Dakota COUNTY

2006 Capital Bonding Request

Affordable Assisted Living Development

Name of Local Government	:	Dakota County
Project Title	:	Affordable Assisted Living Development
Project Location	:	Dakota County. (location to be determined).
Total Project Cost	:	$ 6,200,000
Request for State Funds, 2006	:	$ 3,100,000
Non-State Funds Available or to be Contributed	:	$ 3,100,000
Previous State Appropriations	:	None.

Project Description and Rationale : The combination of housing and personal care services associated with assisted living developments can be costly and unattainable for extremely low and low-income seniors. The proposed affordable assisted living development project will combine the advantages of assisted living services, with the affordability of Dakota County Community Development Agency (CDA) housing.

The overall size of the proposed building will be between 36,000 and 45,000 square feet, with 45-50 living units. Typical living units will be efficiency or small one-bedroom style apartments. In addition to affordable rents, the development will offer traditional assisted living services, such as meals, housekeeping, security, transportation, and assistance with activities of daily living (e.g., dressing, bathing, and eating).

The CDA will be responsible for the housing aspect of the development and will lend its expertise as a housing provider to the construction, lease up, and ongoing management of the development. Assisted living services at the development will be contracted by the CDA, through an experienced service provider.

Owner and Operator : Dakota County Community Development Agency

Project Costs, by Category :

Category	Projected Costs
Construction Costs	$5,115,000
Construction Contingency	$ 155,000
Subtotal, Construction	**$5,270,000**
Development Cost	$ 6,000
Title Costs	$ 1,500
Survey/Plat	$ 8,000
SAC/WAC	$ 95,000
City Fees	$ 3,500
Supplies/Equipment/Furniture	$ 100,000
Subtotal, Other Costs/Allowances	**$ 214,000**
Soil/Enviornmental/Engineering	$ 10,000
Architect Fees	$ 180,000
Developer Fee	$ 564,900
Subtotal, Engineering and Testing	**$ 754,900**
Total	**$6,238,900**

Project Schedule : Designed and constructed in 2006 and 2007.

State Operating Costs : None.

Project Predesign Submitted : No.

Senior Housing Development Program

Dakota County Community Development Agency

The Dakota County CDA began developing affordable senior housing in 1989. Since then, 19 developments have been completed providing 1,079 affordable one and two bedroom rental apartments for seniors age 55 and up. A 20th building is currently being planned for South St. Paul.

In order to finance these developments, the CDA issues tax exempt bonds credit enhanced with a general obligation pledge from Dakota County. Proceeds from the sale of the bonds pays for construction costs. Revenue from rents and the CDA's property tax levy is pooled to pay expenses and debt service for all of the buildings.

Each building is beautifully decorated and is equipped with amenities such as a community room with kitchen, sitting areas, library area, laundry facilities, emergency call systems and underground heated parking.

Income Limits

1 person household - $40,600
2 person household - $46,400

Rents

Rents at most of the CDA's senior buildings are based on 30% of annual income for a one-bedroom unit and 32% of annual income for a two-bedroom unit. The minimum and maximum rent for a one-bedroom is $320-$600 and $475-$755 for a two-bedroom unit.

O'Leary Manor and Lakeside Pointe in Eagan have set rents of $495 for a one-bedroom and $605 for a two-bedroom.

Heat, water, sewer and trash are included with the rent. Residents are responsible for electricity. Optional underground heated parking spaces are available for an additional $45 per month.

The Dakotah, West St. Paul

Cortland Square, Apple Valley

Cahill Commons, Inver Grove Heights

Lakeside Pointe, Eagan

Senators Metzen, Belanger and Pariseau introduced--
S.F. No. 2332: Referred to the Committee on Finance.

A bill for an act

relating to capital improvements; authorizing the issuance of state bonds; appropriating money for construction of affordable assisted living housing in Dakota County.

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

Section 1. [APPROPRIATION.]

$3,100,000 is appropriated from the bond proceeds fund to the commissioner of economic development for a grant to Dakota County to design, construct, furnish, and equip affordable assisted living housing in Dakota County.

Sec. 2. [BOND SALE.]

To provide the money appropriated in this act from the bond proceeds fund, the commissioner of finance shall sell and issue bonds of the state in an amount up to $3,100,000 in the manner, upon the terms, and with the effect prescribed by Minnesota Statutes, sections 16A.631 to 16A.675, and by the Minnesota Constitution, article XI, sections 4 to 7.

Sec. 3. [EFFECTIVE DATE.]

Sections 1 and 2 are effective the day following final enactment.

ATTACHMENT "A"

DIVISION PRIORITIES				
Project Ranking (1 thru 18)	Project Title	Agency Priority	2006 Request Agency ($ in thousands)	2006 Request Governor ($ in thousands)
	DEPARTMENT OF HUMAN SERVICES			
	MSOP Expansion – Phase One	1	$44,580	$44,580
	MSOP Expansion – Design Phase Two	2	3,200	3,200
	System-Wide Campus Redevelopment/Reuse/Demo	3	7,000	7,000
	St. Peter – Construct New Program Bldg.	4	2,500	2,500
	System-Wide Campus Security/Safety Improvements	5	2,500	2,500
	System-Wide Roof Repair/Replacement	6	1,500	1,500
	System-Wide Asset Preservation	7	4,000	4,000
	Project Total		**$65,280**	**$65,280**
	HUMAN SERVICES NON-DEPARTMENT			
	Dakota County Assisted Living Facility (SF2332) ($3,100,000)			
	VETERANS NURSING HOMES BOARD			
	Asset Preservation	1	$10,005	$6,000
	Minneapolis Emergency Power	2	2,457	2,457
	Minneapolis Adult Day Care	3	2,261	-0-
	Silver Bay Master Plan Renovation	4	4,851	-0-
	Luverne Dementia Unit/Wander Area	5	599	599
	Minneapolis Dining/Kitchen Renovation	6	5,331	5,331
	Fergus Falls Special Care Unit	7	7,699	637
	Minneapolis Phase 2 – Assisted Living	8	20,104	-0-
	Hastings Supportive Housing	9	6,953	-0-
	Minneapolis Phase 3 – Skilled Nursing Development	10	175	-0-
	Project Total		**$60,435**	**$15,024**

Veterans Homes Board

Project Funding Summary
($ in Thousands)

Project Title	Agency Priority	Funding Source	Agency Request 2006	Agency Request 2008	Agency Request 2010	Governor's Rec 2006	Governor's Planning Estimates 2008	Governor's Planning Estimates 2010
Asset Preservation	1	GO	$10,005	$6,000	$6,001	$6,000	$6,000	$6,000
Minneapolis Emergency Power	2	GO	2,457	0	0	2,457	0	0
Minneapolis Adult Day Care	3	GO	2,261	0	0	0	0	0
Silver Bay Master Plan Renovation	4	GO	4,851	0	0	0	0	0
Luverne Dementia Unit/Wander Area	5	GO	599	0	0	599	0	0
Minneapolis Dining/Kitchen Renovation	6	GO	5,331	0	0	5,331	0	0
Fergus Falls Special Care Unit	7	GO	7,699	0	0	637	7,062	0
Minneapolis Phase 2 - Assisted Living	8	GO	20,104	0	0	0	0	0
Hastings Supportive Housing	9	GO	6,953	0	0	0	0	0
Minneapolis Phase 3 - Skilled Nursing Development	10	GO	175	16,765	0	0	0	0
Project Total			$60,435	$22,765	$6,001	$15,024	$13,062	$6,000
General Obligation Bonding (GO)			$60,435	$22,765	$6,001	$15,024	$13,062	$6,000

Funding Sources:			
	GF = General Fund	THF = Trunk Highway Fund	OTH = Other Funding Sources
	GO = General Obligation Bonds	THB = Trunk Highway Fund Bonding	UF = User Financed Bonding

Human Services, Department of

Project Funding Summary

($ in Thousands)

Project Title	Agency Priority	Funding Source	Agency Request 2006	Agency Request 2008	Agency Request 2010	Governor's Rec 2006	Governor's Planning Estimates 2008	Governor's Planning Estimates 2010
MSOP Expansion - Phase One	1	GO	$44,580	$0	$0	$44,580	$0	$0
MSOP Expansion - Design Phase Two	2	GO	3,200	47,500	0	3,200	47,500	0
System-Wide Campus Redevelopment/Reuse/Demo	3	GO	7,000	4,000	0	7,000	4,000	0
St. Peter - Construct New Program Building	4	GO	2,500	0	0	2,500	0	0
System-Wide - Campus Security/Safety Improvements	5	GO	2,500	2,500	0	2,500	2,500	0
System-Wide Roof Repair/Replacement	6	GO	1,500	3,150	2,000	1,500	1,500	1,500
System-Wide Asset Preservation	7	GO	4,000	4,000	4,000	4,000	4,000	4,000
Project Total			$65,280	$61,150	$6,000	$65,280	$59,500	$5,500
General Obligation Bonding (GO)			$65,280	$61,150	$6,000	$65,280	$59,500	$5,500

Funding Sources:			
	GF = General Fund	THF = Trunk Highway Fund	OTH = Other Funding Sources
	GO = General Obligation Bonds	THB = Trunk Highway Fund Bonding	UF = User Financed Bonding

Agency Profile At A Glance

Health care programs
- Almost 670,000 people served in FY 2005
- Medical Assistance – 483,000 people
- MinnesotaCare – 142,000 people
- General Assistance Medical Care – 37,000 people
- Prescription Drug Program – 7,800 people

Economic assistance programs
- Food Support – 251,000 people in FY 2005
- Minnesota Family Investment Program (MFIP) – 40,000 families in FY 2005
- General Assistance – 13,700 people in FY 2005
- Child Support Enforcement – 250,000 cases in FY 2005
- Child support collections – $596 million in child support payments in FY 2005
- MFIP Child Care Program and Basic Sliding Fee Program – 16,900 families in FY 2005

Child welfare services
- 10,300 children received care from foster families in calendar year 2004
- Almost 8,300 children were cared for by adoptive parents or relatives who receive financial assistance (Relative Custody Assistance and Adoption Assistance) for children's special needs in calendar year 2005
- 643 children under state guardianship were adopted in calendar year 2005

Mental health services
- 106,350 adults received publicly funded mental health services in 2004.
- 41,210 children received publicly funded mental health services in 2004.

Operations and two-year state budget
- FY 2006-07 $8.1 billion general fund budget
- FY 2006-07 $17.8 billion all funds budget
- 87% of DHS' general fund budget is spent on health care and long-term care programs and related services
- 44,180 health care providers
- 46 million health encounters and claims processed
- Approximately 97% of DHS' budget goes toward program expenditures
- Approximately 3% of DHS' budget is spent on central office administration

Agency Purpose

The Minnesota Department of Human Services (DHS) helps people meet their basic needs so they can live in dignity and achieve their highest potential.

Ensuring basic health care for low-income Minnesotans
- ⇒ Medical Assistance (MA), Minnesota's Medicaid program for low-income seniors, children and parents, and people with disabilities.
- ⇒ MinnesotaCare for residents who don't have access to affordable private health insurance and don't qualify for other programs.
- ⇒ General Assistance Medical Care (GAMC), primarily for adults without dependent children.
- ⇒ Prescription Drug Program helped low-income seniors and people with disabilities pay for prescription drugs; it was eliminated as of December 31, 2005, when Part D, the prescription drug program from Medicare went into effect.

Helping Minnesotans support their families

DHS works with counties, nonprofits, and Community Action Agencies to help low-income families with children achieve self-sufficiency through programs such as the Minnesota Family Investment Program (MFIP, the state's welfare reform initiative), child support enforcement, child care assistance, food support, and refugee cash assistance and employment services.

Aiding children and families in crisis
The department supports families to ensure that children in crisis receive the services they need quickly and close to home so they can lead safe, healthy, and productive lives. DHS guides statewide policy in child protection services, out-of-home care, and permanent homes for children.

Assisting people with disabilities
The department promotes independent living for people with disabilities by encouraging community-based services rather than institutional care. DHS sets statewide policy and standards for care, and provides funding for developmental disability services, mental health services, and chemical health services. The department also provides services for people who are deaf or hard-of-hearing through its regional offices in Bemidji, Duluth, Fergus Falls, St. Cloud, St. Paul, St. Peter, Rochester, and Virginia.

Direct care services
DHS provides an array of programs serving people with mental illness, developmental disabilities, chemical dependency, traumatic brain injury, and people who pose a risk to society. These services include psychiatric hospitals being developed throughout Minnesota; a mental health crisis center in Mankato; Minnesota State Operated Community Services, which provides day training, habitation, and residential services to people with disabilities; Community Support Services, which supports people with disabilities in the community and in crisis homes; and other services provided at regional treatment centers in Anoka, Brainerd, Fergus Falls, Moose Lake, St. Peter, and Willmar, and Ah-Gwah-Ching, the state nursing home in Walker. DHS also provides treatment for: people civilly committed as sexual psychopathic personalities and/or sexually dangerous persons in the Minnesota Sex Offender Program at Moose Lake and St. Peter; people committed as mentally ill and dangerous at the Minnesota Security Hospital in St. Peter; and people who are developmentally disabled and present a risk to society at the Minnesota Extended Treatment Options Program in Cambridge.

Promoting independent living for seniors
The department supports quality care and services for older Minnesotans so they can live as independently as possible. Quality assurance and fiscal accountability for the long-term care provided to low-income elderly people, including both home and community-based services and nursing home care, are key features.

Operations

DHS has a wide variety of customers and business partners, including the state's 87 counties, 44,180 health care providers, and more than one in four Minnesotans who are clients or enrollees in DHS programs. DHS provides significant operational infrastructure to Minnesota's human services programs, most of which are provided at the county level.

DHS licenses about 27,000 service providers, including group homes, treatment programs for people with chemical dependency, mental illness, or developmental disabilities, child care providers, and foster care providers. DHS also monitors their compliance with Minnesota laws and rules, investigates reports of possible maltreatment, and completes background studies on individuals who provide direct care.

DHS' operations also support other providers who directly serve Minnesotans. DHS oversees significant computer systems support for: MAXIS, which determines eligibility for economic assistance programs; PRISM, the child support enforcement system; the Medicaid Management Information System (MMIS), which pays medical claims for publicly funded health care programs; the Social Service Information System (SSIS), an automated child welfare case management system for child protection, children's mental health, and out-of-home placement; and MEC^2, the Minnesota Electronic Child Care system.

Budget

DHS is one of the state's largest agencies, comprising 34.5% of the state's total spending from all sources. The department's FY 2006-07 budget from all funding sources totals $17.8 billion. Of the total budget for the biennium, $8.1 billion comes from general fund tax dollars. The remaining $9.7 billion comes from federal revenue and other funds, such as the health care access fund, enterprise fund and agency fund. Department staff includes approximately 6,000 full-time equivalent employees.

Contact

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For information on how this agency measures whether it is meeting its statewide goals, please refer to http://www.departmentresults.state.mn.us.

At A Glance: Agency Long-Range Strategic Goals

Minnesota Department of Human Services (DHS)

- Help people meet their basic needs, live as independently as possible and achieve their highest potential;
- Ensure basic health care for low-income Minnesotans;
- Help support Minnesota families;
- Aid children and families in crisis;
- Promote independent living for seniors; and
- Assist people with disabilities

State Operated Services (SOS)

- Provide direct care safety net services for people with disabilities whose needs can not be met in other ways;
- Reduce the state's cost of caring for persons with serious and persistent mental illness (SPMI);
- Continue the transition of State Operated Services for mentally ill from the regional treatment centers to community-based services;
- Reduce/eliminate the large amount of non-functional surplus space throughout the Regional Treatment Center (RTC) system; and
- Continue to address critical repair, replacement, and renewal needs specific to the physical plants of each RTC

Trends, Policies and Other Issues Affecting the Demand for Services, Facilities, or Capital Programs

State Operated Services

Since its peak in 1960, when state operated residential facilities served an average daily population of 16,355 persons, RTC population levels have steadily declined as part of a deliberate state strategy to integrate persons with disabilities into their home communities where it is beneficial and appropriate to do so. The present licensed capacity of the RTC system is approximately 3,000 beds and the RTCs collectively serve an average daily population of approximately 1,770 persons on their campuses.

This downsizing trend is a result of advances in the treatment of persons with disabilities, coupled with a recognition that all individuals can participate at some level in the activities of daily life in community settings. With increased emphasis on creative and flexible client services in the community, the need for institutional based services will continue to decline. The definition of the state's "safety net" for vulnerable populations is evolving. More and more this "safety net" function emphasizes outreach, training for community providers, and crisis intervention in the community instead of the historic practice of removing the client from their home or community and placing them in RTC campus based programs.

Mental Illness (MI)

Mental Illness programs are currently operated at Anoka, Brainerd, Fergus Falls, St. Peter, and Willmar RTCs, as well as several community-based services in Duluth and Eveleth. During the spring and summer months of 2006, SOS will open 9 new 16-bed state-operated, community-based behavioral health hospitals across the state. These units will be located in Bemidji, Wadena, the Baxter/Brainerd area, Alexandria, Fergus Falls, Annandale, St. Peter, Rochester, and the St. Cloud/Sartell area.

The RTC adult MI average daily population was 385 in November 2005. Since 1984, RTC annual admissions and discharges have increased dramatically, but average daily population has slowly declined due to significant reductions in the average length of stay. In the past patients often spent a year or more in treatment; however, today the average length of stay at an RTC is less than 60 days. This decline is directly attributable to the development of new psychotropic medications that have been successful in controlling the symptoms of MI and expanded community-based services.

In 1995, the department began establishing creative partnerships between the RTCs and the local mental health authorities in the regions served by the RTC. The purpose behind this effort was to build upon and strengthen the existing community mental health system and utilize state staff and resources to support patients after they are discharged from the hospital in order to help clients handle crises in the community and avoid reentering the hospital. Implementation of these efforts continues and is considered a valuable part of the transition of state-operated adult mental health services to community-based operations.

Governor Pawlenty's 2006-07 budget proposal built on these types of reforms by fostering a broad array of community-based mental health services. This budget proposal began to address concerns that 20% to 30% of people in inpatient psychiatric settings and 30% of those in residential treatment facilities could be better served in alternative settings. It also explores the need for a range of permanent housing options for people who have a mental illness.

Forensic Programs

Minnesota Security Hospital (MSH)
Located on the St. Peter campus, the MSH provides 250 secure treatment and evaluation beds, is JCAHO (Joint Commission on Accreditation of Healthcare Organizations) accredited and provides competency and criminal responsibility assessments. The program serves mentally ill and dangerous patients (MI&D) and provides rehabilitation in a secure environment. MSH admits emergency transfers from other state operated sites and also operates a treatment to competency program.

Transition Services
The transition program is also located on the St. Peter campus. It currently has a capacity of 58 non-secure beds. This program is JCAHO accredited and operates under DHS Rule 36 licensure as a supervised living facility. The transition program serves MI&D patients who have completed the Minnesota Security Hospital program and are ready for a less secure environment. The program focuses on psychosocial rehabilitation, skill enhancement, and community skills development, and collaborates with community resources for patients' successful transition and community reintegration.

Community Preparation Services
Specialized inpatient and outpatient services operated outside a secure environment but administered by a secure treatment facility on the St. Peter campus. The program utilizes a portable continuum of monitoring for patients who qualify for campus liberty or a reduction in custody. The goal is to allow patients to progress in their treatment with increased liberty while best assuring public safety.

Minnesota Sex Offender Program (MSOP)
The MSOP provides services to patients committed as sexual psychopathic personalities (SPP) or sexually dangerous persons (SDP). It operates as one program on two campuses, St. Peter and Moose Lake. The MSOP program provides evaluation and treatment programs in secure facilities.

Special Needs Service
This specialized program operates 60 secure beds on the St. Peter campus. It serves low-functioning, cognitively impaired individuals with sexually dangerous behavior and utilizes a psychosocial rehabilitation model emphasizing relapse prevention.

Minnesota Extended Treatment Options (METO)
The METO program has a capacity of 48 beds for individuals with developmental disabilities who present a public safety risk and/or who have involvement with the criminal justice system. METO is located on the old regional treatment center in Cambridge.

MSOP Capacity Issues
Over the last several years the Department of Human Services has been required to revise plans for developing new secure capacity for the MSOP several times. These change in plans have been implemented to address the escalating increase in "annual net growth" to the forensic programs.

In the fall of 2000 net growth of the MSOP was projected to range between 18 and 24 patients per year. By 2002, the projected net growth for SPP/SDP commitments was actually reduced to a rate of 15 to 18 per year, and it appeared that the Department's 2000 capital plan for MSOP expansion would provide adequate bed capacity through 2006.

In the late fall of 2003, the Department of Corrections (DOC) changed its policies associated with the referral to civil commitment of level-three sex offenders upon completion of their sentences. This new approach for referral by DOC was initially projected to increase civil commitments to the Department's MSOP to 36 per year, which would require the program to open a new 25-bed unit every eight months.

This dramatic increase to the forensic population necessitated the Department revise its earlier plans for developing/maintaining adequate capacity for the forensic division's programs, and the 2004 Six-Year Plan included funds to design and construct new bed capacity for the MSOP at the St. Peter campus.

The revised 2004-05 plan for maintaining capacity in the sex offender treatment program was to implement the construction of new facilities before the remodeling in Shantz Hall, and to use Shantz to maintain the needed bed capacity until the new facilities were completed in 2008. The construction of the new facilities was hoped to provide adequate time to complete the Shantz remodeling project before the new beds are filled. Completion of the 2004-05 revised plan for the St. Peter campus would have provided a total program bed capacity of 550 beds, which at that time, was anticipated to meet program space requirements until March 2013.

In late spring 2005, it became apparent that the earlier projections for MSOP growth were being greatly exceeded. By mid June, the annual net growth to the MSOP had escalated to a projected 80 sex offenders per year. The new projections indicate that the MSOP population will reach the 550 level by January 2008.

This unprecedented growth has once again necessitated the Department to make major revisions to its Capital Budget Six-Year Plan to ensure that adequate bed capacity is maintained to accommodate the continuing increase in annual referrals/commitments to the Department's MSOP and MSH programs.

Change in Plans for Developing Additional Capacity

The DHS 2006 Capital Budget Plan still requests funds to construct new MSOP facilities; however, a review of DHS' *2006 Project Funding Summary* illustrates that DHS has modified its request for 2006 by locating the new facilities on the Moose Lake MSOP campus. It also includes additional projects focused on addressing the bed capacity and program space needs for the expanding forensic populations. These additional proposals include funding requests to: design further expansion for the sex offender program on the Moose Lake campus in 2006 and to implement construction of this additional program capacity in 2008; implement system-wide security upgrades and improvements on the Department's campuses; and, design and construct a program building on the St. Peter campus to address programming demands associated with the increasing MI&D population served by the MSH.

This revised six-year plan is designed to address the program capacity problem that the MSOP is experiencing. This future work will focus on the continued development of additional capacity for the MSOP and upgrading/improving existing space on the lower campus of the St. Peter RTC for utilization of the various programs operated by the MSH.

Immediate Needs for Additional Bed Capacity

To address the immediate capacity problem for MSOP beds, DHS and DOC are implementing a plan to utilize several buildings on the existing Minnesota Correctional Facility (MCF) – Moose Lake as temporary facilities for the MSOP. This plan provides a short term solution for addressing the serious bed capacity problem that the MSOP program faces until the proposed new facilities for the program are completed and ready for occupancy. It also expands program capacity (staffing) for the MSOP at a site that is adjacent to the department's primary MSOP facility (*Please note that the option to use MCF beds at Moose Lake is only possible because of the recent slow-down in DOC's inmate population expansion. These beds will not be available for the long term).*

The initial problem associated with the plan to use temporary beds at MCF – Moose Lake was the idea of developing a large number of new staff in an area different from our 2005 sex offender program facilities development plan (constructing new MSOP facilities on the St. Peter campus). The costs and problems associated with hiring and training new staff for the temporary facilities at the MFC – Moose Lake, and then asking these staff to relocate to St. Peter to work in the new facilities appeared to be unmanageable. It therefore became evident that because of the significant increase in annual admissions the Department was experiencing, the 2005 plan to construct the first phase of the MSOP expansion at St. Peter would have to be modified, and the expansion of new facilities for MSOP would need to be redirected to Moose Lake.

This revised plan will: allow the Department to develop the necessary temporary beds on the MCF – Moose Lake campus; construct the new MSOP facilities in the community within which the new staff resources will be

developed; facilitate an easy transition from the temporary facilities to the new facilities without incurring significant costs for such line items as staff relocation, and without causing disruption to the families of the approximately 300 staff that will be hired for the temporary facilities being developed at MCF – Moose Lake.

In addition, the Department conducted a preliminary analysis of potential building and operations models for MSOP residential facilities. It has been determined that utilizing the residential K building model that has been established by the DOC, with some modifications particular to DHS licensing requirements, will allow DHS to construct more secure space for less dollars. This new residential model (referred to as the modified K model) will provide enhanced security features while reducing operational costs associated with the security staff levels currently used for the existing 25-bed model.

The modified K model will also yield significantly more beds within the costs proposed for the originally 150 bed facility proposed in 2005. The cost of the 150 bed proposal was projected on utilization of the Moose Lake 25-bed residential model. The preliminary estimate on operational efficiency for the five-wing model proposal indicates that there will be substantial savings in salaries when compared with the use of the 25-bed model currently utilized by the MSOP.

Developmental Disabilities (DD)
In 1960, the RTCs provided residential care for 6,008 individuals with mental retardation and other developmental disabilities. By the end of FY 1997, this number had declined to 244. In June 2000, DHS completed the transition to community placements for the remaining population. This downsizing of campus-based DD programs has been accomplished in part through the development of state operated day training and habilitative (DT&H) programs and waiver services in community settings. "Safety net" services for persons with DD have been redefined to include community support service teams throughout Minnesota and the small METO program facility located on part of the old Cambridge RTC campus.

The METO program has a capacity of 48 beds for individuals who present a public safety risk and/or who have involvement with the criminal justice system. Construction of the first 36 beds was completed in the spring of 1998. Construction of 12 additional beds was completed in the fall of 2001. SOS has no plans to expand the program facilities at this time. However, the design of the METO residential units will allow for incremental bed development in modules of 6 or 12 should additional capacity be required in the future.

Chemical Dependency (CD)
Since January 1988, the RTC CD programs have operated as an enterprise operation and competed in the marketplace with other vendors for CD funding from the Consolidated Chemical Dependency Treatment Fund (CCDTF) and other third party sources. The average daily population as of August 2003 was 224. The state operated CD system has captured a defined market niche and the operations remain stable.

Nursing Homes (NH) / Long Term Care (LTC)
DHS involvement as a provider of NH services is currently limited to the Ah-Gwah-Ching Center (AGCC) near Walker. As the AGCC program continues its transition to community-based services, the facility's average daily population has steadily declined. In November 2005, the population of AGCC was down to 55. In January 2006, it is anticipated that AGCC will complete the transition of its non-forensic patients to community-based services. This will include the transfer of patients to community nursing homes, and as authorized by the 2005 Legislature, the transition of up to 20 patient to foster care homes in the Walker area.

The 2005 Legislature also authorized the development of a forensic skilled nursing home on the St. Peter campus. Planning for this facility began in the fall of 2005 with substantial completion scheduled for the summer/fall of 2007. Upon completion of this new secure forensic facility, the forensic nursing home patients at AGCC will be transferred to the secure nursing facility at St. Peter and the AGCC nursing home program will be closed.

Other Forces Impacting Capital Planning
As community-based services for mental health continue to develop, more buildings will become unoccupied on the RTC campuses. As the resident tenant of state property, the responsibility to maintain vacant and unused buildings and grounds falls to the RTC system. The costs of these maintenance efforts are consuming a greater proportion of the funding allocated to the state operated system. Accordingly, DHS, in collaboration

with the Department of Administration, is taking steps to sell or demolish the surplus property and buildings.

Comprehensive Redevelopment Plans (Master Plans)
The 2003 Legislature authorized DHS to collaborate with local government entities to complete a comprehensive redevelopment plan (master plan) for the future use of the RTC campuses (grounds and vacant buildings) vacated as a result of further expansion of community-based care (Laws 2003, 1st Special Session, Chapter 14, Section 64, Subd. 2). The Department, in collaboration with the Department of Administration, and local units of government completed this process for Ah-Gwah-Ching, Fergus Falls, and Willmar in 2004.

DHS and Administration intend to complete the comprehensive master planning process for the Brainerd campus during the next 12 months. The Brainerd campus master planning will be coordinated by Crow Wing County. This time period coincides with the development of enhanced mental health services in the community, which will result in a significant decrease in total space utilization on the Brainerd campus.

The master plan process, done in collaboration with local units of government, is intended to generate viable reuse or redevelopment strategies for the old campus properties and buildings. To implement these master plans the Department anticipates the need for funds for infrastructure modification, building modifications, and demolition of structures that are determined to be non-functional for future utilization.

The 2005 Legislature appropriated approximately $8.9 million for the first phase of this request: $4 million for the Ah-Gwah-Ching campus; $1.9 million for the Willmar campus; and approximately $3 million for the Fergus Falls campus.

At the time this narrative was developed (fall 2005) final details for the transfer/sale of the Willmar campus were being worked out between the State, Kandiyohi County, and a private company from the Willmar area. The Department of Administration was also working closely with Cass County and the City of Fergus Falls for the respective campuses, with expectations that final disposition plans could be approved and ready for implementation by the summer of 2006.

Provide a Self-Assessment of the Condition, Suitability, and Functionality of Present Facilities, Capital Projects, or Assets
Over the last 25 years facilities have been constructed an/or remodeled for the MSH at St. Peter, the Anoka-Metro RTC, the METO program at Cambridge, and the MSOP at Moose Lake and St. Peter. With the exception of upgrading existing and the development of adequate new secure capacity to address the continuing growth of the sex offender population, projected improvements for these campuses over the next six years will focus on: replacing and upgrading antiquated and worn infrastructure with requests for asset preservation; improvements (including demolition) associated with the effective and efficient operation of the RTC system; and, the redevelopment/reuse of the surplus RTC campuses.

Long-Range Strategic Goals and Objectives of State Operated Services
Historically, one of the primary roles of SOS in the mental health system has been to provide inpatient care to persons with SPMI. This also happens to be one of the most expensive services in the mental health system, and to the extent that there is overcapacity in those programs, resources are not available for other important community mental health programs.

Another primary role of SOS, as required by various laws (M.S. 246B.02, 253B.18, and 253B.185), is to accept individuals who are committed by the court system as MI&D, SDP, or SPP into the Forensic Service Treatment programs located at St. Peter and Moose Lake at anytime.

The Department's first strategic objective is shift to an array of community-based MH services that provide appropriate levels of care closer to each patient's home. This strategy will provide better care to patients, increase federal participation in funding of care, and reduce use of less effective, more expensive RTC based services.

The second strategic objective focuses on the need to ensure that the state maintain an adequate bed capacity required to serve the increased number of persons being committed to the state's forensics programs. As previously mentioned, the projected increase in commitments to the sex offender treatment program will place significant demands on the system.

The third strategic objective focuses on the reduction/elimination of the large amount of non-functional, surplus space throughout the RTC system. In the

spring of 2001, DHS initiated a program to address this issue with the objective to convert surplus property to other ownership. In addition, funds were requested and appropriated during the 2002 legislative session to start the process of demolishing buildings that are determined to be non-functional and/or are considered to have exceeded their useful, designed life.

In 2005 SOS, in partnership with local communities, completed comprehensive redevelopment/reuse plans for the AGCC, FFRTC and WRTC campuses. In the fall of 2005 SOS and the Department of Administration, in conjunction with Crow Wing County and the City of Brainerd, began the process of developing a comprehensive redevelopment plan for the Brainerd Regional Human Services Center.

The 2005 Legislature authorized the disposition of the Ah-Gwah-Ching, Fergus Falls and Willmar campuses. In addition the 2005 Legislature appropriated funds for improvements to facilitate the redevelopment/disposition of these three campuses, including funds for demolition of deteriorated, unsafe, non-functional buildings.

The fourth strategic objective relates to asset preservation. This objective centers on the need to address critical repair, replacement, and renewal needs specific to the physical plants of RTCs. Extensive assessments of the facilities include the following: safety hazards, code compliance issues, and mechanical and structural deficiencies; major mechanical and electrical utility system repairs/replacements/improvements; abatement of asbestos containing materials; roof work and tuck pointing; and other building envelope work such as window replacement, elevator repairs/upgrades, and road and parking lot maintenance. Asset preservation projects included in this capital plan are consistent with the anticipated needs of the evolving state operated mental health service system.

Agency Process Used to Arrive at These Capital Requests

Each SOS program develops a well-defined, long-range operational program for its facility. These operational programs are updated biennially with the intent to outline and describe services to be provided, methods of delivering these services, and resources required for providing these services in the future. These operational programs must demonstrate a strategic link to the agency's system-wide strategic plan. Upon review and approval of each facility's operational strategic plan, the facilities initiate long-range capital planning. This process includes:

- a comprehensive facilities analysis and planning program;
- identification of viable alternatives for meeting future physical plant needs;
- identification of any surveys or studies (predesign) that may be required to assess viable alternatives;
- a long range space utilization plan; and
- a preliminary campus master plan.

After completion of this work each facility revises their long-range (six-year) physical plant project budgets. These six-year plans should outline all capital projects proposed for the facility and also identify all known physical plant deficiencies, scheduled maintenance, or proposed/required improvements. Each project is evaluated and listed in the appropriate budget category (R&R, R/R Special Projects, Asset Preservation, Capital Asset Preservation and Repair Account (CAPRA), or Capital). This information is then used to:

- establish potential costs associated with improving specific buildings or groups of buildings;
- determine the appropriateness of related or proposed expenditures;
- assess alternatives for meeting an individual facility's operational program; and
- develop recommendations for the agency's senior staff to review and consider for inclusion in the agency's Six-Year Capital Budget Plan.

The following six-year plan outlines an incremental plan for improving and upgrading the physical plant resources required to support future operational programs at the SOS facilities in accordance with the strategic goals and objectives outlined in preceding sections of this Strategic Planning Summary document.

Major Capital Projects Authorized in 2002, 2003 and 2005 ($000's)

Laws of Minnesota, 2002, Chapter 393, Section 22		**$ 16,533**
State-Wide	Roof Renovation and Repair	$ 2,789
State-Wide	Asset Preservation	$ 4,000
State-Wide	Demolition	$ 2,750
Fergus Falls RTC	Facilitate relocation of programs from The Kirkbride Building	$ 3,000
St. Peter RTC	Convert Steam System to Low Pressure	$ 3,619
Laws of Minnesota, 2005 Chapter 20 Section 20		**$ 26,073**
Forensic Programs - Design New Facilities		$ 3,259
System-wide Redevelopment, Reuse & Demolition		$ 17,600
Forensic Nursing Home (St. Peter)		$ 8,600
AGC Site Develop/Prep/Demo		$ 4,000
WRTC Meth Renovation/Demo		$ 1,000
Fergus Falls Incinerator Debt Retirement		$ 2,210
Fergus Falls Incinerator Demolition		$ 400
Grant Conditions Incinerator		N/A
WRTC Demo, Predesign, Remodel, etc.		$ 900
System-Wide Roof Renovation/Replacement		$ 1,014
System-Wide Asset Preservation		$ 3,000
Grave Markers at RTCs		$ 300
Amendment to 2002 Capital Approp. for FFRTC		$ 3,000

2006 STATE APPROPRIATION REQUEST: $44,580,000

AGENCY PROJECT PRIORITY: 1 of 7

PROJECT LOCATION: Minnesota Sex Offender Program - Moose Lake

Project At A Glance

- Design, construct, furnish, and equip additional residential, program and ancillary service capacity for the Moose Lake Sex Offender Treatment Program facilities;
- Provide needed secure bed capacity to address the escalating rate of referrals/commitments to the Forensic programs; and
- Implement construction of the first phase of a multiple phase facility expansion at Moose Lake.

Project Description

This is the first phase of a two phase project to expand program capacity for the Minnesota Sex Offender Program (MSOP) outlined in the Department's 2006 – 2011 Capital Budget Plan.

The first phase of the project is for funding to construct, furnish, and equip additional residential, program, and ancillary service facilities for the MSOP at the Moose Lake program site. Design funds for expanding capacity for the sex offender treatment program were approved by the legislature during the 2005 Session.

With this request, the Department plans to develop sufficient new secure treatment space to accommodate 400 additional new patients at the MSOP facility in Moose Lake. The new facilities will have a total of approximately 159,000 gross square feet. With approximately 103,000 square feet (SF). for housing units, 31,666 sq. ft. for new program space, and 24,761 SF. of additional general support space.

The estimated construction cost of the proposed "modified K building" is $20.1 million, and the estimated construction cost for the proposed program and general support spaces totals approximately $9.33 million. Design fees, infrastructure/roads/utilities, artwork, site/grading, furniture, fixtures, and equipment (FF&E), security/telecom, project management, project contingency and inflation costs total $15,180.

The scope of this request (phase one) includes construction of secure residential facilities (bedrooms, toileting and bathing, dining and day space areas); program space (treatment, work activity, group rooms, recreation, visitation, medial treatment, etc.); and ancillary space (mechanical and electrical, power plant, storage space, controls centers, program administration, etc.) In addition, this project will also require exterior/interior security systems (including fencing, electronic surveillance, and man-down systems), re-configuration of some roadways and parking areas, and changes to basic utility infrastructure. Funds will also be used to purchase furnishings, fixtures, equipment, and specialized telecommunications equipment/systems.

Changes in Population Growth

The growth of the forensics program at State Operated Services' (SOS) has been of concern for some time now. Traditionally, growth of the forensic program population was stable and predictable. In 2003, the Department of Corrections (DOC) changed their referral policy for individuals released from prison, increasing the number of individuals referred for civil commitment to SOS.

Until 2003, the MSOP and the mentally ill and dangerous (MI&D) populations grew fairly consistently. The MSOP population grew by approximately 18 per year while the MI&D population grew by approximately five per year, a total of 23. After the policy change, the department estimated that growth would increase to 36 per year in the MSOP.

The Department witnessed a significant increase in admissions beginning in 2004 and continuing in 2005, but believed that was a one-time occurrence in response to the new referral policy. As time has progressed, additional data on MI&D and MSOP admissions demonstrated that the increase was not an isolated occurrence and earlier projections significantly underestimated

population growth. Based on this additional data for actual referrals, the department is now projecting population growth at 100 per year, 80 in the MSOP and 20 in MI&D.

Because of this unprecedented growth, the agency has had to alter its six year plan to increase capacity for both the MI&D and MSOP populations. In order to accommodate this growth, SOS has little choice but to request resources for additional capacity.

Utilizing the residential K building model that has been established by the DOC, with some modifications particular to the Department of Human Services (DHS) licensing requirements, allows DHS to construct significantly more beds within the costs proposed for the original 150 bed facility proposed in 2005.

The modified K model will also reduce future operational costs for the MSOP program. This will be accomplished because the use of much larger residential units (from the current 25-bed MSOP unit design currently used in the existing MSOP facilities) will reduce the number of security staff required to operate the much larger units of the new facilities.

Further analysis indicated that it would be in the best interest of the program to consolidate MSOP on one campus. Doing so will: eliminate the need to transfer high risk patients back and forth between two campuses; allow the department to develop the same level of security for all of MSOP facilities; focus program expertise at one facility; enable the MSOP program to incorporate the new more cost effective (operationally) residential building design for all of the program except for the existing six 25-bed units at Moose Lake which will be utilized as high control units (for high risk, difficult to manage, non-cooperative patients) after the completion of the proposed two phases of expansion.

Consolidating the MSOP to one campus will also allow Minnesota Security Hospital to utilize the facilities that have been developed for MSOP on the St. Peter campus to facilitate the need for additional programs to address the growth in population of the MI&D patients it is experiencing.

Background

In late spring 2005 it became apparent that earlier projections the forensics program significantly underestimated growth in commitments. This unprecedented growth has caused a very serious capacity problem for the forensic programs. At the current rate of admissions, all of the department's "secure" capacity that is appropriate for housing sex offenders will be occupied by April 2006.

In order for the Department be able to house individuals committed to the forensics program, it is necessary to find temporary space for these individuals until the necessary capital improvements can be made. To address this capacity problem, DHS and DOC are implementing a plan to utilize space at the Minnesota Correctional Facility – Moose Lake as temporary facilities for the MSOP. Because the program will already be operating at the temporary site, staff and resources can then be easily transferred to DHS's new facility once it is completed.

(Please not that the option to use space at DOC's Moose Lake facility is temporary and is due to the recent slowdown in DOC's population growth. These beds will not be available long term)

Impact on Agency Operating Budgets (Facilities Notes)

The increasing sex offender population will impact the agency's operating budget. Please refer to the project detail page for this project to review the change in operating costs.

Previous Appropriations for this Project

The legislature appropriated funds to construct the original 100-bed facility in 1994. Funds for the first 50-bed addition were appropriated in 1998. In 2005 the legislature appropriated $3.259 million for design for new forensic facilities. However, because this appropriation was specified in law for the St. Peter campus—and therefore cannot be used—the design money is being re-requested here for the Moose Lake project.

Other Considerations

The Department's six-year plan outlines SOS plan to request design funds in 2006 for an additional facility expansion at Moose Lake, and funding for construction and FF&E for this expansion in 2008.

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Governor's Recommendations

The Governor recommends general obligation bonding of $44.580 million for this project.

MSOP Expansion - Phase One | ($ in Thousands)

TOTAL PROJECT COSTS All Years and Funding Sources	Prior Years	FY 2006-07	FY 2008-09	FY 2010-11	TOTAL
1. Property Acquisition	0	0	0	0	0
2. Predesign Fees	0	0	0	0	0
3. Design Fees	0	2,815	0	0	2,815
4. Project Management	0	235	0	0	235
5. Construction Costs	0	35,197	0	0	35,197
6. One Percent for Art	0	100	0	0	100
7. Relocation Expenses	0	0	0	0	0
8. Occupancy	0	2,107	0	0	2,107
9. Inflation	0	4,126	0	0	4,126
TOTAL	**0**	**44,580**	**0**	**0**	**44,580**

CAPITAL FUNDING SOURCES	Prior Years	FY 2006-07	FY 2008-09	FY 2010-11	TOTAL
State Funds :					
G.O Bonds/State Bldgs	0	44,580	0	0	44,580
State Funds Subtotal	0	44,580	0	0	44,580
Agency Operating Budget Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Local Government Funds	0	0	0	0	0
Private Funds	0	0	0	0	0
Other	0	0	0	0	0
TOTAL	**0**	**44,580**	**0**	**0**	**44,580**

CHANGES IN STATE OPERATING COSTS	Changes in State Operating Costs (Without Inflation)			
	FY 2006-07	FY 2008-09	FY 2010-11	TOTAL
Compensation -- Program and Building Operation	0	15,985	63,940	79,925
Other Program Related Expenses	0	286	1,142	1,428
Building Operating Expenses	0	382	1,528	1,910
Building Repair and Replacement Expenses	0	100	400	500
State-Owned Lease Expenses	0	0	0	0
Nonstate-Owned Lease Expenses	0	0	0	0
Expenditure Subtotal	0	16,753	67,010	83,763
Revenue Offsets	0	<1,675>	<6,701>	<8,376>
TOTAL	0	15,078	60,309	75,387
Change in F.T.E. Personnel	0.0	0.0	0.0	0.0

SOURCE OF FUNDS FOR DEBT SERVICE PAYMENTS (for bond-financed projects)	Amount	Percent of Total
General Fund	44,580	100.0%
User Financing	0	0.0%

STATUTORY AND OTHER REQUIREMENTS Project applicants should be aware that the following requirements will apply to their projects after adoption of the bonding bill.	
Yes	MS 16B.335 (1a): Construction/Major Remodeling Review (by Legislature)
Yes	MS 16B.335 (3): Predesign Review Required (by Administration Dept)
Yes	MS 16B.335 and MS 16B.325 (4): Energy Conservation Requirements
No	MS 16B.335 (5): Information Technology Review (by Office of Technology)
Yes	MS 16A.695: Public Ownership Required
No	MS 16A.695 (2): Use Agreement Required
No	MS 16A.695 (4): Program Funding Review Required (by granting agency)
No	Matching Funds Required (as per agency request)
No	MS 16A.642: Project Cancellation in 2011

2006 STATE APPROPRIATION REQUEST: $3,200,000

AGENCY PROJECT PRIORITY: 2 of 7

PROJECT LOCATION: Minnesota Sex Offender Program - Moose Lake

Project At A Glance

- Design funding for the second phase of the bed expansion to provide additional secure facilities for the Moose Lake Sex Offender Treatment Program facilities; and
- Funds for construction, furnishing, fixtures, and equipment will be requested in the 2008 legislative session.

Project Description

This project requests funds to design and develop construction documents for phase two of the proposed facility expansion for the Minnesota Sex Offender Program (MSOP) at Moose Lake. Funds to construct phase one of the expansion are requested in the Department's number one priority request for the 2006 Capital budget.

The scope of construction for the Moose Lake phase two expansion is very similar to the request for phase one. The Department envisions it will request the additional funding to complete the project in 2008. This request will include but not be limited to: secure residential facilities (bedrooms, toileting and bathing, dining and day space); expansion of program areas (treatment, work activity, group rooms, outdoor recreation, visitation, medical treatment, etc.); and ancillary space (mechanical and electrical, storage space, control centers, program administration, etc.). In addition, this project will also require expansion of exterior security systems (including fencing and electronic surveillance systems), and some changes/modification to the facility's basic utility infrastructure.

The second phase of expansion proposed for the Moose Lake campus is needed to ensure that adequate bed capacity is maintained to manage the current trend level of court ordered commitments that the Department projects will continue until such time as longer sentencing guidelines for sex offenses mandated by statues in 2005 actually begin to impact the annual number of referrals to the MSOP program.

Background

In late spring 2005 it became apparent that earlier projections the forensics program significantly underestimated growth in commitments. This unprecedented growth has caused a very serious capacity problem for the forensic programs, At the current rate of admissions, all of the Department's "secure" capacity that is appropriate for housing sex offenders will be occupied by April 2006.

In order for the Department be able to house individuals committed to the forensics program, it is necessary to find temporary space for these individuals until the necessary capital improvements can be made. To address this capacity problem Department of Human Services (DHS) and Department of Corrections (DOC) are implementing a plan to utilize space at the Minnesota Correctional Facility – Moose Lake as temporary facilities for the MSOP. Because the program will already be operating at the temporary site, staff and resources can then be easily transferred to DHS's new facility once it is completed.

(Please not that the option to use space at DOC's Moose Lake facility is temporary and is due to the recent slowdown in DOC's population growth. These beds will not be available long term)

Change in Plans for Developing Additional Capacity

The growth of the forensics program at State Operated Services' (SOS) has been of concern for some time now. Traditionally, growth of the forensic program population was stable and predictable. In 2003, the DOC changed their referral policy for individuals released from prison, increasing the number of individuals referred for civil commitment to SOS.

Until 2003, growth in the MSOP and the mentally ill and dangerous (MI&D) populations was fairly consistent. The MSOP population grew by approximately 18 per year while the MI&D population grew by approximately

five per year, a total of 23 per year. After the policy change, the Department estimated that growth would increase to 36 per year in the MSOP.

The Department witnessed a significant increase in admissions beginning in 2004 and continuing in 2005, but believed that was a one-time occurrence in response to the new referral policy. As time has progressed, additional data on MI&D and MSOP admissions demonstrates that the increase was not an isolated occurrence and earlier projections significantly underestimated population growth. Based on this additional data for actual referrals, the department is now projecting population growth at 100 per year, 80 in the MSOP and 20 in MI&D.

Because of this unprecedented growth, the agency has had to alter its six-year plan to increase capacity for both the MI&D and MSOP populations. In order to accommodate this growth, SOS has little choice but to request resources for additional capacity.

Impact on Agency Operating Budgets (Facilities Notes)

The increasing sex offender population will impact the agency's operating budget. Please refer to the project detail page for this project to review the change in operating costs.

Previous Appropriations for this Project

The legislature appropriated funds to construct the original 100-bed facility in 1994. Funds for the first 50-bed addition were appropriated in 1998. In 2005 the legislature appropriated $3.259 million for design for new forensic facilities.

Other Considerations

The Department's six-year plan outlines SOS's plan to request construction and furniture, fixtures, and equipment (FF&E) funds for the first phase of expansion for MSOP facilities at Moose Lake in 2006. It also indicates the Department's intention to request funds for construction and FF&E for phase two in 2008. Completion of both phase one and phase two will provide a total MSOP capacity at Moose Lake of approximately 950 licensed beds.

Project Contact Person

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Governor's Recommendations

The Governor recommends general obligation bonding of $3.2 million for the project. Also included are budget planning estimates of $47.5 million in 2008.

Human Services, Department of

MSOP Expansion - Design Phase Two

Project Detail

($ in Thousands)

TOTAL PROJECT COSTS All Years and Funding Sources	Prior Years	FY 2006-07	FY 2008-09	FY 2010-11	TOTAL
1. Property Acquisition	0	0	0	0	0
2. Predesign Fees	0	0	0	0	0
3. Design Fees	0	2,749	0	0	2,749
4. Project Management	0	0	217	0	217
5. Construction Costs	0	0	37,936	0	37,936
6. One Percent for Art	0	0	100	0	100
7. Relocation Expenses	0	0	0	0	0
8. Occupancy	0	0	2,450	0	2,450
9. Inflation	0	451	6,797	0	7,248
TOTAL	**0**	**3,200**	**47,500**	**0**	**50,700**

CAPITAL FUNDING SOURCES	Prior Years	FY 2006-07	FY 2008-09	FY 2010-11	TOTAL
State Funds :					
G.O Bonds/State Bldgs	0	3,200	47,500	0	50,700
State Funds Subtotal	0	3,200	47,500	0	50,700
Agency Operating Budget Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Local Government Funds	0	0	0	0	0
Private Funds	0	0	0	0	0
Other	0	0	0	0	0
TOTAL	**0**	**3,200**	**47,500**	**0**	**50,700**

CHANGES IN STATE OPERATING COSTS	Changes in State Operating Costs (Without Inflation)			
	FY 2006-07	FY 2008-09	FY 2010-11	TOTAL
Compensation -- Program and Building Operation	0	0	15,985	15,985
Other Program Related Expenses	0	0	286	286
Building Operating Expenses	0	0	382	382
Building Repair and Replacement Expenses	0	0	100	100
State-Owned Lease Expenses	0	0	0	0
Nonstate-Owned Lease Expenses	0	0	0	0
Expenditure Subtotal	0	0	16,753	16,753
Revenue Offsets	0	0	<1,675>	<1,675>
TOTAL	0	0	15,078	15,078
Change in F.T.E. Personnel	0.0	0.0	0.0	0.0

SOURCE OF FUNDS FOR DEBT SERVICE PAYMENTS (for bond-financed projects)	Amount	Percent of Total
General Fund	3,200	100.0%
User Financing	0	0.0%

STATUTORY AND OTHER REQUIREMENTS Project applicants should be aware that the following requirements will apply to their projects after adoption of the bonding bill.	
Yes	MS 16B.335 (1a): Construction/Major Remodeling Review (by Legislature)
Yes	MS 16B.335 (3): Predesign Review Required (by Administration Dept)
Yes	MS 16B.335 and MS 16B.325 (4): Energy Conservation Requirements
No	MS 16B.335 (5): Information Technology Review (by Office of Technology)
Yes	MS 16A.695: Public Ownership Required
No	MS 16A.695 (2): Use Agreement Required
No	MS 16A.695 (4): Program Funding Review Required (by granting agency)
No	Matching Funds Required (as per agency request)
No	MS 16A.642: Project Cancellation in 2011

2006 STATE APPROPRIATION REQUEST: $7,000,000

AGENCY PROJECT PRIORITY: 3 of 7

PROJECT LOCATION: Fergus Falls

Project At A Glance

- Upgrade building/facility components to facilitate redevelopment/reuse of surplus properties at the Ah-Gwah-Ching Center, Brainerd Regional Human Services Center and Fergus Falls Regional Treatment Center;
- Demolish old, non-functional buildings and infrastructure considered non-functional for redevelopment/reuse or determined too expensive to redevelop for an alternative reuse; and
- Address other issues associated with disposition of three surplus regional treatment center (RTC) campuses.

Project Description

This capital budget request is for funds necessary for the disposition (sale/transfer of ownership) of the Department of Human Services' (DHS's) surplus RTC campuses. This request focuses on several key objectives:

⇒ To repair, replace and/or improve key building components and basic infrastructure necessary to support initiatives to redevelop/reuse surplus RTC properties, especially buildings listed on the National Register of Historic Sites.

⇒ To demolish buildings and campus infrastructures that are considered non-functional for current or future use by state programs, or those that are determined non-functional as part of the final disposition plan is approved/implemented in conjunction with master planning efforts for these three RTC campuses.

⇒ To address other issues that may surface as the disposition of these surplus campuses proceeds.

Funds will be used for: professional design and engineering services; implementation of improvements of basic utility systems (heating, water supply, sewage lines, electrical distribution, life safety systems, etc.); structural integrity and building envelope issues (tuckpointing, building foundation restoration, windows, doors, and roofing issues); addressing building code and other regulatory issues associated with change of occupancy/reuse; and other physical plant issues that are further defined as the disposition plans for these surplus RTC campuses are finalized.

Funds will also be used for professional design and project management services and implementation of hazardous materials abatement, demolition of buildings, and disposal of materials in accordance with federal law, Minnesota statutes, and local governmental rules and regulations. In addition, funds will be utilized for site restoration, the demolition/capping/sealing of utility tunnels and buildings services leading to buildings/structures to be demolished, and other infrastructural issues associated with the disposition of buildings on these campuses, including demolition of sidewalks, roads, and parking lots.

Background Information

The 2003 Legislature authorized DHS to collaborate with local government entities to complete a comprehensive redevelopment plan (master plan) for the future use of the RTC campuses (grounds and vacant buildings) vacated as a result of further expansion of community-based care (Laws 2003, 1st Special Session, Chapter 14, Section 64, Subd. 2). The Department, in collaboration with the Department of Administration and local units of government, completed this process for Ah-Gwah-Ching, Fergus Falls, and Willmar in 2004.

The Brainerd campus master planning will be coordinated by Crow Wing County, and should be completed during the next twelve months. This time period coincides with the development of enhanced mental health services in the community, which will result in a significant decrease in total space utilization on the Brainerd campus.

The master plan process, done in collaboration with local units of government, is intended to generate viable reuse/redevelopment strategies for the old campus properties and buildings. To implement these master

plans the Department anticipates the need for funds for infrastructure modification, building modifications, and demolition of structures that are determined to be non-functional for future utilization.

At the time this narrative was developed final details for the transfer/sale of the Willmar campus were being worked out between the state, Kandiyohi County, and a private company from the Willmar area. The Department of Administration was also working closely with Cass County and the city of Fergus Falls for the respective campuses, with expectations that the final disposition plans will be approved and ready for implementation in late spring or early summer 2006.

Impact on Agency Operating Budgets (Facilities Notes)

The impact on the agency's operating budget will be contingent on the level of services provided in the future, and the location and the type of facilities developed to provide these services. However, just reducing the costs associated with heating and maintaining the unused/oversized spaces in the numerous vacant buildings in the system will provide significant savings to the facility's program overhead costs.

For example, preservation of the Fergus Falls RTC buildings could prove to be very expensive for the state if an economically viable alternative reuse cannot be found. Preliminary estimates to provide minimal heat, basic building and grounds maintenance and security for this large campus indicate expenditures could exceed $1 million a year after the existing treatment programs on the Fergus Falls RTC complete the transition to community-based operations.

Previous Appropriations for this Project

The 2005 legislature appropriated $8.91 million for redevelopment, reuse, or demolition: $4 million for the Ah-Gwah-Ching campus; $1.9 million for the Willmar campus; and approximately $3 million for the Fergus Falls campus.

In addition, the 2005 legislature re-authorized $3 million appropriated in the 2002 Bonding Bill for the Fergus Falls RTC so it could be used for this purpose.

Other Considerations

The extensive surplus space on the RTC campuses, the age of the facilities, and the estimated cost for ongoing maintenance of the physical plants has created financial pressures that cannot be ignored. If viable reuse cannot be identified the Department's recommendation is to demolish these non-functional facilities and eliminate the associated operating expenses.

Funding of this proposal will enable the Department to work aggressively to convert surplus facilities (land and buildings) to other ownership and alternative uses. If an alternate use cannot be found, adequate funds will be available for demolition, and the need to expend state dollars to maintain these non-utilized, non-functional buildings in the future can be eliminated.

Funding of this request should also provide enough flexibility in the use of the funds to address other issues that may surface as the disposition of the surplus campuses proceeds.

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Governor's Recommendations

The Governor recommends general obligation bonding of $7 million for this project. Also included are budget planning estimates of $4 million in 2008.

System-Wide Campus Redevelopment/Reuse/Demo — ($ in Thousands)

TOTAL PROJECT COSTS All Years and Funding Sources	Prior Years	FY 2006-07	FY 2008-09	FY 2010-11	TOTAL
1. Property Acquisition	0	0	0	0	0
2. Predesign Fees	0	0	0	0	0
3. Design Fees	0	577	307	0	884
4. Project Management	0	116	65	0	181
5. Construction Costs	0	5,825	3,100	0	8,925
6. One Percent for Art	0	0	0	0	0
7. Relocation Expenses	0	0	0	0	0
8. Occupancy	0	0	0	0	0
9. Inflation	0	482	528	0	1,010
TOTAL	**0**	**7,000**	**4,000**	**0**	**11,000**

CAPITAL FUNDING SOURCES	Prior Years	FY 2006-07	FY 2008-09	FY 2010-11	TOTAL
State Funds :					
G.O Bonds/State Bldgs	0	7,000	4,000	0	11,000
State Funds Subtotal	0	7,000	4,000	0	11,000
Agency Operating Budget Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Local Government Funds	0	0	0	0	0
Private Funds	0	0	0	0	0
Other	0	0	0	0	0
TOTAL	**0**	**7,000**	**4,000**	**0**	**11,000**

CHANGES IN STATE OPERATING COSTS	Changes in State Operating Costs (Without Inflation)			
	FY 2006-07	FY 2008-09	FY 2010-11	TOTAL
Compensation -- Program and Building Operation	0	0	0	0
Other Program Related Expenses	0	0	0	0
Building Operating Expenses	0	0	0	0
Building Repair and Replacement Expenses	0	0	0	0
State-Owned Lease Expenses	0	0	0	0
Nonstate-Owned Lease Expenses	0	0	0	0
Expenditure Subtotal	0	0	0	0
Revenue Offsets	0	0	0	0
TOTAL	0	0	0	0
Change in F.T.E. Personnel	0.0	0.0	0.0	0.0

SOURCE OF FUNDS FOR DEBT SERVICE PAYMENTS (for bond-financed projects)	Amount	Percent of Total
General Fund	7,000	100.0%
User Financing	0	0.0%

STATUTORY AND OTHER REQUIREMENTS Project applicants should be aware that the following requirements will apply to their projects after adoption of the bonding bill.	
Yes	MS 16B.335 (1a): Construction/Major Remodeling Review (by Legislature)
No	MS 16B.335 (3): Predesign Review Required (by Administration Dept)
Yes	MS 16B.335 and MS 16B.325 (4): Energy Conservation Requirements
No	MS 16B.335 (5): Information Technology Review (by Office of Technology)
Yes	MS 16A.695: Public Ownership Required
No	MS 16A.695 (2): Use Agreement Required
No	MS 16A.695 (4): Program Funding Review Required (by granting agency)
No	Matching Funds Required (as per agency request)
Yes	MS 16A.642: Project Cancellation in 2011

St. Peter - Construct New Program Building

2006 STATE APPROPRIATION REQUEST: $2,500,000

AGENCY PROJECT PRIORITY: 4 of 7

PROJECT LOCATION: St. Peter

Project At A Glance

- Design, construct, furnish and equip new program/activity space on the lower campus of the St. Peter Regional Treatment Center (RTC) for individuals committed to the forensic division of State Operated Services (SOS);
- Provide patient work/activity programming for patients served by the Minnesota Security Hospital (MSH) and/or the facility's transition program; and
- Meet required licensure and certification standards.

Project Description

This request is for funds to design, construct, and furnish, and equip a new program/activity building on the lower campus of the St. Peter RTC for the MSH programs located on the lower campus. The building will provide work and activity space for various work and programming activities, warehouse space for the industrial/work programs, loading dock, secure tool cribs, break areas, locker areas, etc. In addition, it will need to provide appropriate security elements for moving patients, staff, supplies, and completed products.

Background Information

In the spring/summer of 2006, the St. Peter adult mental health program will complete its transition to the community. Two 16-bed Community Behavioral Health Hospitals are currently under construction for the St. Peter RTC service area, one in St. Peter and one in Rochester. As part of the transition of the adult mental health program to the community, a 10-bed mental health crisis center was also opened in Mankato earlier this year.

At the completion of the facility's transition of the adult mental health program to community settings, the St. Peter campus will only serve forensic programs. In the past, the lower campus was primarily used for non-forensic purposes and there was much less need for work/industrial/activity space for patients served. Generally mentally ill (MI) patients spent far less time at the facility and work/industrial activity was not considered an integral part of treatment, at least not in the same manner as it is in the longer term forensic programs. Accordingly, work activities were very simple, did not require specialized spaces, and generally took place in any space that was available on the lower campus.

As forensic patients have moved into space previously used by the MI program, the limited space for work and activity programming has become a problem. The patients in Shantz use space in the basement for work activity; however, the location, size and configuration of this space significantly limit the type of work activity that can be undertaken. Patients in Pexton also use space in the basement. Other available space on the lower campus is set to house patients early in 2006, which severely limits the Department's ability to work around the lack programming space.

Parts of building #25 have been used for patient work program for a number of years. However, plans call for the use of this building to change to house patients starting in the spring of 2006. This will limit the type of work activities that can be engaged in this building, and reduce the amount of space available for industrial/work programs on the campus.

Approval of this request will provide the building resources needed by the facility's program staff to design and develop appropriate work/activity programs for individuals served on the campus which have progressed in their treatment to a level that enables them to travel on campus with limited or no escort with no risk to public safety. This type of programming is extremely important for these individuals in facilitating progression with treatment, and their community reintegration.

Funding of this request will also make possible the use other space to house residents in the Department's efforts to develop/maintain adequate bed capacity for the forensic programs.

Impact on Agency Operating Budgets (Facilities Notes)

This new building will increase the facility's annual fuel and utility budget by a small percentage. It will also cause a slight increase in the facility's annual maintenance budget.

Previous Appropriations for this Project

This is the first time funds have been requested for this project.

Other Considerations

This project allows the space currently utilized for programs/activities, in building #25, to be used to provide additional bed capacity in 2006. Adding new program/activity space and converting building #25 to residential usage is more cost effective than adding new, more expensive residential space.

Project Contact Person

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Governor's Recommendations

The Governor recommends general obligation bonding of $2.5 million for this project.

St. Peter - Construct New Program Building — ($ in Thousands)

TOTAL PROJECT COSTS All Years and Funding Sources	Prior Years	FY 2006-07	FY 2008-09	FY 2010-11	TOTAL
1. Property Acquisition	0	0	0	0	0
2. Predesign Fees	0	0	0	0	0
3. Design Fees	0	148	0	0	148
4. Project Management	0	0	0	0	0
5. Construction Costs	0	1,995	0	0	1,995
6. One Percent for Art	0	0	0	0	0
7. Relocation Expenses	0	0	0	0	0
8. Occupancy	0	185	0	0	185
9. Inflation	0	172	0	0	172
TOTAL	**0**	**2,500**	**0**	**0**	**2,500**

CAPITAL FUNDING SOURCES	Prior Years	FY 2006-07	FY 2008-09	FY 2010-11	TOTAL
State Funds :					
G.O Bonds/State Bldgs	0	2,500	0	0	2,500
State Funds Subtotal	0	2,500	0	0	2,500
Agency Operating Budget Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Local Government Funds	0	0	0	0	0
Private Funds	0	0	0	0	0
Other	0	0	0	0	0
TOTAL	**0**	**2,500**	**0**	**0**	**2,500**

CHANGES IN STATE OPERATING COSTS	Changes in State Operating Costs (Without Inflation)			
	FY 2006-07	FY 2008-09	FY 2010-11	TOTAL
Compensation -- Program and Building Operation	0	0	0	0
Other Program Related Expenses	0	0	0	0
Building Operating Expenses	0	29	0	29
Building Repair and Replacement Expenses	0	10	0	10
State-Owned Lease Expenses	0	0	0	0
Nonstate-Owned Lease Expenses	0	0	0	0
Expenditure Subtotal	0	39	0	39
Revenue Offsets	0	<4>	0	<4>
TOTAL	0	35	0	35
Change in F.T.E. Personnel	0.0	0.0	0.0	0.0

SOURCE OF FUNDS FOR DEBT SERVICE PAYMENTS (for bond-financed projects)	Amount	Percent of Total
General Fund	2,500	100.0%
User Financing	0	0.0%

STATUTORY AND OTHER REQUIREMENTS Project applicants should be aware that the following requirements will apply to their projects after adoption of the bonding bill.	
Yes	MS 16B.335 (1a): Construction/Major Remodeling Review (by Legislature)
Yes	MS 16B.335 (3): Predesign Review Required (by Administration Dept)
Yes	MS 16B.335 and MS 16B.325 (4): Energy Conservation Requirements
No	MS 16B.335 (5): Information Technology Review (by Office of Technology)
Yes	MS 16A.695: Public Ownership Required
No	MS 16A.695 (2): Use Agreement Required
No	MS 16A.695 (4): Program Funding Review Required (by granting agency)
No	Matching Funds Required (as per agency request)
Yes	MS 16A.642: Project Cancellation in 2011

2006 STATE APPROPRIATION REQUEST: $2,500,000

AGENCY PROJECT PRIORITY: 5 of 7

PROJECT LOCATION: St. Peter Regional Treatment Center

Project At A Glance

- Design and construct security/safety improvements/upgrades to State Operated Services' (SOS) campus-based facilities that provide secure programs;
- Implement recommendations provided by Department of Corrections (DOC) Inspections and Enforcement Unit's Audit Report; and
- Focus on physical plant upgrades/improvements that relate to both public safety and program integrity.

Project Description

This is a two-phase system-wide request for funds to design/construct/install security/safety physical plant improvements to SOS's campus-based program facilities which support secure programs. The request for 2006 represents phase one and will focus on the St. Peter Regional Treatment Center (RTC) campus. Phase two will be requested in the 2008 session and will address safety/security issues at Anoka Metro Regional Treatment Center, Minnesota Extended Treatment Options Program (Cambridge), Minnesota Sex Offender Program at Moose Lake, and the balance of projects proposed for the St. Peter RTC.

The scope of work to be completed with this request will focus on system-wide needs and will include, but not be limited to: upgrading/installing building and facility perimeter security systems/components (windows, control centers, security fencing, nuisance fences, electronic monitoring/surveillance systems, etc.); securing critical life safety/utility systems/equipment (emergency generators, gas meters/valves, electrical distribution system, etc.); improving building/facility entrances (vehicle sally-ports, building sally-ports, control stations, etc.); purchase of other equipment necessary to upgrade security and safety, and to better control/monitor patient activity at SOS' campus-based facilities.

Funding of this request will enable Department of Human Services (DHS)/SOS to implement improvements/upgrades needed to address known security/safety issues for programs that support secure programs throughout the SOS system. These improvements will be designed to address issues of public safety, and to upgrade physical plant components that could pose a risk to the well-being of patients, staff, and the general public.

Background Information

In May 2005, at the request of DHS, the DOC Inspection and Enforcement Unit conducted a security audit on the Minnesota Sex Offender Program (MSOP) and the Minnesota Security Hospital (MSH) program facilities located on the St. Peter RTC campus.

The final report from the DOC audit found that there were specific security issues on the campus that required upgrades and new equipment. These changes recommended by DOC will be completed, as time and funding allows. Because of the DOC audit's findings, the department believed it prudent to conduct similar audits at all other program sites that require secure treatment environments.

Because many of the recommendations by the DOC audits exceed SOS's operating budget limitations and the nature of the work being performed is capital in nature, the Department is seeking capital funds to address the physical plant security/safety issues that pose a risk to patients, staff and the general public. This two-phase request will address security/safety issues at each of the facilities with secure programs.

Impact on Agency Operating Budgets (Facilities Notes)

Some of the recommended physical plant corrections will have a slight impact on operating budgets by increasing utility costs. Future preventive maintenance of these improvements should be able to be addressed with existing maintenance budgets for both personnel and supplies.

Previous Appropriations for this Project

None, this is the first time DHS/SOS has requested capital funds specifically for security/safety improvements.

Other Considerations

The Department has implemented temporary measures to address the most immediate concerns for public safety. Approval of this request will fund the necessary permanent, long-term improvements, modifications, and upgrades.

Project Contact Person

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Governor's Recommendations

The Governor recommends general obligation bonding of $2.5 million for this project. Also included are budget planning estimates of $2.5 million in 2008.

System-Wide - Campus Security/Safety Improvements — ($ in Thousands)

TOTAL PROJECT COSTS All Years and Funding Sources	Prior Years	FY 2006-07	FY 2008-09	FY 2010-11	TOTAL
1. Property Acquisition	0	0	0	0	0
2. Predesign Fees	0	0	0	0	0
3. Design Fees	0	210	200	0	410
4. Project Management	0	0	0	0	0
5. Construction Costs	0	2,105	1,970	0	4,075
6. One Percent for Art	0	0	0	0	0
7. Relocation Expenses	0	0	0	0	0
8. Occupancy	0	0	0	0	0
9. Inflation	0	185	330	0	515
TOTAL	**0**	**2,500**	**2,500**	**0**	**5,000**

CAPITAL FUNDING SOURCES	Prior Years	FY 2006-07	FY 2008-09	FY 2010-11	TOTAL
State Funds :					
G.O Bonds/State Bldgs	0	2,500	2,500	0	5,000
State Funds Subtotal	0	2,500	2,500	0	5,000
Agency Operating Budget Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Local Government Funds	0	0	0	0	0
Private Funds	0	0	0	0	0
Other	0	0	0	0	0
TOTAL	**0**	**2,500**	**2,500**	**0**	**5,000**

CHANGES IN STATE OPERATING COSTS	Changes in State Operating Costs (Without Inflation)			
	FY 2006-07	FY 2008-09	FY 2010-11	TOTAL
Compensation -- Program and Building Operation	0	0	0	0
Other Program Related Expenses	0	0	0	0
Building Operating Expenses	0	35	0	35
Building Repair and Replacement Expenses	0	17	0	17
State-Owned Lease Expenses	0	0	0	0
Nonstate-Owned Lease Expenses	0	0	0	0
Expenditure Subtotal	0	52	0	52
Revenue Offsets	0	<5>	0	<5>
TOTAL	0	47	0	47
Change in F.T.E. Personnel	0.0	0.0	0.0	0.0

SOURCE OF FUNDS FOR DEBT SERVICE PAYMENTS (for bond-financed projects)	Amount	Percent of Total
General Fund	2,500	100.0%
User Financing	0	0.0%

STATUTORY AND OTHER REQUIREMENTS Project applicants should be aware that the following requirements will apply to their projects after adoption of the bonding bill.	
No	MS 16B.335 (1a): Construction/Major Remodeling Review (by Legislature)
No	MS 16B.335 (3): Predesign Review Required (by Administration Dept)
No	MS 16B.335 and MS 16B.325 (4): Energy Conservation Requirements
No	MS 16B.335 (5): Information Technology Review (by Office of Technology)
Yes	MS 16A.695: Public Ownership Required
No	MS 16A.695 (2): Use Agreement Required
No	MS 16A.695 (4): Program Funding Review Required (by granting agency)
No	Matching Funds Required (as per agency request)
Yes	MS 16A.642: Project Cancellation in 2011

2006 STATE APPROPRIATION REQUEST: $1,500,000

AGENCY PROJECT PRIORITY: 6 of 7

PROJECT LOCATION: Anoka Metro Regional Treatment Center, Brainerd Regional Human Services Center, Minnesota Extended Treatment Option - Cambridge, Minnesota Sex Offender Program - Moose Lake, St. Peter Regional Treatment Center

Project At A Glance

- Provide repairs to extend life of building roofing systems;
- Replace roofing systems with deficiencies that cannot be addressed with repairs;
- Prevent damage to building interiors, heating, ventilating and air conditioning (HVAC) and electrical systems;
- Eliminate conditions that can foster serious indoor air problems associated with mold; and
- Upgrade roof insulation and building energy efficiency.

Project Description

This project request outlines system-wide roof repair and replacement needs for the Department of Human Services (DHS) State Operated Services (SOS) facilities.

In recent years, asset preservation has become a fundamental component of the capital budget process. The key objective of asset preservation is to help reduce the amount of deferred maintenance and deferred renewal referred to as the "capital iceberg." Roof repair/replacement is generally considered an asset preservation project. However, because of the system-wide scope of roof repair/replacement in the regional treatment center (RTC) system, and the serious ramifications associated with not maintaining the weatherproofing integrity of roofs, DHS has separated roof repair/replacement from other asset preservation projects in previous capital budget requests and is continuing this practice for the FY 2006-07 capital budget request.

Background Information

SOS maintains a roof maintenance and repair/replacement plan for each of the RTC campuses. These plans are used to monitor each building's roofing program and are updated annually. Buildings proposed for roof repair/replacement are not evaluated simply on the building's roof system deficiency, but rather on an assessment of the building's overall condition, current utilization, and projected or proposed future use.

Facility staff must demonstrate that a building's life cycle characteristics and program suitability is in balance and that the building warrants the cost of roof replacement before a building is included in SOS's final roof replacement schedule. Because of the continued downsizing at DHS facilities and/or the deactivation of individual buildings, these issues are also reviewed when SOS considers the need to seek or expend any capital appropriation for any building in the RTC system.

Impact on Agency Operating Budgets (Facilities Notes)

Lack of funding of this request would require the use of limited repair and replacement operating funds to address critical roof repair and replacement projects. This action would limit the agency's ability to address routine preventive and correct facility maintenance and would actually compound the deferred maintenance problem this request is attempting to address. Replacing/repairing the roofs associated with this request will not reduce or increase the agency's operating budget.

Previous Appropriations for Roof Replacement and Repairs

The 2005 Legislature appropriated $1.014 million.
The 2002 Legislature appropriated $2.789 million.
The 2000 Legislature appropriated $1.971 million.
The 1998 Legislature appropriated $1.9 million.

Other Considerations

Deferred repairs or replacement of roof systems can result in a significant increase in total project costs. Leaking roofs can damage interior surfaces

and jeopardize structural integrity. Leaking roofs can also ruin roof insulation, result in significant damage or deterioration to roof decks, deteriorate HVAC and electrical systems, and cause significant damage or destruction of program equipment and furnishings.

In addition, failure to address leaking roofs can cause the development of serious indoor air quality problems by generating conditions which facilitate mold growth and building contamination. Mold contamination can become a serious health issue and can result in the vacating of a building until the problem is corrected. Vacating a residential building at an RTC would cause considerable/significant programmatic problems. This situation would not only increase costs associated with roof maintenance and/or replacement, but would have a dramatic impact on the operating cost of the affected program.

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Governor's Recommendations

The Governor recommends general obligation bonding of $1.5 million for this project. Also included are budget planning estimates of $1.5 million in 2008 and $1.5 million in 2010.

($ in Thousands)

TOTAL PROJECT COSTS All Years and Funding Sources	Prior Years	FY 2006-07	FY 2008-09	FY 2010-11	TOTAL
1. Property Acquisition	0	0	0	0	0
2. Predesign Fees	0	0	0	0	0
3. Design Fees	0	114	249	150	513
4. Project Management	0	0	0	0	0
5. Construction Costs	0	1,275	2,485	1,468	5,228
6. One Percent for Art	0	0	0	0	0
7. Relocation Expenses	0	0	0	0	0
8. Occupancy	0	0	0	0	0
9. Inflation	0	111	416	382	909
TOTAL	**0**	**1,500**	**3,150**	**2,000**	**6,650**

CAPITAL FUNDING SOURCES	Prior Years	FY 2006-07	FY 2008-09	FY 2010-11	TOTAL
State Funds :					
G.O Bonds/State Bldgs	0	1,500	3,150	2,000	6,650
State Funds Subtotal	0	1,500	3,150	2,000	6,650
Agency Operating Budget Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Local Government Funds	0	0	0	0	0
Private Funds	0	0	0	0	0
Other	0	0	0	0	0
TOTAL	**0**	**1,500**	**3,150**	**2,000**	**6,650**

CHANGES IN STATE OPERATING COSTS	Changes in State Operating Costs (Without Inflation)			
	FY 2006-07	FY 2008-09	FY 2010-11	TOTAL
Compensation -- Program and Building Operation	0	0	0	0
Other Program Related Expenses	0	0	0	0
Building Operating Expenses	0	0	0	0
Building Repair and Replacement Expenses	0	0	0	0
State-Owned Lease Expenses	0	0	0	0
Nonstate-Owned Lease Expenses	0	0	0	0
Expenditure Subtotal	0	0	0	0
Revenue Offsets	0	0	0	0
TOTAL	0	0	0	0
Change in F.T.E. Personnel	0.0	0.0	0.0	0.0

SOURCE OF FUNDS FOR DEBT SERVICE PAYMENTS (for bond-financed projects)	Amount	Percent of Total
General Fund	1,500	100.0%
User Financing	0	0.0%

STATUTORY AND OTHER REQUIREMENTS Project applicants should be aware that the following requirements will apply to their projects after adoption of the bonding bill.	
No	MS 16B.335 (1a): Construction/Major Remodeling Review (by Legislature)
No	MS 16B.335 (3): Predesign Review Required (by Administration Dept)
Yes	MS 16B.335 and MS 16B.325 (4): Energy Conservation Requirements
No	MS 16B.335 (5): Information Technology Review (by Office of Technology)
Yes	MS 16A.695: Public Ownership Required
No	MS 16A.695 (2): Use Agreement Required
No	MS 16A.695 (4): Program Funding Review Required (by granting agency)
No	Matching Funds Required (as per agency request)
Yes	MS 16A.642: Project Cancellation in 2011

2006 STATE APPROPRIATION REQUEST: $4,000,000

AGENCY PROJECT PRIORITY: 7 of 7

PROJECT LOCATION: Anoka Metero RTC, Brainerd Regional Human Services Center, Cambridge Regional Treatment Center - METO Program, Minnesota Sex Offender Program - Moose Lake, St. Peter Regional Treatment Center

Project At A Glance

- Provide repairs and replacements to basic facility infrastructure and key mechanical, electrical, utility, and heating, ventilating and air conditioning (HVAC) systems;
- Address known safety hazards, health risks and code deficiencies;
- Maintain basic building envelope systems of the state's buildings; and
- Maintain and preserve capital investments in state assets.

Fast Facts

- Agency/Facility: Department of Human Services/State Operated Services (DHS/SOS)
- Total Acres: 1,494
- Number of State Owned Buildings: 252
- Total Building Square Footage: 3,582,665 square feet
- Estimated Deferred Maintenance: $23 million
- Estimated Deferred Renewal: $40 million
- Estimated Replacement Value of Capital Assets: $560 million

Project Description

This project request involves the repair, replacement, and renewal needs specific to the operations of each regional treatment center (RTC). These needs developed over time, and represent a system-wide assessment of the facilities' deficiencies, including, but not limited to the following:

- safety hazards and code compliance issues;
- emergency power/egress lighting upgrades (life safety);
- mechanical and structural deficiencies;
- tuck pointing and other building envelope work (window and door replacement, fascia and soffit work, re-grading around foundations);
- elevator repairs/upgrades/replacements;
- road and parking lot maintenance;
- major mechanical and electrical utility system repairs, replacements, upgrades and/or improvements, including the replacement of boilers and upgrading steam systems;
- abatement of hazardous materials (e.g., asbestos containing pipe insulation, floor and ceiling tile, lead paint); and
- Demolition of deteriorated/unsafe/non-functional buildings and structures.

Background Information

Funding of this request will enable the Department, and its facilities, to address this continuing problem and to reduce the level of deferred maintenance at the RTCs. Failure to fund this request will only intensify the problem. Additional deterioration will result and the state's physical plant assets will continue to decline. Future costs may actually compound, as complete replacement may become the most cost effective and efficient alternative for addressing related deficiencies.

The key objective of asset preservation is to help reduce the amount of deferred maintenance and deferred renewal referred to as the "capital iceberg." Although most projects associated with this request are considered nonrecurring in scope, all facility components require scheduled maintenance and repair, and eventually many require replacement. The average life cycle of most projects associated with this request range between 25 and 30 years; however, some have longer life cycles, (i.e. tuck pointing, window replacement), and a few may have shorter life cycles, (i.e. road and parking lot seal coating and overlays, water tower cleaning and painting). These projects involve significant levels of repair and replacement, and because of

the system-wide magnitude, cannot be addressed with the current level of repair and replacement funding in the agency's operating budget.

Each of the Department's facilities is responsible for maintaining a list of projects required to preserve their fixed assets. These perpetual and ever changing lists are comprised of projects directly related to asset preservation or deferred maintenance and renewal. The facilities' asset preservation plans must support the future need and projected use of the facility. Building components are not evaluated on an individual deficiency basis, but rather on an overall building evaluation or assessment basis to determine that its life cycle characteristics and program suitability are in balance.

Impact on Agency Operating Budgets (Facilities Notes)

Lack of funding of this request, will require the use of a large percentage of limited repair and replacement operating funds to address critical and expensive asset preservation projects. This action would limit the agency's ability to address routine preventative, predictive and corrective facility maintenance and would actually compound the existing deferred maintenance problem and result in a substantial increase in the long-range deferred maintenance/renewal at the agencies facilities. Funding of this request will not require the agency's operating budget to increase or decrease.

Previous Appropriations for Asset Preservation

2005 Legislature appropriated $3 million
2002 Legislature appropriated $4 million
2000 Legislature appropriated $3 million
1998 Legislature appropriated $4 million

Other Considerations

Continued funding at the requested level for several biennia will enable the Department to make a significant impact on the system's deferred maintenance problem.

In some cases repair and improvement may be a very prudent measure, while in other cases total replacement may be the most viable alternative. However, in light of the Department's current excess building capacity, demolition of some buildings may be determined to be the most economical and prudent choice of action. In addition, downsizing of facilities and/or deactivation of individual buildings must also be considered when determining which buildings should have funds requested for or committed to asset preservation.

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Governor's Recommendations

The Governor recommends general obligation bonding of $4 million for this project. Also included are budget planning estimates of $4 million in 2008 and $4 million in 2010.

($ in Thousands)

TOTAL PROJECT COSTS All Years and Funding Sources	Prior Years	FY 2006-07	FY 2008-09	FY 2010-11	TOTAL
1. Property Acquisition	0	0	0	0	0
2. Predesign Fees	0	0	0	0	0
3. Design Fees	0	364	320	320	1,004
4. Project Management	0	0	0	0	0
5. Construction Costs	0	3,636	3,680	3,680	10,996
6. One Percent for Art	0	0	0	0	0
7. Relocation Expenses	0	0	0	0	0
8. Occupancy	0	0	0	0	0
9. Inflation	0	0	0	0	0
TOTAL	**0**	**4,000**	**4,000**	**4,000**	**12,000**

CAPITAL FUNDING SOURCES	Prior Years	FY 2006-07	FY 2008-09	FY 2010-11	TOTAL
State Funds :					
G.O Bonds/State Bldgs	0	4,000	4,000	4,000	12,000
State Funds Subtotal	0	4,000	4,000	4,000	12,000
Agency Operating Budget Funds	0	0	0	0	0
Federal Funds	0	0	0	0	0
Local Government Funds	0	0	0	0	0
Private Funds	0	0	0	0	0
Other	0	0	0	0	0
TOTAL	**0**	**4,000**	**4,000**	**4,000**	**12,000**

CHANGES IN STATE OPERATING COSTS	Changes in State Operating Costs (Without Inflation)			
	FY 2006-07	FY 2008-09	FY 2010-11	TOTAL
Compensation -- Program and Building Operation	0	0	0	0
Other Program Related Expenses	0	0	0	0
Building Operating Expenses	0	0	0	0
Building Repair and Replacement Expenses	0	0	0	0
State-Owned Lease Expenses	0	0	0	0
Nonstate-Owned Lease Expenses	0	0	0	0
Expenditure Subtotal	0	0	0	0
Revenue Offsets	0	0	0	0
TOTAL	0	0	0	0
Change in F.T.E. Personnel	0.0	0.0	0.0	0.0

SOURCE OF FUNDS FOR DEBT SERVICE PAYMENTS (for bond-financed projects)	Amount	Percent of Total
General Fund	4,000	100.0%
User Financing	0	0.0%

STATUTORY AND OTHER REQUIREMENTS Project applicants should be aware that the following requirements will apply to their projects after adoption of the bonding bill.	
No	MS 16B.335 (1a): Construction/Major Remodeling Review (by Legislature)
No	MS 16B.335 (3): Predesign Review Required (by Administration Dept)
Yes	MS 16B.335 and MS 16B.325 (4): Energy Conservation Requirements
No	MS 16B.335 (5): Information Technology Review (by Office of Technology)
Yes	MS 16A.695: Public Ownership Required
No	MS 16A.695 (2): Use Agreement Required
No	MS 16A.695 (4): Program Funding Review Required (by granting agency)
No	Matching Funds Required (as per agency request)
Yes	MS 16A.642: Project Cancellation in 2011

Excerpt from 12/19/05 APHSA letter to states

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TANF BLOCK GRANT

The TANF reauthorization provisions in the conference report would discourage the present state practice of placing families in separate state programs. The report contains many provisions found in House and Senate versions of TANF reauthorization bills debated this year. However, the bill does not include the following provisions that were included in earlier bills: changes to state plans; significant data reporting changes; cash management improvements, including a definition of carry-over funds; an increase in work rates to 70 percent; a two-tier work structure split between direct and other work activities; full-family sanctions; universal engagement requirements; mandatory drug testing; or extensive tribal-related provisions.

Highlights of provisions contained in the conference report include the following. Changes to the participation rates and to the caseload reduction credit are effective October 1, 2005; all other effective dates are as noted below.

Authorizations in the report – The conference report authorizes TANF through September 30, 2010; the TANF Emergency Response and Recovery Act through September 30, 2010; the High Performance Bonus and the Out-of-Wedlock bonus through September 30, 2006 (both bonuses are eliminated after that date); the Supplemental Grants through FY 2008; and extends Transitional Medical Assistance (TMA) through 2006.

Funding – The conference report provides funding for the TANF block grant at the current level, $16.5 billion through 2010. Funding for the TANF supplemental grants to states is provided at current funding levels through FY 2008. The measure also continues the $2 billion contingency fund through FY 2010.

The bill also provides an additional $150 million a year from FY 2006 to FY 2010 for marriage promotion grants to states, territories, tribal governments, tribal organizations, faith-based organizations, and community groups. Of the $150 million, up to $50 million can fund new Fatherhood Grants. The report also allows up to $2 million per year for demonstration projects for coordination of child welfare and TANF services to tribal families.

Caseload Reduction Credit – Effective October 1, 2006, the conference report changes the base year for the credit to 2005 from the current base year of 1995. In addition, state-only program recipients are added to the numerator and denominator for determining the credit.

Participation Rates –The report maintains separate two-parent work rate at 90% and maintains the all families work rate at 50 percent. In the conference report, state-only program recipients are counted in the calculation of the participation rate for all-families and two-parent families rates. It also permits the Secretary of HHS to define work activities and hours in federal regulation. Also, states must establish work participation verification procedures by September 30, 2006.

Verification and Oversight Procedures – The conference report establishes a new penalty for states by allowing the secretary of HHS to assess a penalty for states' failure to establish and maintain work participation verification procedures. The penalty would be a minimum of 1 percent and not more than 5 percent of the state's TANF block grant. The penalty would be based on severity of failure. The report also requires the secretary of HHS to promulgate regulations no later than June 30, 2006, to ensure consistent measures of work rates for programs funded with federal and state TANF funds. The regulations are to address what activities may be treated as work; uniform methods for reporting hours of work; circumstances under which a parent who resides with a child-only TANF recipient should be included in the work participation rate calculation; and the type of documentation need to report the number of hours worked.

Data Reporting – The conference report applies the current quarterly reporting requirements to all clients served in separate state programs.

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CHILD CARE AND DEVELOPMENT FUND (CCDF)

The conference agreement reauthorizes CCDF for five years and provides $1 billion in new mandatory funding. CCDF mandatory funding would be $2.917 billion for each of FYs 2006 through 2010. The bill contains no additional discretionary funding. The agreement also does not include any of the policy changes to the child care program that had been in the House budget reconciliation bill.

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CHILD SUPPORT

As of October 1, 2007, the states are prohibited from using federal funds earned through incentive grants to draw federal match. In addition, starting on October 1, 2006, the match rate for lab paternity tests is decreased from 90 percent down to 66 percent, and states must institute a mandatory fee of $25 after the state has collected at least $500 of support for families who have never received TANF assistance.

In addition, the report includes the following provisions that were included in the House or Senate TANF reauthorization proposals.

Collections and Distribution – The report stipulates that assignment covers only child support accrued during the period that the family receives TANF. It also provides a state option to discontinue pre-1997 support assignments and hence distribute those amounts collected to the family. It would also provide a state option to discontinue post-1997 assignments. The report also maintains that any collections to current TANF recipients are distributed as follows: (1) pay the federal government the federal share (starting in FY 2009, state can pass through the federal share up to $100 per month, or $200 for family with two or more children); (2) retain or pay to the family the state's share of the amount collected while on assistance; (3) pay to the family the remaining amount.

The report also adds provision for a state option to pay all current support collections to former TANF families without paying the federal government share, as long as the amount collected does not exceed the current support amount. For arrearages that exceed current support amount, the state shall: (1) first pay family excess amount necessary to satisfy support arrearages; (2) then pay the federal government share; (3) then retain state share or pay it to the family; and (4) pay the family the remaining amount.

Federal Parent Locator Service (FPLS) – The conference report amends funding for FPLS from 2 percent of the federal share of support collected to whichever is greater, 2 percent of the federal share or the amount appropriated for FY 2002, thereby freezing funds for the service at FY 2002 levels. It also authorizes HHS to use the FPLS to compare information of non-custodial parents who owe past-due child support with information maintained by insurers regarding claims, settlement, awards, and payments and share with the state. The secretary of HHS may furnish information resulting from the match to state child support agencies. The report includes state reimbursement of federal costs.

Medical Support – The report requires medical support be provided by either or both parents and authorizes the state CSE office to enforce provision. It clarifies that medical support can be health coverage, premiums, co-pays, or payment of medical expenses.

Other Provisions – The report adds a provision requiring states to review and adjust child support orders in TANF cases every three years. It also requires that passport denial, revocation, or restriction would be triggered by $2,500 in past-due support owed, not the present level of $5,000 (effective October 1, 2006). It authorizes use of federal income tax refund offset program to collect arrearages on behalf of children who are no longer minors, effective October 1, 2007. It amends the amount used for technical assistance from 1 percent of the federal share of support collected to 1 percent of the federal share or the amount appropriated for FY 2002, whichever is greater. It also authorizes a state to open a case high-volume automated administrative enforcement service to assist other states in collecting child support in interstate cases where automated systems cannot be used.

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CHILD WELFARE

Foster care administrative claims

The conference agreement includes the House provisions that limit federal foster care administrative claiming. Title IV-E administrative claims are eliminated for otherwise-federally eligible children in unlicensed foster homes, with the exception that claims can be made for up to 12 months for a child in a relative home that is in the process of becoming licensed or approved. They are also eliminated for children in ineligible facilities such as detention centers, psychiatric and medical hospitals, and institutions with more than 25 beds, with the exception that claims can be retroactively made for one calendar month (but only if the child is returned to an eligible foster care setting). A new requirement is added to conduct foster care candidacy redeterminations every six months. This and all other child welfare provisions are effective October 1, 2005.

Eligibility for IV-E foster care maintenance and adoption assistance
The agreement also recedes to the House bill to limit the determination of eligibility for IV-E foster care maintenance and adoption assistance. The language would reverse the *Rosales v. Thompson* decision. The agreement would restrict determination of IV-E eligibility based on the broader criterion of a specified relative with whom a child may have resided within six months of removal.

Promoting Safe and Stable Families program
The conference agreement increases the mandatory funding for the Promoting Safe and Stable Families (PSSF) program (Title IV-B, subpart 2) to $345 million for FY 2006. This is an increase of $40 million.

Court Improvement section of Title IV-B
The agreement amends the Court Improvement section of Title IV-B to add that funds may be expended for ensuring that the safety, permanence, and well-being of children are met in a timely and complete manner; and to provide training for judges, attorneys, and other legal personnel in child welfare cases. The language also specifies the information on collaboration and cross-training that must be submitted with an application for grants. Funds for improved data collection and training are appropriated at $100 million, or $20 million per year over five years. Language is included to add requirements to demonstrate meaningful collaboration between courts and child welfare agencies in the state plans for Title IV-E, Title IV-B, and Child and Family Services Reviews (CFSR) Program Improvements Plans. Finally, flexibility is provided for states to determine state policies relating to public access to child abuse and neglect court proceedings.

National Random Sample Study
The conference agreement extends the authority to conduct the National Random Sample Study of Child Welfare through September 30, 2010. HHS has used this authority to conduct the National Survey of Child and Adolescent Well-Being (NSCAW).

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LOW-INCOME HOME ENERGY ASSISTANCE PROGRAM (LIHEAP)

The conference agreement provides a total of $1 billion in new LIHEAP funding for FY 2007. Of the new funding, $250 million will be used for formula grants to states and $750 million will be for emergency allocations. The additional funds will expire on September 30, 2007.

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FOOD STAMP PROGRAM

The conference report did not include any cuts to the Food Stamp Program (FSP). The House bill had cut the program by about $650 million over five years by curtailing categorical eligibility and legal immigrant eligibility, but the cuts were dropped at the insistence of the Senate. The report also did not include proposed changes in the definition of TANF assistance that would have limited the ability of certain states to extend categorical FSP eligibility linked to certain TANF benefits and services.

NASMD

National Association of State Medicaid Directors

an affiliate of the American Public Human Services Association

To: Medicaid Directors
From: Martha Roherty
Re: Budget Reconciliation
Date: January 10, 2006

On December 21, 2005 the Senate passed the budget savings package conference report. The Medicaid cuts are closer to the original House version and include the option for states to impose cost sharing and provide states the option to create flexible benefit packages. In addition, the final bill includes restrictions on seniors who transfer their assets to qualify Medicaid. There were no substantial changes to the problematic language on targeted case management or third-party liability. According to the Congressional Budget Office, the proposed package of cuts would save a net total of $4.8 billion from Medicaid.

Areas for additional spending in the legislation include reimbursement for the coverage of Hurricane Katrina evacuees. The bill also includes some additional spending on provisions for individuals with disabilities and their families.

Included in this summary are a breakdown of CBO scores, effective dates, and a more detailed explanation of the provisions. Please find an index at the end of this document to direct you to the specific text in the conference report. The House returns to session on January 31, 2006 and must pass the agreement again before it is signed into law by the President.

Payment for Prescription Drugs

Federal Upper Payment Limit (FUL) – Established FUL at 250% of the average manufacturer price (AMP), as opposed to average wholesale price (AWP), for multi-source drugs where the FDA has rated 2 or more products as equivalent, and the newly established Retail Survey Price (RSP) for single source innovator drugs. This excludes prompt pay discounts for lowest cost drugs. A drug qualifies as a multi-source drug if there is at least one other drug sold and marketed during the period that is rated therapeutically equivalent to it. Does not establish a new FUL for single source drugs. Effective date: January 1, 2007. (CBO score over 5 years: $-3.6 billion).

Increased Transparency - Requires monthly average manufacturer price (AMP) reporting to states on multi-source drugs. Also requires quarterly updating of public AMP reporting website. Requires AMP definition clarification including exclusion of prompt pay discounts to wholesalers. Conference agreement requires manufacturers to report

within 30 days, prompt pay discounts, AMP, and best price data. The HHS Inspector General is to report on AMP requirements and make recommendations for changes beginning July 1, 2006.

Best Price - Beginning with quarters after January 1, 2007, manufacturers would need to report Medicaid nominal price drug sales. The conference agreement defines nominal sales for computing best prices as made by a manufacturer of covered drugs at nominal prices to a) entities eligible for discounted prescription drug prices under Section 340 (B); b) intermediate care facilities for the mentally retarded; c) state owned or operated nursing facilities; d) any other facility or entity that the Secretary determines is a safety net provider to which sales of such drugs at nominal process would be appropriate.

Authorized Generics - The report drops "authorized generic" terminology and replaces it with any manufacturer drug sold under new drug applications (NDAs) approved by FDA. There is no definition of authorized generic. Best price would include all FDA approved NDAs sold during the rebate period to any manufacturers, wholesalers, HMO, retailer, non-profit or government entity. The bill includes authorized generics in the new FUL and calculation of best price. Effective date: January 1, 2007. (CBO score over 5 years: $-150 million).

Dispensing Fees - There are no dispensing fee provisions in the conference agreement.

Rebates - Rebate increases were excluded from the conference agreement. It requires states to submit annual reports with payment rates for all Medicaid-covered drugs as well as dispending fees under state plans. The Secretary of HHS will compare the 50 most widely prescribed drugs for national retail sales price data for each state. (CBO score over 5 years: $-70 million).

* The conference report excluded any provisions relating to the use of the TRICARE formulary, effective January 1, 2007. In addition, the conference report does not include a carve-out for mental health pharmaceuticals.

Long Term Care

Asset Transfer Rules - Increased the look-back period from three to five years; sets the home equity limit at $500,000; however, gives states the option of electing a greater value not to exceed $750,000, and provides penalty periods to begin at time of application; requires that partial months of ineligibility be imposed; includes the hardship waiver process; sheltering of assets: maintains broad definition of assets including annuities; requires all new applicants to declare all interest in annuities and to name the state as the remainder beneficiary; requires states to use the "income first" rule; clarifies that Continuing Care Retirement Communities (CCRC) are countable resources; gives states the authority to accumulate multiple transfers into one penalty period; includes certain notes and loans, as well as transfers to purchase life estates, under asset transfer rules. Effective date: The calendar quarter beginning on or after enactment of the bill. (CBO score over 5 years: $-2.4 billion).

Long Term Care Partnership Program – Expands the long term care partnership program beyond the initial state (CA, CT, IN, IA, and NY), requiring that existing partnership programs not allow consumer protection standards and allow certain individuals to be exempt from estate recovery requirements. Inflation protection would be required for Partnership policies issues to individuals under age 76, with compound inflation protection for those under age 61. The bill would require the Secretary, in consultation with the states, to develop uniform minimum data sets for Partnership policies and set standards for reciprocity between state programs. Effective date: No earlier than the first day of the first calendar quarter in which the state plan amendment was submitted to the HHS Secretary. (CBO score over 5 years: $30 million).

Home and Community Based Services (HCBS) - States may provide HCBS through a state plan amendment. States are required to establish *needs-based* criteria for determining an individual's eligibility for the HCBS option. In addition, eligible individuals must be under 150 percent FPL. Effective date: January 1, 2007. (CBO score over 5 years: $770 million).

Cash and Counseling - At state option, provides states the ability to offer cash and counseling services. (CBO score over 5 years: $100 million).

Waste, Fraud, & Abuse

Contingency Fees - There are no provisions included in the conference report limiting contingency fees.

Medicaid Integrity Program – The conference report establishes a Medicaid Integrity Program within HHS that is funded at $5 million in FY 2006 and approximately $50 million in FY 2007-2008 and $75 million thereafter. Expands the Medicare-Medicaid data match project (Medi-Medi) as a required Medicare activity. Medi-Medi expansion would include in addition to HCFAC appropriations, designated funding of $12 million in FY 2006; $24 million in FY 2007; $36 million in FY 2008; $48 million in FY 2009; $60 million in FY 2010 and each year thereafter. (CBO score over 5 years: $529 million). The report also prohibits double-billing and restocking of prescription drugs.

State False Claims Acts – If a state has in effect a law relating to false claims that meets certain criteria, states would be eligible for an enhanced FMAP. The criteria are as follows: the law must be determined to a) establish liability to the state for false claims in the federal False Claims Act, with respect to Medicaid expenditures, b) contain a requirement for filing an action seal for 60 days with review by the state Attorney General, and c) contain a civil penalty that is not less than the amount authorized by the federal False Claims Act. (CBO score over 5 years: $-25 million). In addition, states must train employees on the False Claims Act and ways to detect and prevent fraud, waste, and abuse. Effective date: January 1, 2007. (CBO score over 5 years: $-7 million).

Third-Party Identification and Payment – The language remains the same as the House and Senate bills. It strikes the term "health maintenance organization" and substitutes it with "managed care organizations, pharmacy benefit managers, other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service." The conference agreement specifies that states must require parties legally responsible for payment of a claim to provide, upon request of the state, information to determine during what period an individual or their spouse and dependents may be covered by an insurer, and the nature of the coverage. Effective date: January 1, 2006. (CBO score over 5 years: $-570 million).

Cost Sharing and Benefits

Premiums and Cost Sharing - The report provides increased enforceable cost sharing for certain beneficiaries at state option. Explicit cost sharing limits for individuals in families with income under 100% FPL are dropped in the conference agreement. Includes indexing of nominal co-pay amounts beginning at $3. (CBO score over 5 years: $-960 million). Includes tiered co-pays for prescription drugs. (CBO score over 5 years: $-960 million). Effective date: March 31, 2006. Also includes provisions to give states an option to deter non-emergency use of the ER. (CBO score over 5 years: $-10 million). Effective date: January 1, 2007.

Benefits Package Flexibility – It also provides flexibility to provide benchmark coverage to certain beneficiaries at state option. For any child under the age of 19 in one of the major mandatory and optional eligibility groups, wrap-around benefits to the benchmark coverage consists of EPSDT services as defined under current Medicaid law. However, the agreement drops the benchmark dental coverage provision. The agreement also expands the list of specified groups that would be exempted from benchmark coverage. (CBO score over 5 years: $1.250 billion savings). Effective date: January 1, 2007.

State Financing

Managed Care Organizations - The report expands the Medicaid MCO provider class to include all MCOs and limits states' ability to use MCO provider taxes. Existing taxes are disallowed as of October 1, 2009, provided that the taxes were enacted in a state by December 8, 2005. (CBO score over 5 years: $-435 million).

Targeted Case Management - The conference agreement on targeted case management (TCM) modifies the House and Senate versions to differentiate between *case management* and *targeted case management*. Case management is defined as services that will assist Medicaid eligible individuals in gaining access to needed Medicaid, social, educational, and other services. Targeted case management is defined as case management services that are provided to specific classes of individuals or to individuals who reside in specific areas. The language in the conference report prohibits certain foster care services from being covered by Medicaid's Targeted Case Management

benefit, as well as limits federal financial participation for case management *and* targeted case management services when a third party would also be liable to pay for these services. Effective date: January 1, 2006. (CBO score over 5 years: $-760 million).

FMAP Calculation - Alaska's FY 2006-07 FMAP would remain at the higher of FY 2005 or FY 2006-07 levels (if Alaska's rate decreased in FY 2006-07 then it would remain at FY 2005 levels). At the discretion of the HHS Secretary, Medicaid and SCHIP FMAP rates for states that received significant Hurricane Katrina evacuees could exclude income for Hurricane Katrina evacuees for years after FY 2006. (CBO score over 5 years: $125 million)

Payments to insular areas - The bill provides additional funding to the Virgin Islands, Guam, the Northern Marianas, and American Samoa. Puerto Rico will not receive additional funding. Effective date: Total annual Medicaid caps will be increased as of FY 2006. (CBO score over 5 years: $140 million).

*The conference report does not mandate podiatric services under the Medicaid program.
*The overall request to adjust the FMAPs was not included in the conference report.

Other Provisions

Family Opportunity Act - At state option, the conference report allows families of disabled children to purchase Medicaid coverage for disabled children. Defines qualifying children as those considered disabled under the SSI program without any regard to any income requirements that apply under SSI, and whose families do not exceed 300% FPL. The conference agreement allows states to impose income-related premiums. (CBO score over 5 years: $1.4 billion). Effective date: January 1, 2007.

HCBS Alternatives to Psychiatric Treatment Facilities for Children – The conference report authorizes the HHS Secretary to conduct demonstration projects in up to ten states during the period from FY 2007 through FY 2011 to test the effectiveness of improving or maintaining a child's functional level, and cost-effectiveness of HCBS as opposed to residential psychiatric facilities. The projects must follow the requirements of the HCBS waiver program. The report appropriates $218 million for FY 2007 through FY 2011 for the projects, evaluations, and reports.

Family-to-Family Health Information Centers – The agreement increasing funding under the Special Projects of Regional and National Significance Program (SPRANS) for the development and support of new family-to-family health information centers. These centers provide information and assistance to families of children with special health care needs. The provision requires the HHS Secretary to develop centers in at least 25 states in FY 2007, 40 states in FY 2008, and all states in FY 2009, including the District of Columbia. (CBO score over 5 years: $11 million).

Emergency Services in Managed Care – The agreement states that a Medicaid provider that does not have a contract with a Medicaid MCO that provides emergency care to a

beneficiary in that MCO must accept as payment the amount applicable outside of managed care; the fee for service rate. This rate is the maximum payment rate. Effective date: January 1, 2007. (CBO score over 5 years: $-50 million).

Medicaid Eligibility for SSI Beneficiaries – The report extends Medicaid eligibility to those under the age of 21 and eligible for SSI on the later of a) the date the application was filed, or b) the date SSI eligibility was granted. Effective date: One year after enactment of the bill. (CBO score over 5 years: $105 million).

Money Follows the Person – Demonstration projects in states to increase the use of home and community based services (HCBS) instead of institutions. In order to be eligible, the individual must require the level of care in an institution. States that are awarded the demonstration will receive an increased FMAP rate. Effective date: January 1, 2007. (CBO score over 5 years: $340 million).

Medicaid Transformation Grants - Provides $100 million in Medicaid Transformation grants for states that are innovative in improving effectiveness and efficient in the Medicaid program, specifically in reducing patient error rates, collections from estates, and reducing fraud and abuse. (CBO score over 5 years: $150 million).

Documentation Requirements – The conference report requires states to present documentation of citizenship prior to enrollment in Medicaid. Evidence of citizenship may include a U.S. passport, Certificate of Naturalization, or Certificate of United States Citizenship. Multiple documents from a list of satisfactory evidence may also be provided, including a U.S. birth certificate, Certificate of Birth Abroad, United States Citizen Identification Card, and a state issued driver's license from a state that requires proof of U.S. citizenship before issuance. Effective date: The provision would apply to determinations of initial eligibility made on or after July 1, 2006. (CBO score over 5 years -$220 million).

Health Savings Accounts – The report establishes a demonstration program for states to provide health opportunity accounts (HOAs). Effective date: January 1, 2007. (CBO score over 5 years: $64 million).

Non-Emergency Medical Transportation - At state option, the report establishes a non-emergency medical transportation brokerage program to more cost-effectively provide transportation for individuals eligible for medical assistance. The brokerage programs do not have to be available statewide. Effective date: Upon enactment of the bill. (CBO score over 5 years: -$55 million).

Transitional Medical Assistance (TMA) and Abstinence Education Program - Extends TMA from December 31, 2005 to December 31, 2006 and extends the abstinence education block grant program fiscal year 2006 and provides an additional $12.5 million for the first quarter of fiscal year 2007. (CBO score over 5 years: $761 million).

SCHIP

SCHIP Funds - Provides additional SCHIP allotments to shortfall states in FY 2006, in the amount of $283 million. Shortfall states are defined as those states with an approved SCHIP plan whose projected FY 2006 expenditures exceed the available funds for that year. The report prohibits the ability to cover non-pregnant childless adults with SCHIP funds in the form of new Section 1115 waivers. The provision allows for the continuation of existing waiver projects. The HHS Secretary can continue to approve projects that expand the SCHIP program to caretaker relatives of Medicaid or SCHIP eligible children. Effective date: Applies to items and services furnished on or after October 1, 2005. (CBO score over 5 years: $20 million).

Authority for States to Use Certain Funds for Medicaid Expenditures – Qualifying states will continue to have authority to apply for federal SCHIP matching funds toward the coverage of certain children enrolled in Medicaid, as is currently the law. Specifically, the bill would allow qualifying states to use any available FT 2004 and FY 2005 SCHIP funds for such services. Effective date: Expenditures made on or after October 1, 2005.

Katrina Relief

Federal Payments Under Section 1115 Demonstrations - Includes $2 billion in health care-related relief to survivors and evacuees in and/or from the major disaster counties in Alabama, Louisiana, and Mississippi. Such finding will be available for qualifying Medicaid and SCHIP services provided through June 30, 2006 and uncompensated care through January 31, 2006. Provides for 100 percent FMAP for 10 months. (CBO score over 5 years: $2.1 billion).

State High Risk Health Insurance Pool Funding – The conference agreement appropriates $75 million for FY 2006 for the losses incurred by states in connection with the operation of their qualified high risk pool. This funding will apply upon the enactment of the State High Risk Pool Funding Extension Act of 2005. (CBO score over 5 years: $80 million).

Proposal: Targeted Case Management Reform
House § 3146
Senate § 6031
Both the House and the Senate language contain severe restrictions from what states can currently provide through the optional targeted case management option. In Minnesota, this represents a potential loss of $86 million per year in FFP for targeted case management, and an additional $35 million per year if this bill is also intended to affect case management provided through home and community based waivers. See attached analysis for further detail.

In recent years, CMS began disapproving state plan amendments and taking disallowances based on the theory that local programs are primary to Medicaid, even though that policy is not supported by current law. States are challenging CMS policy in the courts. Even if this proposed language is stricken from the bill, we recommend that Congress revise section 1915(g) to prevent CMS from refusing FFP on the grounds that the underlying services are required to be provided under state law or are available in part through other state and local funding mechanisms. Without clarifying language in federal law, CMS will continue to force states into court over these issues.

Minnesota has made great strides in the last 20 years, in major part because of the targeted case management option, to ensure that our most vulnerable people have their treatment needs identified and addressed. Loss of the TCM option would create a gaping hole in the safety net, in particular for children at risk, people with severe mental illness, people with developmental disabilities, and vulnerable adults.

Proposal: Third Party Recovery
House § 3144
Senate §6021
Similar to the above proposal regarding case management, this proposal would represent an enormous loss of federal funding for current Medicaid rehabilitative services provided to people with mental illness and chemical dependency. This section designates as primary to Medicaid any party that is "by statute, contract, or agreement legally responsible" for health care. This goes far beyond the current TPL requirements in Medicaid. In essence, it prohibits federal matching funds for any service that CMS believes would be provided by state or local government in the absence of Medicaid coverage. Prior to Medicaid, state and local government were largely responsible for the types of rehabilitative services that were not covered by insurance (CD treatment, mental health counseling and supports, etc.). If this language is enacted, Minnesota will lose millions in federal funding, and more importantly, will lose much of the progress that has been made over the last twenty years.

Proposal: Restructuring Medicaid Pharmacy payments
House §3101
Senate §§6001 - 6004
We support efforts to increase pricing transparency. The current use of the artificial (and usually inflated) average wholesale price is problematic. Efforts to provide states with better information that may be used in setting rates are welcome changes. However, we have concerns with four related items:

1) FUL. Both bills change the calculation of the Federal Upper Limit (FUL). The House bill prevents states from paying rates for any individual drug in excess of the FUL. Currently law allows states to pay more than the FUL for any individual drug as long as states pay less than the aggregate FUL for all drugs. The house language takes away some flexibility to pay a higher rate where the costs in the local market are higher, and can result in pharmacies receiving less than their cost.

2) Dispensing Fees. The Senate bill requires that dispensing fees for generics exceed the dispensing fees for multiple source innovator drugs. The House bill requires states to pay dispensing fees at a minimum of $8.00 per prescription for multiple source drugs. Neither of these provisions sufficiently addresses the problem because the dispensing fee is only one part of the reimbursement for prescription Medications. Mandating the dispensing fee without thoughtful changes to the whole pricing formula will increase Medicaid costs.

3) Rebates. The Senate provision to increase rebates to 17% of AMP will have a positive financial impact on Minnesota. We are concerned, however, that the increase may negatively impact the ability of generic producers of drugs, producers that Medicaid relies on to contain costs, to continue to succeed in the market.

4) Anti-psychotics and Antidepressants. The House bill puts restrictions on when a state may require prior authorization (PA) for single-source anti-psychotics and antidepressants. It would require a determination by the state drug utilization review board that imposing restrictions would neither harm patients nor increase overall costs. It also requires states to cover new "me-too" drugs, at least initially, without restrictions and forbids states from using cost-saving measures such as pill-splitting when appropriate. These restrictions limit the state's ability to manage pharmacy costs—a significant cost-driver. While Minnesota Medicaid currently covers all anti-psychotics and antidepressants, this language prevents the state from implementing clinically-sound cost-saving measures in the future.

Proposal: Medicaid Long-Term Care Reform
House §§3111 - 3115
Senate §6011
Minnesota strongly favors the House proposal over the Senate. The House version is much stronger in curtailing asset transfers and asset sheltering. It also adopts a uniform longer look-back period of 60 months and starts the penalty period on the later of the first month of Medicaid eligibility for LTC, or the month of or month after the transfer; these were requests Minnesota included in its LTC §1115 waiver. We would recommend some minor revisions to a few other provisions to assure clarity: undue hardship procedures; the disclosure of annuities and large transaction; and application of the income-first rule.

The Senate provisions actually appear to create new vehicles and methods for asset sheltering and have the potential to increase state Medicaid LTC costs. These provisions would also remove some of the flexibility states have had to date in crafting their own strategies to curtail asset sheltering.

Proposal: LTC Partnership
House §3133
Senate 6012
Minnesota favors the House version with the dollar for dollar LTC policy usage to identify the amount of assets excluded in eligibility and protected from estate recovery. There may be concern with the House provision that does not require the LTC policies to have inflation protection (although it must be offered).

The Senate places a $250,000 cap on the policy benefit and hence the amount of asset protection; requires inflation protection; delays implementation until 2007 and would impose certain NAIC model provision on

partnership LTC policies (not applicable to other LTC policies, creating a market disparity). The existing partnership states would have to convert to the new partnership model.

Proposal: Katrina Relief
House §3201, 3202
Senate §6032
Minnesota supports federal payment of 100% of the Medicaid and SCHIP costs of Katrina survivors in either a home or host state found in both bills. Minnesota supports the House provision, which ends the enhanced funding on July 31, 2006. The Senate provision ends the enhanced funding earlier--May 15, 2006.

In the House bill, there is additional funding for a high risk insurance pool and is presumably Katrina-related. Minnesota has enrolled Katrina survivors not eligible for federally-funded health care programs and would also support funding for this population.

Proposal: Reduction in Payments to Nursing Facilities for Bad Debt
Senate §6102
This provision reduces the Medicare payment for allowable bad debt attributable to Medicare deductibles and coinsurance by 30%. Minnesota Medicaid pays the nursing home copayment for dual eligibles, but is allowed by federal law to limit the copay so that the total amount paid to the facility does not exceed the Medicaid rate, which can result in a loss to the nursing home. Under current law, that loss is reimbursable through Medicare as bad debt. If this reduction in allowable bad debt is enacted, Minnesota nursing homes will lose a significant amount of Medicare funding.

Proposal: Revising SCHIP funding rules
Senate §6051
This section includes a provision that reduces the enhanced matching rate to the regular Medicaid matching rate for redistribution funds used for expenditures related to adults. This will create the potential for loss of federal funding to Minnesota, if we cannot use all redistributed funds for pregnant women covered in our S-CHIP program.

Given the uncertainties that may be created by revisions to the SCHIP funding rules, we favor the provision extending the time period in which certain states (including Minnesota) may use up to 20% of the SCHIP allotment for Medicaid child expenditures but would prefer to see it extended beyond 2005.

Minnesota Budget Project

The Budget Conference Agreement's Impact on Minnesota

The week of December 18, 2005, the U.S. Senate and U.S. House passed slightly different versions of a budget conference agreement that would have a profound and damaging impact on Minnesota. The budget agreement would cause Minnesotans to lose access to health care services and prescription drugs, lose the child care assistance that enables parents to work, and receive less of the child support that they are owed. While there is a provision to increase funding for energy assistance, that money will not be able to help families this winter. In addition, the conference agreement puts substantial financial pressure on the state of Minnesota, which is only starting to recover after four years of crippling budget deficits. Because the Senate made slight modifications to the conference agreement, it now goes back to the U.S. House for another vote in late January or early February.

Health Care

One in 9 Minnesotans receives health care coverage funded in part by Medicaid. The budget reconciliation bill before the Senate would let copayments be substantially increased in Medicaid and would let health care providers deny services to those who cannot meet the copayments.

In 2003, Minnesota increased copayments for drugs and medical services in Medicaid. A study from Hennepin County Medical Center showed that a large number of people covered by Medicaid **ended up in the emergency room or being admitted to the hospital because they were unable to afford their medications**. This issue was the subject of a lawsuit and a state court determined that current law makes it illegal for pharmacists to deny medications to persons covered by Medicaid.

The budget bill will undo these legal protections. It will allow people on Medicaid to be charged copayments that are far above current levels for prescription drugs, physician care, inpatient hospital care, and many other services. As a consequence, low-income people would go without needed care, and use of emergency room and other hospital services would increase.

Also, under the bill, **many beneficiaries in Minnesota, particularly those with disabilities, could lose access to medically-necessary services** like therapy services, personal care, eyeglasses, hearing aids, and crutches.

The bill **creates a new unfunded mandate on states** regarding eligibility determinations: a new requirement that U.S. citizens applying for Medicaid must provide documentation of their citizenship, generally by producing a birth certificate or passport. States already require applicants to attest under penalty of perjury that they are citizens, and federal auditors have found no problem with this approach. This provision would only **end up reducing or delaying enrollment of eligible citizens**, because many low-income citizens do not have birth certificates in their possession and do not have passports. This would be a particular problem for people in need of immediate medical care, including people with disabilities. This provision would also make it more difficult for Minnesota to administer its Medicaid program. Medicaid officials across the country have reported that this provision would increase administrative costs.

The budget reconciliation conference report would significantly limit Medicaid coverage of case management services — a benefit covered by Minnesota's Medicaid program. It would prohibit federal matching funds for case management wherever another state program could pay for such services, even if that program is not required to cover those services. Since many programs theoretically could pay for these services but do not have the capacity to actually serve more people, this provision could end up completely undercutting this vital benefit for low-income individuals in Minnesota. Often these case management services are used to help the elderly and persons with disabilities stay out of long-term care institutions.

Welfare-to-Work and Child Care

The provisions on the nation's welfare-to-work program, Temporary Assistance to Needy Families (TANF), would **impose expensive new expectations on states without providing them with adequate resources**. The Congressional Budget Office (CBO) has estimated that the cost to states of meeting the new requirements would be $8.4 billion over five years. This includes $4.3 billion in costs associated with operating significantly larger welfare-to-work programs and $4.1 billion in additional child care costs. Yet the bill includes just $1 billion in additional child care funding — less than states need just to ensure that their current child care funding keeps pace with inflation — and no additional welfare-to-work funding.

The Center on Budget and Policy Priorities estimates that **nationally some 255,000 fewer children will receive child care assistance**, as states would likely divert significant child care funding away from low-income working families not participating in the state welfare-to-work programs in order to meet the new TANF program requirements.

In 2003, Minnesota made a series of substantial cuts to its child care assistance programs for low-income working families. Those cuts dramatically reduced the income level at which families can receive child care assistance and substantially increased the copayments that families pay. The conference agreement's welfare-to-work provisions could **force Minnesota to make still larger cuts in child care** subsidies for low-income working families not receiving TANF cash assistance, undermining Minnesota's long-standing (if already scaled back efforts) to "make work pay" as part of its welfare reform agenda.

Under these new provisions, Minnesota would have to significantly increase the number of parents participating in welfare-to-work programs, at significant cost to the state. Moreover, the bill **would significantly restrict the flexibility Minnesota now has when helping families move towards self-sufficiency** — this flexibility has been the key to successes in Minnesota's welfare-to-work programs.

Child Support Enforcement

The conference agreement includes $1.5 billion in cuts to federal funding for child support enforcement efforts over the next five years and $4.9 billion over the next ten years. This is funding that states use to locate absent parents, establish legally enforceable child support orders, and collect and distribute child support owed to families. Minnesota stands to lose $47 million in funding for child support enforcement over the next five years and $141 million over the next ten years. As shown in the table, **these cuts take billions of dollars out of the pockets of parents and children** who are owed child support.

Amount of uncollected child support		
	5 year total	**10 year total**
U.S.	$2.9 billion	$8.4 billion
Minnesota	$83 million	$241 million

Energy Assistance
There has been considerable attention to the high heating costs that Minnesotans will face this winter. The conference agreement includes $1 billion for the federal energy assistance program called LIHEAP, but these funds are not made available until fiscal year 2007, so **none of these funds would help Minnesotans this winter.**

ASSOCIATION OF AMC MINNESOTA COUNTIES

Memorandum

To: **Senator Linda Berglin and Members of Senate HHS Finance Committee**

From: **Patricia Coldwell, Health and Human Services Policy Analyst**

Date: **January 18, 2006**

Re: **Federal Budget Reconciliation**

I am writing express Minnesota counties' concerns about the pending federal health and human services budget reconciliation proposals. Counties believe that many elements in this bill could have a negative impact on counties' ability to help vulnerable individuals survive and thrive. In particular, the bill potentially limits use of federal dollars for case management for child protection, children's and adult mental health, elderly, and people with developmental disabilities. These services are critical to reducing costs for deeper end services, such as acute health care and out-of-home placements. Eliminating use of federal dollars for these services will likely shift costs to the state or local property tax.

The attached background summary was jointly prepared by Hennepin and Ramsey counties and provides further description of counties' perspectives. It also includes estimates of dollars and staff that would be lost under a "worst-case scenario". Since the language is subject to interpretation, however, it is unclear what the exact effect on Minnesota will be if this bill passes.

AMC sent the attached letter to our congressional delegation and have continued to voice our concerns to our representatives. In fact, a bipartisan delegation of county officials visited Washington D.C. in December to meet with our congressmen about this bill. AMC is gathering additional information from all counties and is posting this information on our web site as we receive it.

If you would like additional information on counties perspectives, please contact me.

Cc: Commissioner Kevin Goodno

Association of Minnesota Counties
125 Charles Avenue, St. Paul 55103-2108
Phone: (651) 224-3344, Fax: (651) 224-6540
www.mncounties.org

ASSOCIATION OF
AMC
MINNESOTA COUNTIES

The Honorable Gil Gutknecht
U.S. Representative
425 Cannon House Office Building
Washington, D.C. 20515

October 21, 2005

Dear Congressman Gutknecht:

The Association of Minnesota Counties, representing Minnesota's 87 counties would like to call your attention to several provisions specific to social services and health funding programs that are threatened by the proposed reconciliation budget cuts. The Association of Minnesota Counties recognizes the importance of controlling the growth in federal spending. However, we believe that some proposals for savings presented in the budget reconciliation package will adversely affect Minnesota citizens and result in increased costs to future generations.

Minnesota is one of a handful of states in which federal funding for some social services and health programs flow directly to counties. Minnesota counties provide critical social and public health services to a vast population throughout the state. Our counties work locally to administer critical programs such as the Minnesota Family Investment, Social Services Block Grant (SSBG), and Title IV-E (Foster Care) Programs. Through efficient and effective execution Minnesota county programs resolve the obstacles people face in their efforts toward self-sufficiency. Minnesota's unique approach has made it a leader as the healthiest state in the nation, as well as a human services model for states throughout the county.

Minnesota counties are particularly concerned about proposed reductions to the Medicaid program. We are concerned that some of these proposals will increase long-term costs to the federal, state and local governments by reducing access to needed preventive, public health, and primary health care services. Although committees have not released reconciliation language current proposals reflect most of the $10 million in savings to the Senate Finance and House Energy and Commerce Committees will come from Medicaid changes.

Specific concerns about the proposed Medicaid changes include the following:

- The proposal to clarify the definition of case management services will reduce access to needed services and move toward more expensive acute and long-term care services. It will also result in additional administrative costs for increased reporting at the state and county level. Providing targeted case management, as

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occurs under the current program, prevents child and vulnerable adult abuse and neglect and helps keep families together by preventing out-of-home placements.

- The proposal to clarify the definition of rehabilitation services could be interpreted to discriminate against individuals with mental illness, developmental disabilities, and dual disorders. Excluding coverage when services are provided "as an intrinsic element of another program" could be seen as a maintenance of effort requirement. This would penalize counties that have developed a community-based infrastructure to serve people in smaller residential facilities.
- The proposal for cost-limited reimbursement of governmental providers would put county providers at a competitive disadvantage with private health care providers. It likely would also create additional administrative costs, as additional cost reporting would likely be required.
- The proposal for allotment limits for Medicaid administrative costs would limit innovative approaches, preclude capital improvements in a base year, and require states to fund the total cost of new administrative mandates. This would result in loss of millions of dollars of federal funding to Minnesota.

Thank you for considering our perspectives on these proposals. If you require additional information, please contact Patricia Coldwell, Health and Human Services Policy Analyst, at 651-224-3344.

Sincerely,

Harlan Madsen

Harlan Madsen, President
Association of Minnesota Counties

Ramsey County

Hennepin County

220 Court House, 15 West Kellogg Boulevard
St. Paul, Minnesota 55102
(651) 266-8350 FAX: (651) 266-8370

A2400 Government Center
Minneapolis, Minnesota 55487-0240
(612) 348-3081 FAX: (612) 348-8701

MEDICAID – BACKGROUND AND BUDGET RECONCILIATION

Essential Points

- Child Protection services in Ramsey and Hennepin Counties are funded through Targeted Case Management. The State has historically not funded child protection services; these services are a county responsibility.
- The proposed changes take away money and resources from our efforts to relocate individuals from state institutions and reduce more expensive out of home placements. Limiting case management will lead to higher public and governmental costs in the future as more deep-end services are needed. For families, this is another example of the trend in which we are no longer helping people survive and thrive, but they are expected to barely survive at the margin.
- Working poor families who are doing what we ask to become self-reliant will likely have incomes fall into the area where they will qualify for TANF benefits.

Likely Long Term Consequences for Families and Individuals Served

- ***Case Management*** – Case management coordinates other needed services, controls utilization, and substitutes community support services for expensive institutional services. The most obvious examples are out of home placement and deep end medical costs. It is an integral part of services to abused and neglected children, elderly, and adults with physical, emotional, or cognitive disabilities.
- ***Third Party Liability*** – reduces the rehabilitative services money that keeps individuals with mental illness and chemical dependency out of expensive institutions.
- ***Child Support*** – Ramsey County collects $4.95 in child support for every $1 invested. Hennepin County collects over $114 million annually in child support payments, or $4.53 for every $1 invested. Child support enforcement is a critical component of welfare reform, keeping working family incomes from dropping to where they qualify and have to enter the program to make ends meet. In Ramsey County, 73% currently served are not on the TANF/MFIP program (57% were once on public assistance). In Hennepin, 78% of the cases are not on the TANF/MFIP program (60% were once on public assistance).
- ***Title IV-E*** – decrease the ability to keep children out of foster care and keep them with relatives. This will lead to more placements with non-relatives. This will most affect children with special or emotional needs. Studies have demonstrated that placements with relatives are more stable and educational success is greater.

Immediate Impacts on Families and Individuals Served

- ***Medicaid co-payments*** – charging $20 – 100 for health care services for which they are now charged no more than $3. Congressional Budget Office concluded that such increases in co-payments are likely to lead many Medicaid patients to forgo needed health care services and the imposition of premiums are likely to induce some to fail to enroll in Medicaid at all.
  - Family of three with an income below $16,000, co-payments that will increase at twice the level of inflation.
  - Family of three with an income of $16,000 – 24,0000, co-payments up to 10%,
  - Family of three above $24,000, co-payments up to 20%.
- ***Medicaid Benefit Reductions*** – The vast majority of children below the poverty line will lose access to the comprehensive health care coverage now guaranteed through the Early and Periodic Screening, Diagnostic, and Treatment component of Medicaid.
- ***Medicaid Citizenship Documentation*** – Native-born citizens applying for Medicaid must provide a birth certificate or passport to demonstrate citizenship. People affected by emergencies, homelessness, or with mental illness will be especially affected. Estimates nation-wide are that one in every five African-American born around 1940 lacks a birth certificate.
- *TANF* - Elimination of state flexibility in work requirements for families served entirely with the state's own funds. The Congressional Budget Office expects that states will try to cope with this and other federal mandates by increasing the number of families who are sanctioned off the program and by imposing new barriers to poor families seeking assistance.
- ***TANF, Two-Parent Families*** – 90% of all two parent families would have to participate in work activities for at least 35 hours per week. Researchers and state officials have recognized that such a participation requirement is not attainable because a parent is ill, or needs to care for an ill child, or simply waiting for a work program they are entered in to begin. This provision would encourage states to exclude poor two-parent families from assistance. It also may end up counteracting the new funding initiatives designed to encourage marriage.
- ***Child Care*** – With inadequate child care funding, states will shift available child care dollars from working families to support families on TANF so they can meet the work participation requirements. The net effect is that between TANF and working poor families, nation-wide 255,000 fewer children in low-income families will receive child care assistance - basic sliding fee.
- ***Social Security*** – Eligibility determinations for Social Security generally take many months and, in a significant number of cases, more than a year. Under current law, when found eligible, the recipient receives a lump sum payment back to date of application. The bill changes this so that catch up payments can be no more than 3 months of benefits, delaying Social Security payments for up to a year for individuals with disabilities who are found eligible for SSI.

How Medicaid Dollars Are Used

Ramsey County

	Child Protection	Children's Mental Health	Adult Mental Health	Elderly	Developmental Disabilities	Total
Targeted Case Management (Section 3146)	$5,721,636 Staff – 71.5	$460,000 Staff – 5.75	$1,282,000 Staff 16	$319,000 Staff - 4	$412,557 Staff - 5	$8,195,193 Staff – 102.25
Adult Mental Health Rehab. Services (Section 3144)			$220,000 Staff – 2.75			$220,000 Staff – 2.75
Assertive Community Treatment (Section 3144)			$282,514 Staff - 3.5			$282,514 Staff – 3.5
Total	$5,721,636 Staff – 71.5	$460,000 Staff – 5.75	$1,578,514 Staff – 22.25	$319,000 Staff - 4	$412,557 Staff – 5	$8,491,707 Staff – 108.5

Hennepin County

	Child Protection	Children's Mental Health	Adult Mental Health	Elderly (Nursing Home relocation, estimated)	Developmental Disabilities	Total
Targeted Case Management (Section 3146)	$13,768,000	$2,637,000	$3,753,000	$1,100,000	$867,000	$22,125,000

** In addition, Hennepin estimated $6-10 million is at risk in community case management for adults with behavioral health needs or for children in child protection, plus approximately $6 million in case management under the MA Waiver programs.

MINNESOTA
HEALTH & HOUSING
ALLIANCE

PROMOTING EXCELLENCE AND INNOVATION IN OLDER ADULT SERVICES

Concerns Regarding 2005 Changes to the Alternative Care Program

Members of the Minnesota Health & Housing Alliance (MHHA) report that while the majority of seniors affected by the 2005 changes to the Alternative Care (AC) program are spending down and have, or will soon, qualify for the Elderly Waiver program, there are some seniors for whom the AC changes have been very disruptive. MHHA is concerned that the changes to the AC program will, over the long term, limit access to assisted living services for many seniors who are not poor enough to qualify for Elderly Waiver yet do not have sufficient income and assets to enable them to pay for both rent and needed services. They will simply be priced out of the market. A number of members have already reported that prospective applicants to their housing-with-services settings are unable to cover costs without the assistance of the AC program.

MHHA has gathered information from our members on the impacts of the AC changes, particularly the elimination of "assisted living" as an eligible service under AC. Impacts on those former AC clients who were not able to spenddown to EW eligibility include:

- Relocation. Some former AC clients have been forced to relocate to other settings—to live with families, to other senior buildings without services, and to nursing homes.
- Discontinuation of Some or All Services. While counties and providers have worked hard to assure that vulnerable seniors are not left without critical services, some seniors are not receiving the services they need. For example, one MHHA member noted that because assisted living services are no longer eligible for AC funding, two of their AC clients no longer receive three daily meals plus snacks, assistance with transportation to appointments, 24 hour emergency response or socialization programs.
- Financial Impacts on Seniors. While MHHA agrees that seniors should use their assets to pay for their needed services, the calculations for program eligibility and funding do not always seem equitable. One member reports that the county found that a client's income exceeds the EW limit by only $33. The county has determined that this senior will now receive only $76 per month for personal needs money, which will have to cover prescription co-pays of up to $20 per month, $15 for phone service and other incidentals. If her income had been below the EW limit, she would have about $266 in personal needs money to cover these kinds of expenses.
- Provider Subsidies that Cannot be Sustained Over the Long Term. Some providers are subsidizing the costs that former AC clients can no longer pay, but these subsidies cannot be sustained long-term and will likely end when these particular seniors are no longer residents. One member reported subsidizing former AC clients $354 to $466 per person per month. The inability to pay the cost of rent plus services will continue to affect the access to assisted living services for these seniors of limited means who do not qualify for MA.

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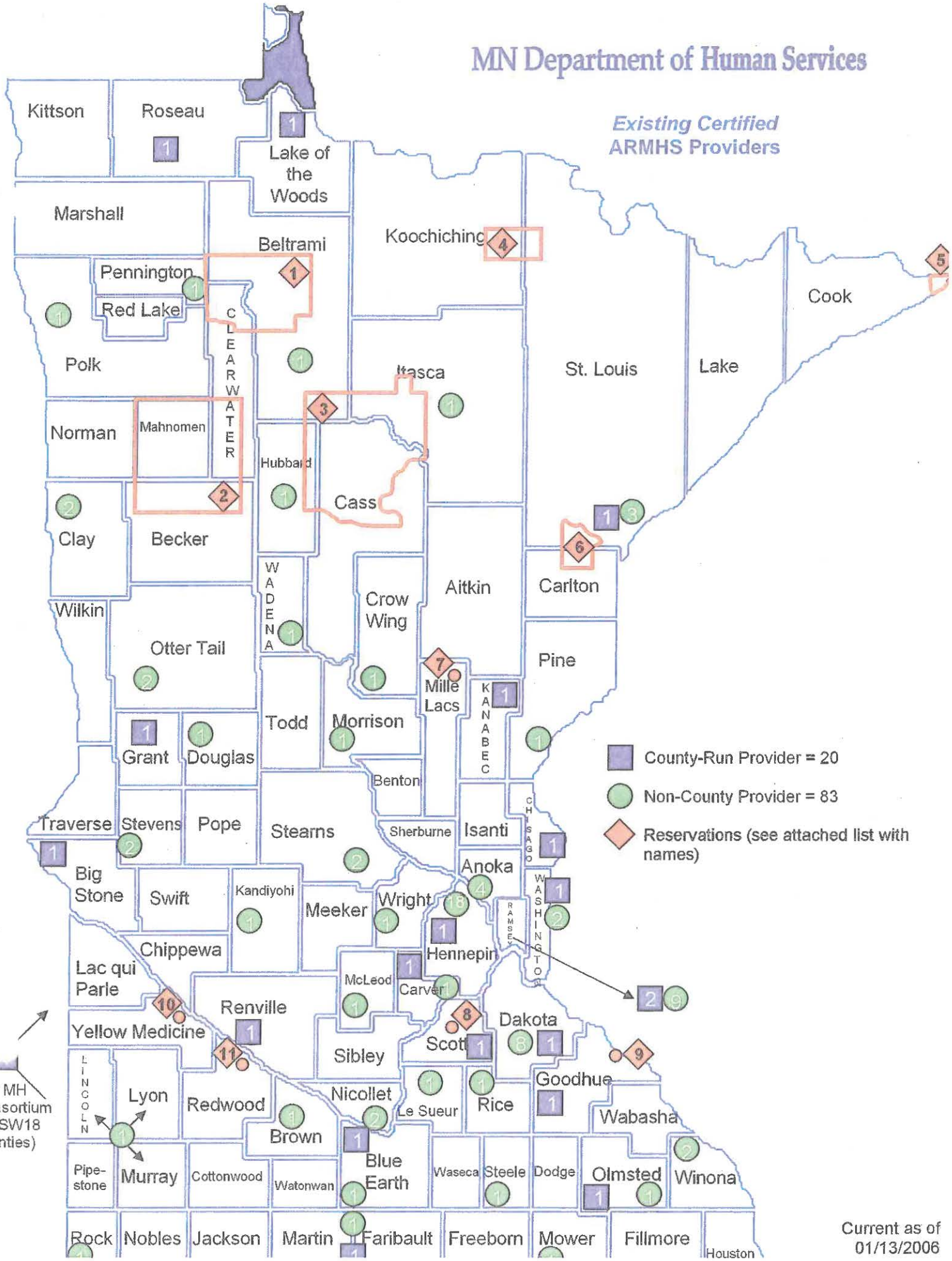
Mental Health Restructuring Documents

Chemical and Mental Health Services Administration
Department of Human Services


MN Department of Human Services
Existing Certified
ARMHS Providers
Kittson
Roseau
Lake of the Woods
Marshall
Beltrami
Koochiching
Pennington
Red Lake
Polk
CLEARWATER
Itasca
St. Louis
Lake
Cook
Norman
Mahnomen
Hubbard
Cass
Clay
Becker
WADENA
Crow Wing
Aitkin
Carlton
Wilkin
Otter Tail
Pine
Mille Lacs
KANABEC
Todd
Morrison
Grant
Douglas
Benton
Traverse
Stevens
Pope
Stearns
Sherburne
Isanti
CHISAGO
Anoka
Big Stone
Swift
Kandiyohi
Meeker
Wright
WASHINGTON
RAMSEY
Chippewa
Hennepin
Lac qui Parle
McLeod
Carver
Renville
Yellow Medicine
Scott
Dakota
Sibley
LINCOLN
Lyon
Redwood
Nicollet
Le Sueur
Rice
Goodhue
Wabasha
Brown
Pipe-stone
Murray
Cottonwood
Watonwan
Blue Earth
Waseca
Steele
Dodge
Olmsted
Winona
Rock
Nobles
Jackson
Martin
Faribault
Freeborn
Mower
Fillmore
Houston
County-Run Provider = 20
Non-County Provider = 83
Reservations (see attached list with names)
SW MH Consortium (all SW18 counties)
Current as of 01/13/2006

MN Department of Human Services

ARMHS Services

Definition of ARMHS Services

Adult Rehabilitative Mental Health Services (ARMHS)

This is Medicaid (MA) funding stream permitting rehabilitation services to be provided one to one and in groups, in home and in the community by qualified staff.

The ARMHS means mental health services enable the recipient to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, and independent living and community skills, when these abilities are impaired by the symptoms of mental illness. Adult rehabilitative mental health services are also appropriate when provided to enable a recipient to retain stability and functioning, if the recipient would be at risk of significant functional decompensation or more restrictive service settings without these services.

Adult rehabilitative mental health services instruct, assist, and support the recipient in areas such as: interpersonal communication skills, community resource utilization and integration skills, crisis assistance, relapse prevention skills, health care directives, budgeting and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills, transportation skills, medication education and monitoring, mental illness symptom management skills, household management skills, employment-related skills, and transition to community living services.

The **primary certification** process determines if the applicant provider entity meets the standards, criteria, assurances, and requirements to be certified as a provider entity of ARMHS, as listed in the legislation. A primary certification can be give to a county (by DHS) or to a non-county provider applying through a county.

Local certification is obtained by an entity already having a primary certification. They can seek "local" certification to provide services in other counties. Receiving local certification requires that the provider be knowledgeable of th local county's health and human service resources.

History of Dates of Implementation/Operation:

ARMHS began March 15, 2002 with five providers. As of January 13, 2006, there are currently 103 providers providing services in all 87 counties.

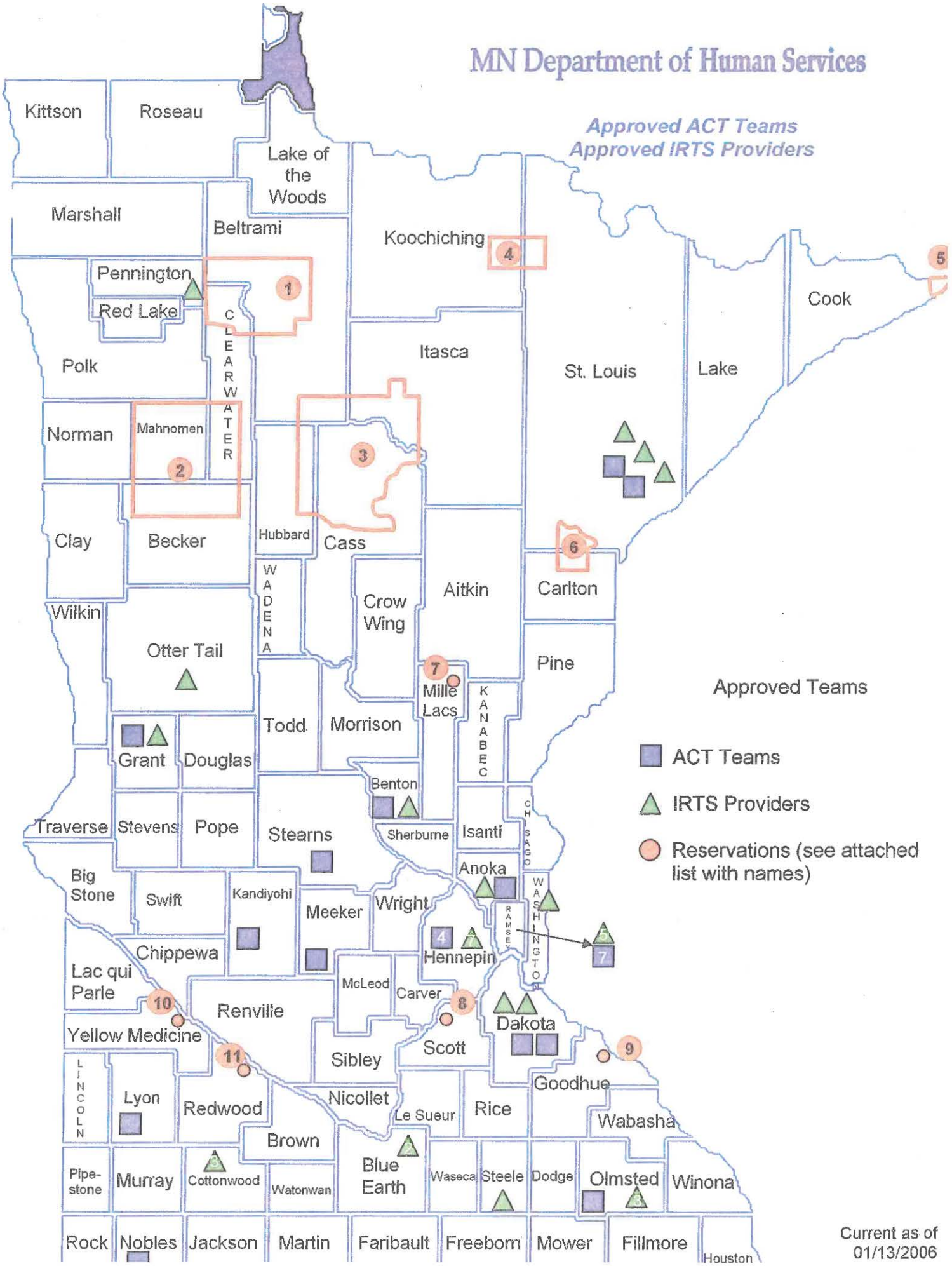
ON THIS MAP:

ARMHS is offered in **all** 87 counties in Minnesota. For the purpose of this map, we are showing only the Primary certifications, or the counties where a provider entity is actually located. The number inside each shape indicates the number of providers in that county. ***If a county doesn't have anything in it, assume that a provider if offering local ARMHS in that county.

Reservations in Minnesota:

1. **Red Lake**
2. **White Earth**
3. **Leech Lake**
4. **Bois Forte/Nett Lake**
5. **Grand Portage**
6. **Fond du Lac**
7. **Mille Lacs**
8. **Shakopee Mdewakanton Sioux**
9. **Prairie Island**
10. **Upper Sioux**
11. **Lower Sioux**

Current as of
01/13/2006


MN Department of Human Services
Approved ACT Teams
Approved IRTS Providers
Kittson
Roseau
Lake of the Woods
Marshall
Beltrami
Koochiching
Pennington
Red Lake
Polk
Clearwater
Itasca
St. Louis
Lake
Cook
Norman
Mahnomen
Hubbard
Cass
Clay
Becker
Wilkin
Wadena
Crow Wing
Aitkin
Carlton
Otter Tail
Pine
Mille Lacs
Kanabec
Todd
Morrison
Grant
Douglas
Benton
Traverse
Stevens
Pope
Stearns
Sherburne
Isanti
Chisago
Anoka
Big Stone
Swift
Kandiyohi
Meeker
Wright
Washington
Ramsey
Hennepin
Chippewa
Lac qui Parle
McLeod
Carver
Renville
Yellow Medicine
Scott
Dakota
Sibley
Goodhue
Lincoln
Lyon
Redwood
Nicollet
Le Sueur
Rice
Wabasha
Brown
Pipe-stone
Murray
Cottonwood
Watonwan
Blue Earth
Waseca
Steele
Dodge
Olmsted
Winona
Rock
Nobles
Jackson
Martin
Faribault
Freeborn
Mower
Fillmore
Houston
Approved Teams
ACT Teams
IRTS Providers
Reservations (see attached list with names)
Current as of 01/13/2006

MN Department of Human Services

ACT/IRT Services

Definition of ACT:
Assertive Community Treatment is provided by multidisciplinary treatment teams with a low client to case manager ratio (10-1). Services can be provided wherever the person needs them. This service is targeted to persons who have the most serious mental illnesses and who have not benefited from conventional community care. Characteristics of ACT are shared caseloads among clinicians (rather than individual caseloads); direct provision of services, rather than brokering services to other providers; 24-hour coverage, including emergencies; close attention to illness management; most services provided in the community, rather than at the clinic; high frequency of contact with clients; and assistance with practical problems in living..

Date of ACT Implementation: January 2005
of Teams: 24

Definition of IRTS:
Intensive Residential Treatment Services Programs are governed by M.S. 256B.0622, M.S.245.472 and Minnesota Rules 9520.0500 to 9520.0690. These are short-term, time-limited services provided in a residential setting to recipients who are in need of this level of supervision and treatment and are at risk of significant functional deterioration if they do not receive these services. People may benefit from this level of service following acute hospitalization, or as a deterrent to it. 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 focus upon supporting recovery through the use of established rehabilitative principles and evidence based practices. Services must be directed toward a targeted discharge date with specified client outcomes.

Date of IRTS Implementation: October 2004
of Teams: 32

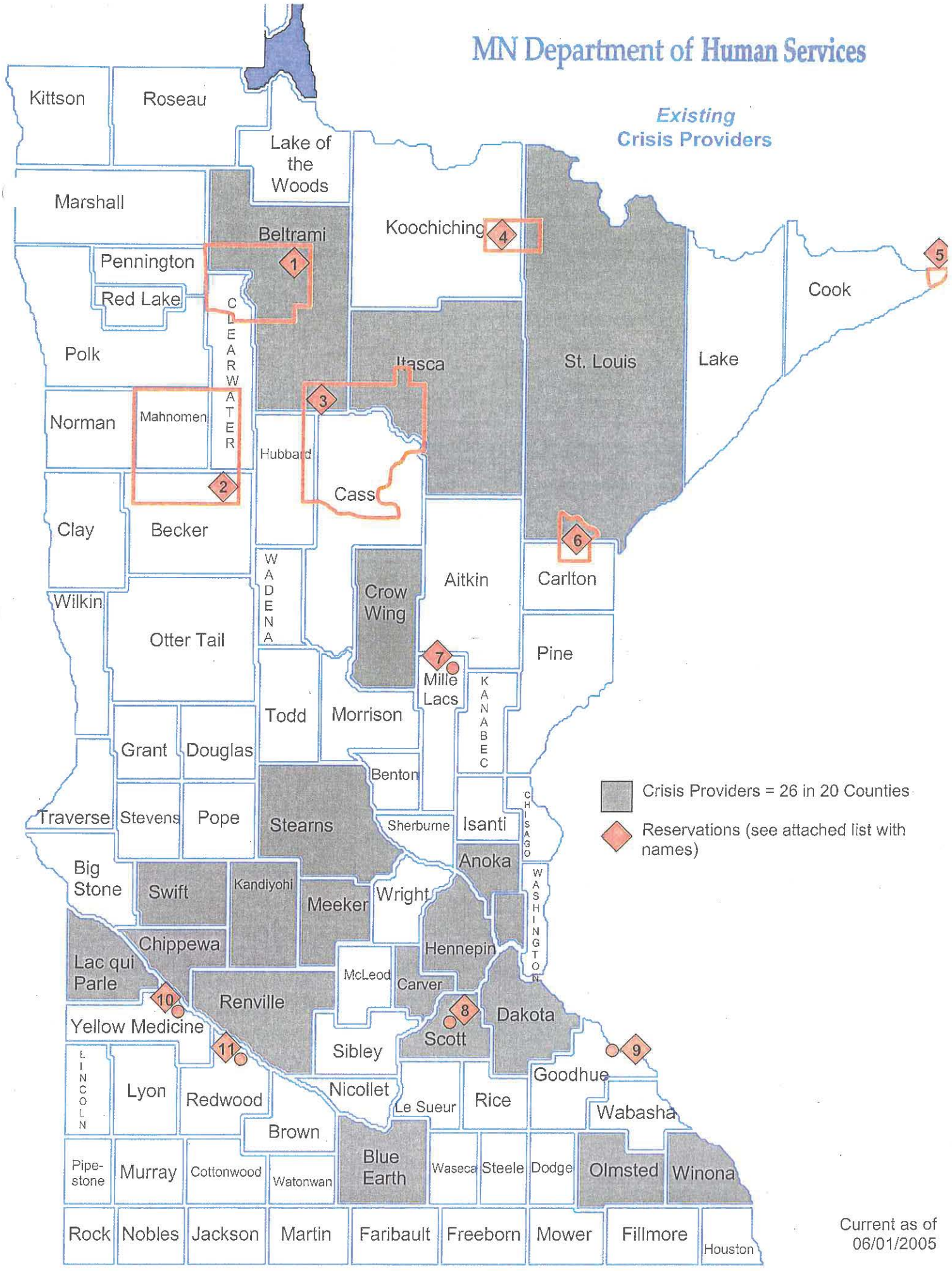
Reservations in Minnesota:

1. **Red Lake**
2. **White Earth**
3. **Leech Lake**
4. **Bois Forte/Nett Lake**
5. **Grand Portage**
6. **Fond du Lac**
7. **Mille Lacs**
8. **Shakopee Mdewakanton Sioux**
9. **Prairie Island**
10. **Upper Sioux**
11. **Lower Sioux**

Current as of
01/13/2006

MN Department of Human Services

Existing Crisis Providers



Current as of 06/01/2005

MN Department of Human Services

Crisis Services

Definition of Crisis Services:

These are MA services targeted to respond to needs of people experiencing a mental health crisis or mental health emergency (see Minnesota Statutes, section 256B.0624, subd. 2. (a) and (b)); and in some cases this will include short-term needs following intervention. These services are intended to assist the recipient to regain functioning to the level of functioning prior to the crisis/emergency or to refer to longer-term supports that will assist the recipient in regaining functioning; to diminish crisis/emergency-related suffering of the recipient; to avoid, where possible, more restrictive service settings; and to maintain community living by the recipient. The services include: crisis assessment, crisis intervention, crisis stabilization (in community and short-term residential), and community intervention.

History of Dates of Implementation/Operation:

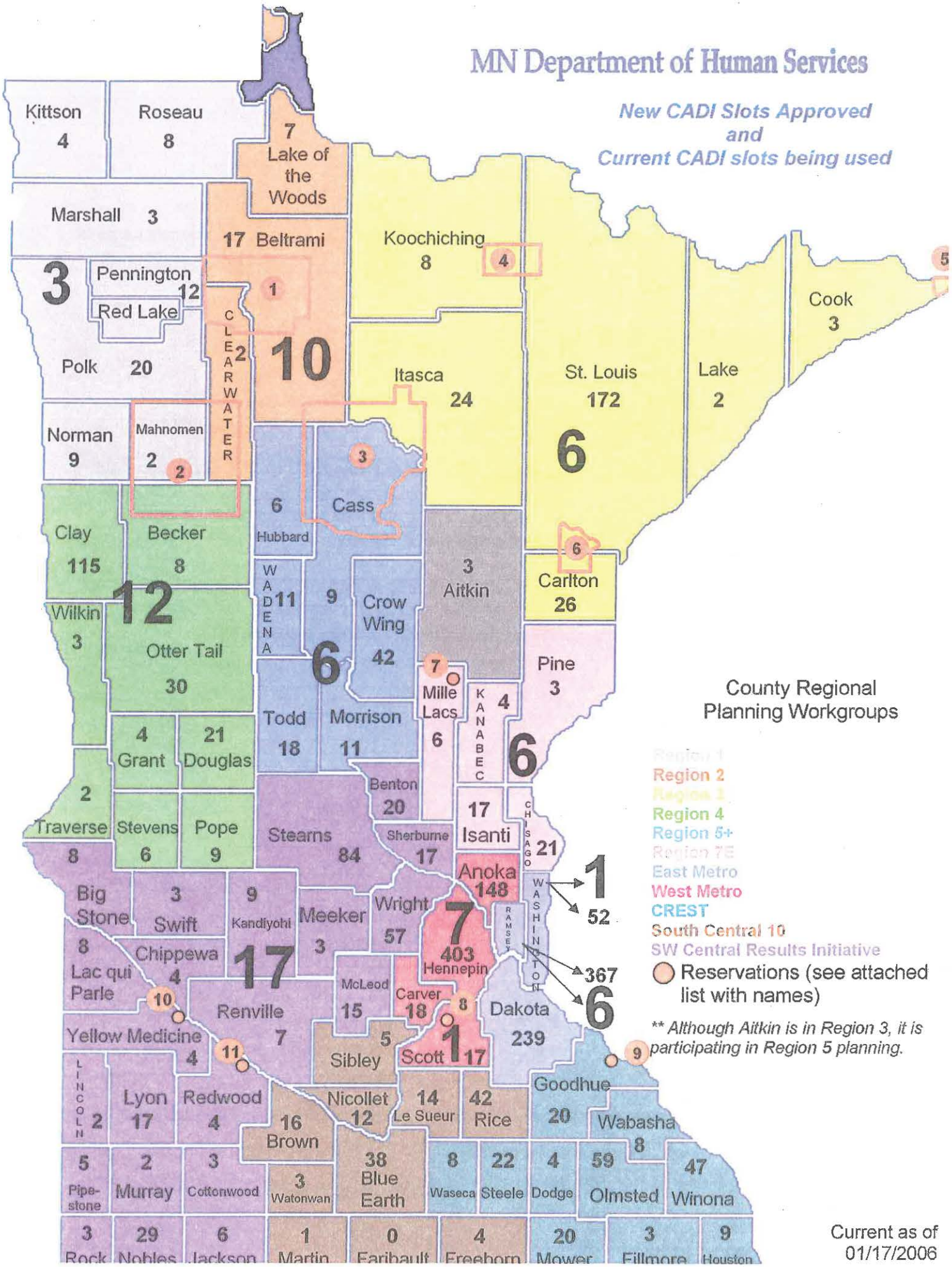
The Crisis Services began operating January 1, 2003. As of June 1, 2005, there are currently 26 crisis providers providing services in 20 counties.

Reservations in Minnesota:

1. **Red Lake**
2. **White Earth**
3. **Leech Lake**
4. **Bois Forte/Nett Lake**
5. **Grand Portage**
6. **Fond du Lac**
7. **Mille Lacs**
8. **Shakopee Mdewakanton Sioux**
9. **Prairie Island**
10. **Upper Sioux**
11. **Lower Sioux**

MN Department of Human Services

New CADI Slots Approved and Current CADI slots being used



County Regional Planning Workgroups

- Region 1
- Region 2
- Region 3
- Region 4
- Region 5+
- Region 7E
- East Metro
- West Metro
- CREST
- South Central 10
- SW Central Results Initiative
- ○ Reservations (see attached list with names)

*** Although Aitkin is in Region 3, it is participating in Region 5 planning.*

Current as of 01/17/2006

MN Department of Human Services

CADI Slots

Definition of CADI:
Community Alternatives for Disabled Individuals (CADI) is a comprehensive package of Medical Assistance services, which can be used to provide care and support for people to live in their own home, instead of in a nursing home.

To be eligible for CADI, the person must:

- Be eligible for MA as a person with a disability
- Require the level of care provided in a NF
- Have a community care plan that reasonably assures health and safety
- Be able to have CADI services provided within the waiver's funding limits

CADI services are provided to approximately 10,000 individuals in MN annually. The service is provided to persons with a wide range of diagnoses. At present, there are 2557 adult persons with a primary diagnosis of mental illness using a CADI waiver. This is represented by the **small numbers** in each county.

As part of the MH restructuring efforts, we have also allocated CADI capacity for those individuals needing the level of service available at Ah Gwah Ching. The **large numbers** in each planning region represent this, depicting 75 statewide.

Reservations in Minnesota:

1. **Red Lake**
2. **White Earth**
3. **Leech Lake**
4. **Bois Forte/Nett Lake**
5. **Grand Portage**
6. **Fond du Lac**
7. **Mille Lacs**
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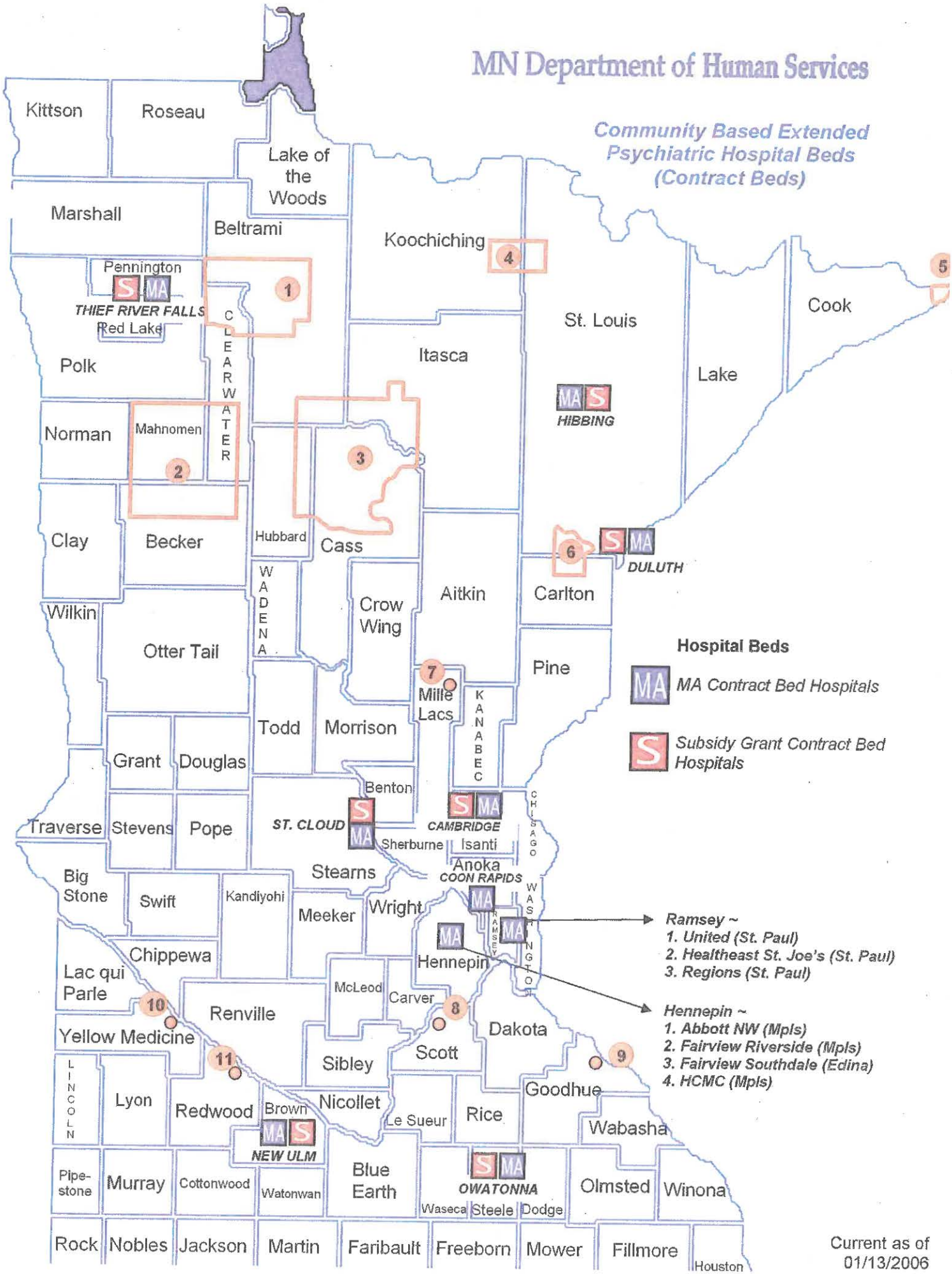
Current as of
01/17/2006


MN Department of Human Services
Community Based Extended Psychiatric Hospital Beds (Contract Beds)
Kittson
Roseau
Lake of the Woods
Marshall
Beltrami
Koochiching
Pennington
THIEF RIVER FALLS
Red Lake
Polk
CLEARWATER
Norman
Mahnomen
Itasca
St. Louis
Cook
Lake
HIBBING
Clay
Becker
Hubbard
Cass
DULUTH
Wilkin
Otter Tail
WADENA
Crow Wing
Aitkin
Carlton
Pine
Mille Lacs
KANABEC
Todd
Morrison
Grant
Douglas
Benton
Traverse
Stevens
Pope
ST. CLOUD
CAMBRIDGE
Sherburne
Isanti
CHISAGO
Anoka
COON RAPIDS
Big Stone
Swift
Kandiyohi
Stearns
Meeker
Wright
WASHINGTON
RAMSEY
Chippewa
Hennepin
Lac qui Parle
McLeod
Carver
Renville
Dakota
Yellow Medicine
Scott
Sibley
LINCOLN
Lyon
Redwood
Brown
Nicollet
Le Sueur
Rice
Goodhue
Wabasha
NEW ULM
Pipe-stone
Murray
Cottonwood
Watonwan
Blue Earth
OWATONNA
Waseca
Steele
Dodge
Olmsted
Winona
Rock
Nobles
Jackson
Martin
Faribault
Freeborn
Mower
Fillmore
Houston
Hospital Beds
MA Contract Bed Hospitals
Subsidy Grant Contract Bed Hospitals
Ramsey ~
1. United (St. Paul)
2. Healtheast St. Joe's (St. Paul)
3. Regions (St. Paul)
Hennepin ~
1. Abbott NW (Mpls)
2. Fairview Riverside (Mpls)
3. Fairview Southdale (Edina)
4. HCMC (Mpls)
Current as of 01/13/2006

MN Department of Human Services

There are two types of contracts; both having a goal of providing statewide availability of extended psychiatric inpatient services for up to 45 days, for recipients of MA, individuals dually eligible under MA and Medicare, and uninsured individuals.

Medical Assistance (MA) Contracts:

The MA contract covers MA fee for service recipients. Funding under the MA contract is for MA eligible adults meeting all of the criteria in # 1 - 6 and one of the criteria in #7:

1. age 18 years or older, or attaining 18 years within 45 days of admission;
2. not under a 72-hour or court ordered hold;
3. not in a prepaid health plan;
4. not dually eligible for MA and Medicare, unless the patient has exhausted Medicare inpatient psychiatric benefits;
5. persons whose county of financial responsibility is in Minnesota, unless otherwise approved by DHS;
6. persons who need psychiatric inpatient services beyond what is normally available under the MA diagnostic-related (DRG) payment; and
7. the need for psychiatric inpatient services must be documented in at least one of the following ways:
    a. a judicial commitment under Minnesota Statutes, Chapter 253B as mentally ill;
    b. a revocation of a provisional discharge;
    c. a stayed commitment; or
    d. a voluntary admission: there must be clear documentation by the attending physician in the patient's hospital record that continued psychiatric inpatient hospitalization is needed for treatment completion, and the patient is capable of giving informed consent for voluntary treatment or has a substitute decision maker who will consent to the treatment. The physician must document that s/he would sign a statement in support of an MI commitment if the patient would not stay voluntarily. In addition, the hospital must have documentation that the county pre-petition screening team has completed a screening and concurs with the physician's documentation that a petition would be filed if the person would not stay voluntarily; or
    e. a continuance of a commitment proceeding, with inpatient services stipulated as part of the condition of the continuance.

Subsidy Grant Contract Bed Hospitals

The subsidy grant contract covers uninsured and underinsured individuals who do not qualify under the MA contract. The criteria for coverage under the subsidy grant contract is the same as above, except:

a. Recipient cannot be covered under the MA contract; and
b. Recipient county of financial responsibility is any Minnesota County, except the 7-county metro area (Anoka, Hennepin, Carver, Scott, Ramsey, Washington, and Dakota Counties).

Reservations in Minnesota:

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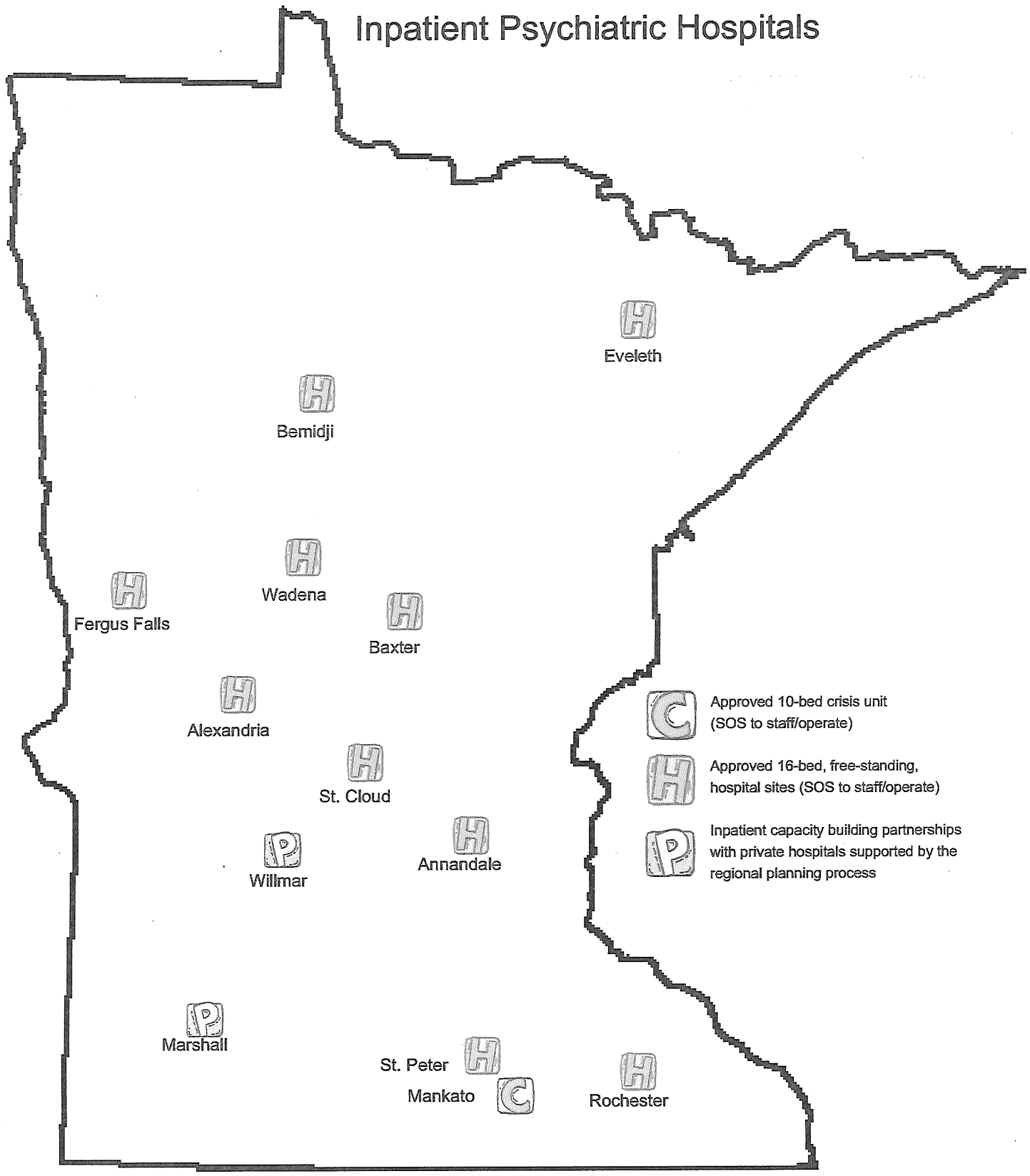
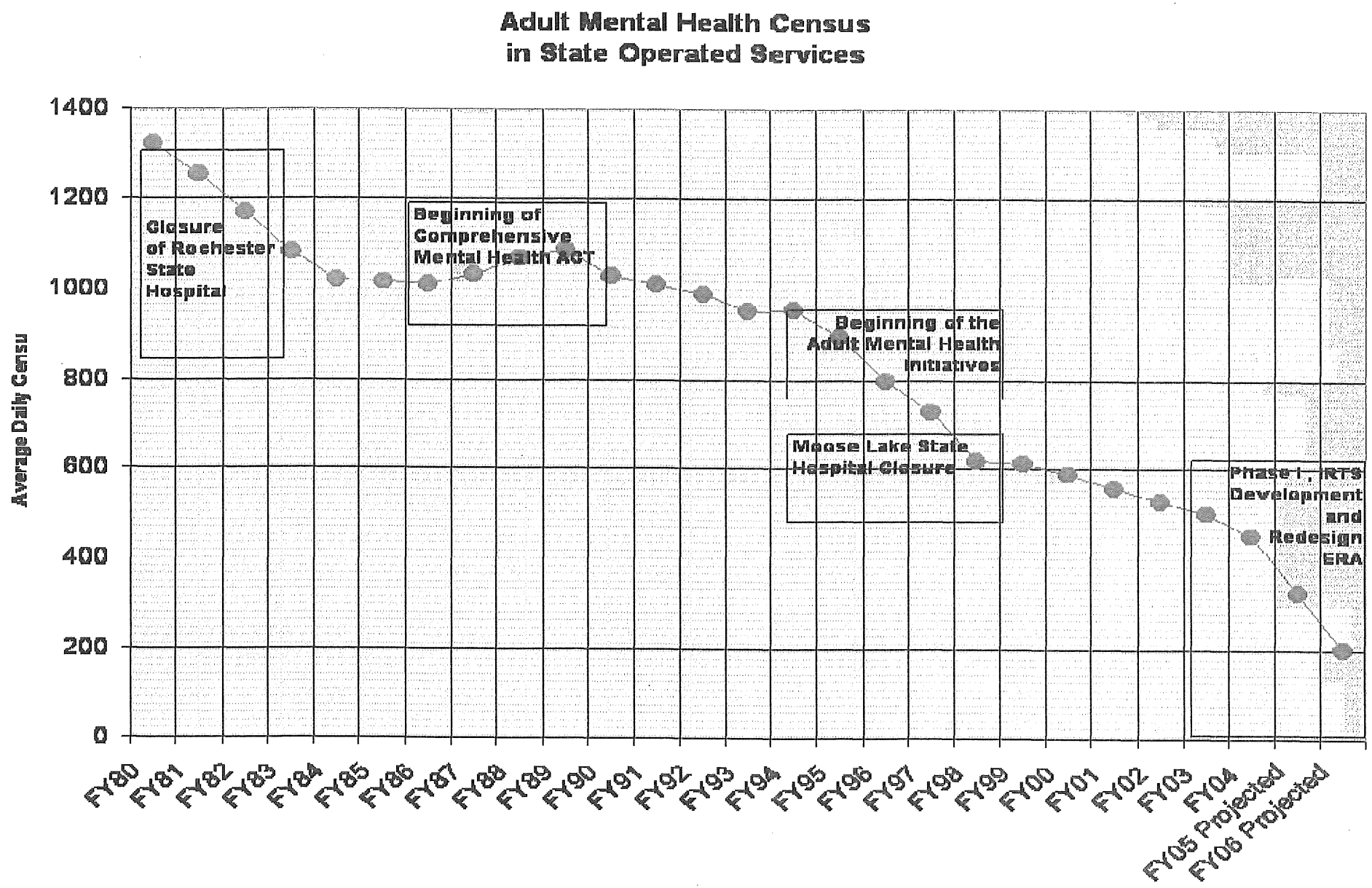
New State-Operated Community-Based Inpatient Psychiatric Hospitals



Community Hospitals.cdr
12/05

A Declining Institutional Census



Minnesota Department of **Human Services**

Key dates: Adult mental health system development

1980 **1,381 mental health patients in regional treatment centers.**
State's population is 3.8 million.

1987 Legislature adopts Adult Comprehensive Mental Health Act with vision for community-based service system.

- Community residential treatment facilities (Rule 36)
- Community Support Programs
- Targeted case management

1990 **1,027 mental health patients in regional treatment centers.**
State's population is 4 million.

1992 Legislature approves Bridges, $3.3 million/biennium temporary Section 8 rental subsidy program for people with serious and persistent mental illness.

1993 Legislature expands community-based mental health services in northeastern Minnesota, resulting in the closure of the Moose Lake Regional Treatment Center

- Crisis services
- Intensive case management teams
- Housing alternatives
- Expanded community support services

1995 Legislature approves Adult Mental Health Initiatives

- Regional service planning process approved
- Targets individuals at risk of RTC placement
- $21 million new investments in the community -- $17 million from RTCs
- Significant reduction in average daily census in Greater Minnesota RTCs

2000 **587 mental health patients in regional treatment centers.**
State's population is nearly 5 million.

2001 Legislature adopts significant community mental health legislation.

- Rehab option (Adult Rehab Mental Health Services/crisis services)
- Community hospitals beds used for civil commitment statewide

2002 Enrollment of people with mental illness in Home and Community-Based Service waivers increases

2003 Legislature adopts a further expansion of community-based mental health services

- Assertive Community Treatment (ACT) teams
- Intensive Residential Treatment Facilities (ITRs)
- Expanded community inpatient capacity

Minnesota Mental Health Action Group formed as unprecedented public-private effort to improve mental health services in Minnesota.

2004 485 adult mental health patients are served in regional treatment centers.
State's population continues to grow in excess of 5 million.

2005 Additional ACTs, IRTs, Community Alternatives for Disabled Individuals service packages and other community-based supports are introduced in the adult mental health system.

385 adult mental health patients are served in regional treatment centers

2006 State Operated Services opens first Community Behavioral Health Hospital in Alexandria. Willmar Regional Treatment Center campus sold.

January 2006

Using Mental Health Financing to Support More Integrated Care — DRAFT 1/18/06

Steps for State-wide Implementation: Improving the integration between mental health care and physical health care	**Benefit Changes:** • Increase benefit set for adults in GAMC / MnCare to match that currently offered in MA • Increase PPHP benefit set to include MA FFS services without a county share (ARMHS, IRTS, ACT, Adult Crisis) • Move remaining FFS services with a county share (MH-TCM, Rule 5) into Pre-paid Health Plans (PPHP) • Add family psycho-education as a benefit to MHCP, to the extent allowed by federal regulations **Enrollment Changes:** • End "opt out" in PMAP for SPMI / SED who are not disabled • Allow voluntary enrollment of persons with a disability in PPHP **Other Changes:** • Provide incentives for PPHP to improve mental health screening in primary care settings • Implement provider outcomes reporting • Improve quality / consistency of behavioral service utilization reporting by prepaid health plans (PPHP) • Related MH Act changes to focus county role on non-MHCP services for people with SED/SPMI below a certain income level, using continuation of current county funding and state grant funding • Target investments to support infrastructure development, workforce problems, and services to the uninsured
Steps for Regional Implementation: Exploring methods for improving integration of mental health care, health care and social services for persons with disabilities.	• CY06 – establish workgroup to develop parameters and performance goals for regional projects for the integration of mental health care, health care and social services. Since these parameters will form the basis of an RFP, the workgroup should not include stakeholders who would be potential bidders for regional projects. Parameters should address the following: o Integration of mental health treatment with physical health care and social services o Partnerships between heath plans, counties, schools, children's collaboratives o Accept and manage risk for cost of services to the pool of covered persons o Access Medicare capitation through use of SNP (preferred but not required), as well as other third party benefits o Implement mandatory enrollment (will require federal waiver) with choice of available plans for persons with disabling mental health conditions (would exclude people with DD and/or physical disabilities) o Improve service accessibility and care coordination to promote earlier ID o Provide incentives for adoption of evidence-based and best practices, including integrated treatment for dual diagnosis clients o Comply with reporting requirements and articulate an evaluation plan o Able to administer client protections / safeguards • CY07 – Issue RFP for integrative funding models and select participating regions. • CY08 – Regional implementation of capitation-based integrative funding model per RFP
Future Steps:	• Increase the number of regions using integrative funding models, targeting expansion to designs that emerge as best practices. • Add cost-effective additional services to complete the MMHAG model benefit set. • Add waivered services and long term care, excluding MR/RC waiver and ICF-MRs.

Minnesota Mental Health Action Group Background Materials

- Vision, Principles & Desired Outcomes
- Ten Action Solutions – September 2004
- Payment Model Key Characteristics – December 2004

Chemical and Mental Health Administration
Department of Human Services

Minnesota Mental Health Action Group
Vision, Principles, and Desired Outcomes

MMHAG's vision for Minnesota's mental health system.

Minnesota embraces a vision of a comprehensive mental health system that is accessible and responsive to consumers, guided by clear goals and outcomes, and grounded in public/private partnerships.

MMHAG's guiding principles for Minnesota's mental health system.

- *Flexible to meet the needs of different populations, ages and cultures*
- *Provides the right care and service at the right time*
- *Delivers care and services in the least intensive site possible*
- *Uses a sustainable and affordable financial framework with rational incentives*
- *Easily navigated by consumers and providers because it operates in efficient, understandable pathways*
- *Uses evidence-based interventions and treatment to produce the desired outcomes*
- *Employs effective health promotion and prevention strategies*
- *Has appropriate providers and service capacity*
- *Clearly defines accountability among all parties*

Desired outcomes for Minnesota's mental health system.

- *Public/private partnerships to assure that all aspects of the mental health system are working to serve consumers and families.*
- *A different fiscal framework for public and private mental health funding that creates rational incentives for the right care to be delivered in the right setting at the right time.*
- *Quality of care for consumers and families, as measured by standardized assessment of performance and outcomes.*
- *Innovative workforce solutions to assure an adequate supply of appropriately trained and qualified mental health professionals.*
- *Earlier identification and intervention so that consumers and families are willing to seek, and able to access help when needed.*
- *Coordination of care and services so that the mental health system is easy for consumers and families to navigate and they receive the right combination of services to achieve the desired health and social outcomes.*

Source: Road Map For Mental Health System Reform In Minnesota, Minnesota Mental Health Action Group - June 2005

Minnesota Mental Health Action Group (MMHAG)
10 "Action Solutions" - Sept. 2004

MMHAG Action Solutions:

1. Increase the public's awareness of mental health care and provide education and support for screening and earlier intervention.

2. Develop a new statewide funding and payment model that is consumer centered and promotes high quality, efficient care provided at the right time in the right setting.

3. Move to a regional system for publicly funded community-based services.

4. Address workforce shortages.

5. Coordinate care and service in the public and private health systems.

6. Establish outcomes for care.

7. Expand opportunities for partnerships between education systems and mental health providers to increase consultation and earlier interventions addressing the continuum of mental health needs for students and their families.

8. Correct financing dysfunctions.

9. Develop a mental health benefit set and promote its adoption by both public and private payers.

10. Establish a statewide public-private partnership where common understandings of mental health system changes are understood and actions initiated.

Statewide Funding and Payment Model for Mental Health Services
Purpose, Policy Objectives and Key Characteristics

Vision / Overall Goal:

A statewide funding and payment model that is consumer-centered and promotes high quality, efficient care provided at the right time in the right setting.

Current Situation:

Funding sources of mental health services are currently cobbled together in myriad ways to pay for needed mental health treatment services and supports. The result is an under-funded, uneven and unreliable system of care that provides limited access to needed services, supplies incentives for cost shifting and cost avoidance, and does not support early and appropriate intervention. The existing system does not adequately meet the needs of consumers, families, providers, or administrators.

Solutions - Policy Objectives:

An improved statewide payment model for the mental health system must ensure access and choices for persons in need of mental health services; support quality and innovative care; and provide accountability for efficient and effective use of resources in achieving positive outcomes.

Access & Choices
- Ensures statewide access to needed services – minimizes geographic differences in access
- Ensures timely access for all services with special consideration for persons in urgent need
- Improves continuity of coverage
- Establishes and defines a uniform entitlement to public funding for mental health services
- Minimizes uncompensated care
- Supports mental health service infrastructure

Quality & Innovation
- Facilitates integration of and parity between physical and mental health care
- Encourages earlier identification and intervention
- Removes negative effects of cost- and risk-sharing on clinical decision making,
- Rewards better (evidence-based) decision making
- Emphasizes best practices and effective care over gate-keeping

Accountability
- Manages public funds more efficiently
- Clarifies public/private health care funder responsibilities
- Builds in continuous evaluation of the effectiveness of the payment model in achieving desired policy objectives
- Discourages cost- and risk-shifting
- Provides for clear and continuous accountability

Solutions - Key Characteristics of an Effective Statewide MH Payment Model:

Access & Choices

- Simplifies consumer access to needed services
- Facilitates consumer choice
- Simplifies and standardizes eligibility determinations statewide
- Allows for presumptive eligibility in crisis situations
- Efficiently reimburses front line providers for services provided
- Funds comprehensive and uniform benefit set
- Allows funding to follow clients to the appropriate services
- Supports / maintains service infrastructure for services in the benefit set
- Allows the combination of public and private resources when needed to assure full benefit to people in need of services
- Sets reimbursement rates at an economic level adequate to assure real consumer choices
- Assures that people can access services voluntarily without court involvement
- Improves efficiency by reducing need for court/ law enforcement involvement

Quality & Innovation

- Is consumer centered and flexible
- Uses risk sharing and financial incentives for consumers and providers to reward better (evidence-based) decision making
- Supports the provision of quality and effective mental health care, including evidence-based practices such as integrated dual-diagnosis MI-CD treatment
- Includes mechanism to allow flexibility and adaptation to changes over time (financial, clinical, etc.)
- Supports technical assistance and other forms of quality improvement.

Accountability

- Adapts to changes in level of resources and statewide need for services
- Maintains balance between adequate funding and reasonable cost control
- Maximizes federal financial participation
- Appropriately matches costs with revenue sources
- Provides comprehensive information to assess results
- Encourages and supports third party and employer-based coverage
- Simplifies administrative procedures and reduces administrative costs at all levels

Existing sources of public mental health services funding under consideration for inclusion in a statewide payment model total over $600 million each year and include:

- State appropriations for adult mental health state RTC operations
- State appropriations for state operated community services.
- State funds in General Assistance Medical Care.
- State and federal funds in the Medical Assistance and MinnesotaCare programs (including SCHIP).
- County funding for mental health services, including state-funded local government aids.
- Children and Community Services Grant funds, incl. Title XX.
- State Children's and Adult Mental Health grants.
- Federal Community Mental Health Services Block Grant funds.
- Federal Title IV-E funds for children's residential care.
- Client and parental fees.