapeutic Services (The First Engrossment)

Author: Senator Linda Berglin

Prepared by: Joan White, Senate Counsel (651/296-3814)

Date: April 13, 2005

S.F. No. 1818 amends the section of law related to children's therapeutic services by defining the terms "care coordination" and "family psychoeducation services." The bill includes these services as a covered service component under the children's therapeutic services program.

The bill become effective upon federal approval, if necessary, or on July 1, 2006, if federal approval is not necessary.

JW:rdr

Fiscal Note Request Worksheet

Bill #: SF1818-1E | Title: Children's Therapeutic Services & Support

Companion #: HF2282 | Author: Berglin | Agency: Human Services

Urgent: | Due Date: 4/13/05 | Committee: Senate Finance: HHS Budget Division

Consolidated: | Lead Agency: | Contact Person: Don Allen – 651.297.5298

What version of the bill are you working on? First Engrossment
(Changing the version of the bill will automatically create a new fiscal note request.)

(The following four fiscal impact questions must be answered before an agency can sign off on a fiscal note.)

Fiscal Impact	Yes	No
State (Does this bill have a fiscal impact to your Agency?)	X	
Local (Does this bill have a fiscal impact to a Local Gov Body?)		X
Fee/Dept Earnings (Does this bill impact a Fee or Dept Earning?)		X
Tax Revenue (Does this bill impact Tax Revenues?)		X

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
General Fund		8,448	9,370	9,647	9,666
Fund					
Fund					
Less Agency Can Absorb					
General Fund		5			
Fund					
Fund					
Net Expenditures		8,443	9,370	9,647	9,666
General Fund					
Fund					
Fund					
Revenues					
Fund					
Fund					
Fund					
Net Cost <Savings>		8,443	9,370	9,647	9,666
General Fund					
Fund					
Fund					
Total Cost <Savings> to the State		8,443	9,370	9,647	9,666

	FY05	FY06	FY07	FY08	FY09
Full-Time Equivalents					
Fund					
Fund					
Fund					
Total FTE					

Bill Description

The bill expands the Children's Therapeutic Services and Supports (CTSS) benefit under the Medical Assistance program to allow reimbursement to enrolled providers for care coordination and family psycho education services.

The language in the first engrossment differs from that in the original bill in that the bill no longer refers to mental health case management and instead defines a new care coordination benefit. This avoids the previous confusion with the existing mental health case management benefit under MS § 256B.0625, Subd. 20.

However, the activities defined as care coordination closely mirror those of mental health case managers, so the federal issues related to the potential for duplication of services among and within a provider remain. Since CTSS providers can potentially provide and bill for case management services simultaneously with counties and county contracted vendors, and may also be a county contracted case management vendor, there is potential for duplication of services and payment – something that may make federal approval difficult to obtain without adding measures to limit the potential for duplication.

Assumptions

Since no language exist to limit care coordination claims which may duplicate mental health case management claims, no discount is made to reflect one.

Expenditure and/or Revenue Formula

The expenditure calculation projects CTSS client caseloads and multiplies this by the anticipated cost of care coordination and family psycho education services projected to be provided by CTSS providers. Since CTSS providers are generally non-profit organizations with lower overhead costs than counties, and because the care coordination activities are a subset of case management activities, the CTSS case management rate is estimated at 65% of the average county monthly rate. Family psycho education charges are estimated at $50 a month.

Background Information

1.	Number of children receiving children's mental health rehab option services in CY2004	4040			
		SFY06	SFY07	SFY08	SFY09
2.	Forecasted growth in children enrolled in MA relative to SFY04 enrollment	11.0%	23.1%	26.8%	27.0%
3.	Average monthly rate for county provided mental health case management services in CY2004	$ 406.00			
4.	Estimated average monthly rate for family psychoeducation services	$ 50.00			

Calculations

	SFY06	SFY07	SFY08	SFY09
Estimated number of children receiving CTSS services adjusted for forecasted enrollment	4483	4975	5122	5132
Estimated annual cost of care coordination services ($406*12*65%)	$ 14,196,764	$ 15,754,830	$ 16,220,350	$ 16,252,018
Estimated annual cost of family psycho education services.	$ 2,689,800	$ 2,985,000	$ 3,073,200	$ 3,079,200
Total estimated increase in CTSS claims	$ 16,886,564	$ 18,739,830	$ 19,293,550	$ 19,331,218
State share of estimated cost for CTSS care coordination and family psycho education services	$ 8,443,282	$ 9,369,915	$ 9,646,775	$ 9,665,609

Federal share of estimated cost for CTSS care coordination and family psycho education services	$ 8,443,282	$ 9,369,915	$ 9,646,775	$ 9,665,609

Administrative cost calculations

MMIS systems programming changes necessary to implement these changes are estimated at a total cost of $13,600 the state share of these costs would be 35% or $4,800. The Department would absorb these costs.

Long-Term Fiscal Considerations

Given that the non-federal share is state paid for these providers, counties are likely to shift case management responsibilities over to CTSS providers whenever possible, which would result in further increases in state costs.

Local Government Costs

See above – counties may be able to use CTSS provided case management as a means of avoiding the current local cost for case management services.

References/Sources

DHS MA claims for CTSS services
DHS February, 2005 forecast for the Medical Assistance

I have reviewed the content of this fiscal note and believe it is a reasonable estimate of the expenditures and revenues associated with this proposed legislation.

Fiscal Note Coordinator Signature: _____ Date: _____

ATTACHMENT "B"

Senator ..... moves to amend S.F. No. 1818 as follows:

Delete everything after the enacting clause and insert:

"Section 1. Minnesota Statutes 2004, section 245.4871, subdivision 4, is amended to read:

Subd. 4. [CASE MANAGEMENT SERVICE PROVIDER.] (a) "Case management service provider" means a case manager or case manager associate employed by the county or other entity authorized by the county board to provide case management services specified in subdivision 3 for the child with severe emotional disturbance and the child's family. The county shall contract with providers of children's therapeutic services and supports no later than January 2006 and within 60 days of certification of new providers to provide case management services for the children residing in that county who are receiving children's therapeutic services and supports.

(b) A case manager must:

(1) have experience and training in working with children;

(2) have at least a bachelor's degree in one of the behavioral sciences or a related field including, but not limited to, social work, psychology, or nursing from an accredited college or university or meet the requirements of paragraph (d);

(3) have experience and training in identifying and assessing a wide range of children's needs;

(4) be knowledgeable about local community resources and how to use those resources for the benefit of children and their families; and

(5) meet the supervision and continuing education requirements of paragraphs (e), (f), and (g), as applicable.

(c) A case manager may be a member of any professional discipline that is part of the local system of care for children established by the county board.

(d) A case manager without a bachelor's degree must meet one of the requirements in clauses (1) to (3):

(1) have three or four years of experience as a case manager associate;

(2) be a registered nurse without a bachelor's degree who has a combination of specialized training in psychiatry and work experience consisting of community interaction and involvement or community discharge planning in a mental health setting totaling three years; or

(3) be a person who qualified as a case manager under the 1998 Department of Human Services waiver provision and meets the continuing education, supervision, and mentoring requirements in this section.

(e) A case manager with at least 2,000 hours of supervised experience in the delivery of mental health services to children must receive regular ongoing supervision and clinical supervision totaling 38 hours per year, of which at least one hour per month must be clinical supervision regarding individual service delivery with a case management supervisor. The other 26 hours of supervision may be provided by a case manager with two years of experience. Group supervision may not constitute more than one-half of the required supervision hours.

(f) A case manager without 2,000 hours of supervised experience in the delivery of mental health services to children with emotional disturbance must:

(1) begin 40 hours of training approved by the commissioner of human services in case management skills and in the characteristics and needs of children with severe emotional disturbance before beginning to provide case management services; and

(2) receive clinical supervision regarding individual service delivery from a mental health professional at least one hour each week until the requirement of 2,000 hours of experience is met.

(g) A case manager who is not licensed, registered, or certified by a health-related licensing board must receive 30 hours of continuing education and training in severe emotional disturbance and mental health services every two years.

(h) Clinical supervision must be documented in the child's record. When the case manager is not a mental health

professional, the county board must provide or contract for needed clinical supervision.

(i) The county board must ensure that the case manager has the freedom to access and coordinate the services within the local system of care that are needed by the child.

(j) A case manager associate (CMA) must:

(1) work under the direction of a case manager or case management supervisor;

(2) be at least 21 years of age;

(3) have at least a high school diploma or its equivalent; and

(4) meet one of the following criteria:

(i) have an associate of arts degree in one of the behavioral sciences or human services;

(ii) be a registered nurse without a bachelor's degree;

(iii) have three years of life experience as a primary caregiver to a child with serious emotional disturbance as defined in section 245.4871, subdivision 6, within the previous ten years;

(iv) have 6,000 hours work experience as a nondegreed state hospital technician; or

(v) be a mental health practitioner as defined in subdivision 26, clause (2).

Individuals meeting one of the criteria in items (i) to (iv) may qualify as a case manager after four years of supervised work experience as a case manager associate. Individuals meeting the criteria in item (v) may qualify as a case manager after three years of supervised experience as a case manager associate.

(k) Case manager associates must meet the following supervision, mentoring, and continuing education requirements;

(1) have 40 hours of preservice training described under paragraph (f), clause (1);

(2) receive at least 40 hours of continuing education in severe emotional disturbance and mental health service annually; and

(3) receive at least five hours of mentoring per week from a case management mentor. A "case management mentor" means a qualified, practicing case manager or case management supervisor who teaches or advises and provides intensive training and clinical supervision to one or more case manager associates. Mentoring may occur while providing direct services to consumers in the office or in the field and may be provided to individuals or groups of case manager associates. At least two mentoring hours per week must be individual and face-to-face.

(l) A case management supervisor must meet the criteria for a mental health professional as specified in section 245.4871, subdivision 27.

(m) An immigrant who does not have the qualifications specified in this subdivision may provide case management services to child immigrants with severe emotional disturbance of the same ethnic group as the immigrant if the person:

(1) is currently enrolled in and is actively pursuing credits toward the completion of a bachelor's degree in one of the behavioral sciences or related fields at an accredited college or university;

(2) completes 40 hours of training as specified in this subdivision; and

(3) receives clinical supervision at least once a week until the requirements of obtaining a bachelor's degree and 2,000 hours of supervised experience are met."

Amend the title accordingly