Minnesota Veterans Homes Board

Supplemental Budget Request

2006/07

Background
Initial Agency Assumptions for Budget Planning 06/07

- There will be no decrease in operating beds or service to veterans.
- There will be no increase in the State appropriation for our agency.
- There will be no wage increase during the biennium.
- A 4% increase was estimated to cover within grades and health benefit increases.

Background
Initial Agency Assumptions for Budget Planning 06/07
(Cont)

- A 3% increase was estimated in non-salary accounts.
- Converted Repair and Betterment funds to operations ($2.38 Million)
- Early in FY 2004, the Agency took a conservative approach with spending to carry over as much funding into FY 05 and FY 06-07.
- A 2.5% annual growth was estimated in other revenues (VA Per diems and resident pay amounts. Revenues of the Board are made up of the biennial funding from the Legislature, per diem revenue from the US Dept of Veterans Affairs and payments from residents.
- Unspent revenues are carried forward from year to year and used to fund anticipated requirements for the upcoming biennium. The Board has traditionally included the provision for unexpected costs in its anticipated funding requirements.

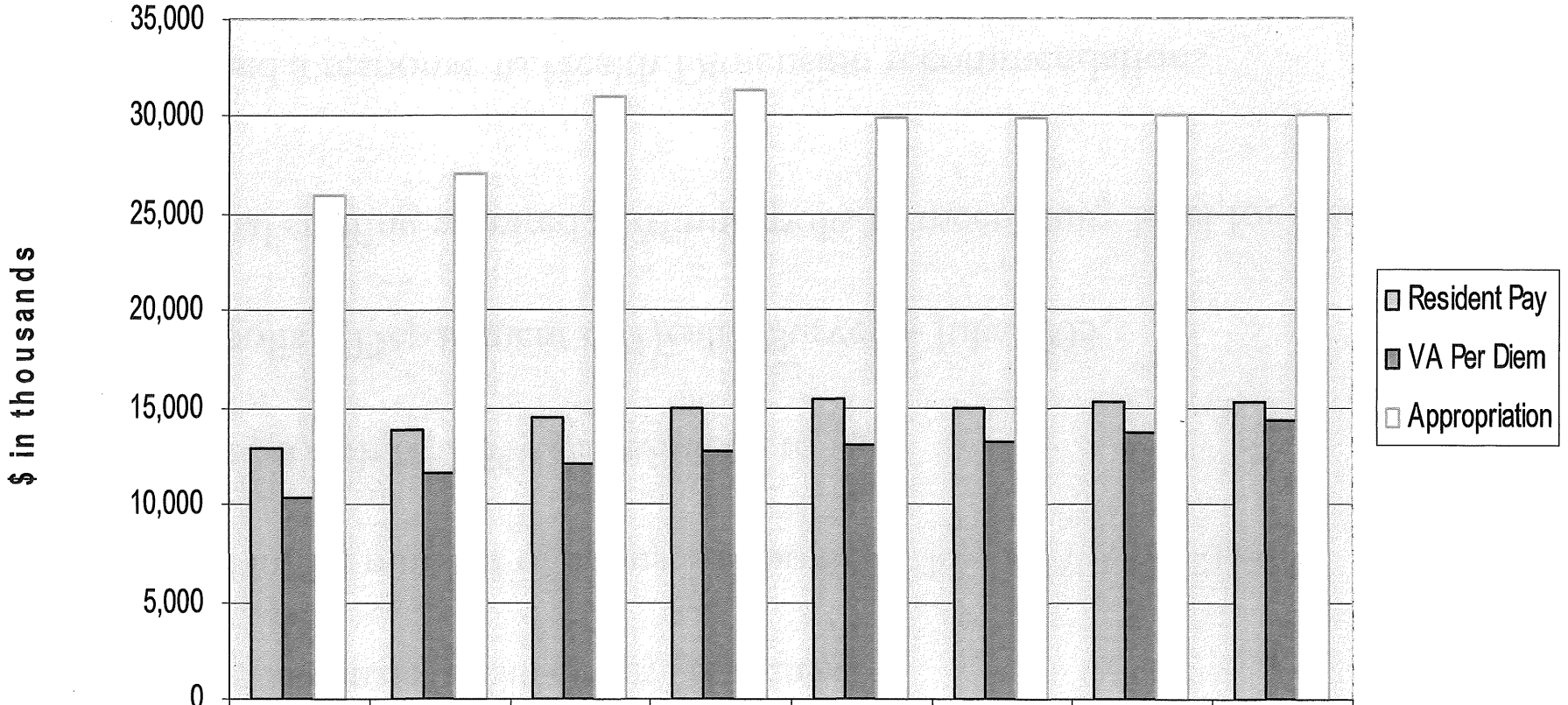
Budget 06-07 Summary

Unspent net revenues from fiscal 1995-2005: Accumulated opening contingency reserve, to be spent down during FY2006-2007		$ 6,641,000
Funding allocated by the Legislature		60,060,000
Expected VA per diems	$ 27,754,000	
Expected resident payments	32,867,000	
Total		60,621,000
Anticipated revenues		120,681,000
Anticipated funds available		$ 127,322,000
Budgeted expenses, approved by the board, prior to requests to the 2005 Legislature		
Budgeted salaries		$ 102,922,000
Budgeted non-salary costs		23,480,000
Anticipated costs		$ 126,402,000
Original Anticipated balance at the end of the biennium, before additional costs below		$ 920,000

What happened....

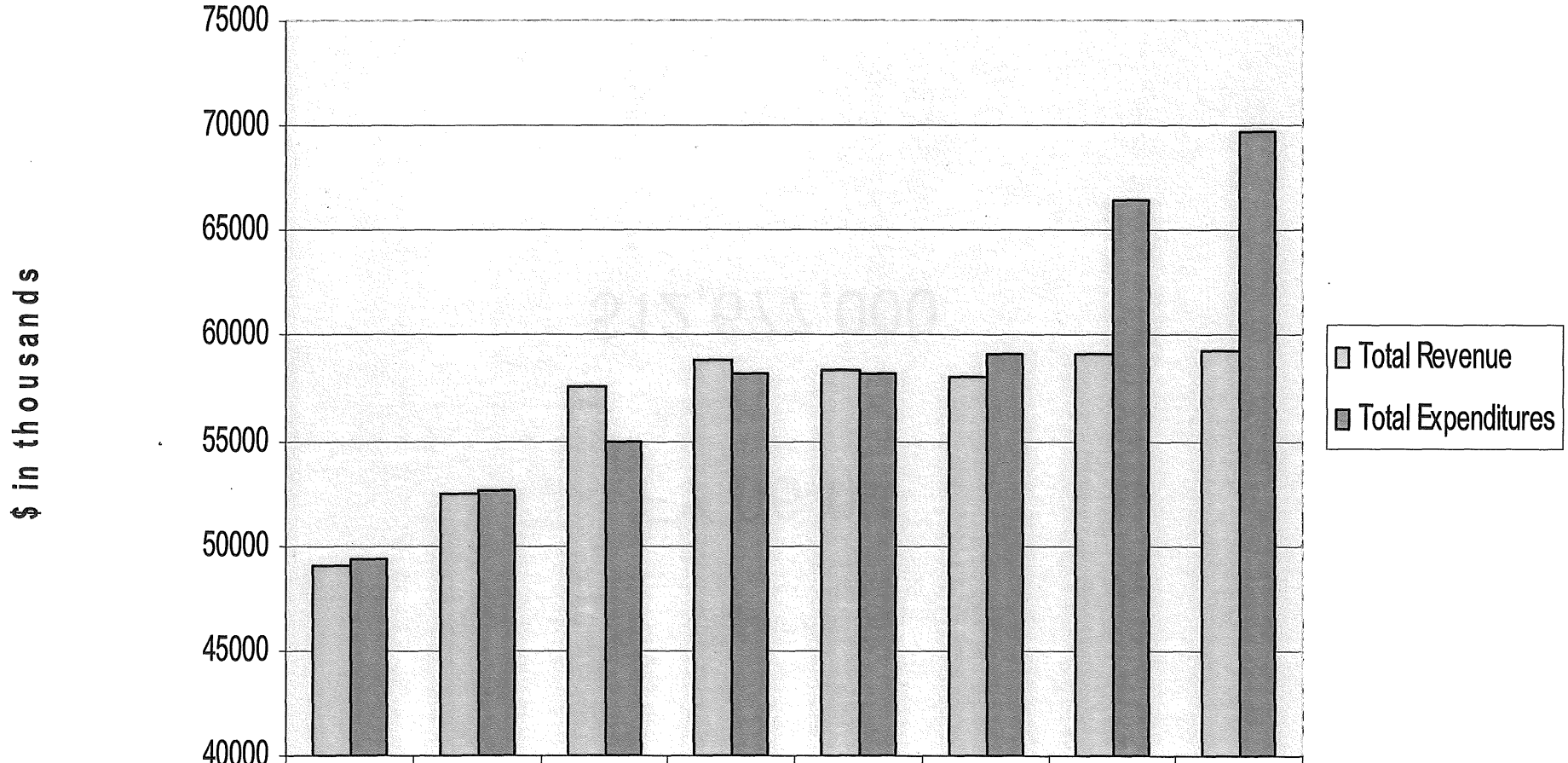
- Decrease in census at Silver Bay/Hastings
- Increase in the number of spouses at homes – loss of VA per diems
- Revenue growth of 2.5% was reduced to zero
- Minneapolis – Department of Health Survey – July 2005
- Additional staffing required at Minneapolis to meet acuity level for resident care
- Developed a response to Health Dimension recommendations
- Energy Cost increase

Revenue Trends



	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY06(est.)	FY07(est.)
Resident Pay	12,902	13,766	14,527	14,877	15,446	14,960	15,211	15,211
VA Per Diem	10,278	11,608	12,132	12,673	13,043	13,127	13,750	14,252
Appropriation	25,892	27,103	30,948	31,266	29,901	29,940	30,030	30,030

Revenue/Expenditure History



	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006est	FY2007est
Total Revenue	49072	52477	57607	58816	58390	58027	59101	59333
Total Expenditures	49362	52605	54958	58189	58273	59170	66376	69754

Supplemental Budget Request

FY 06-07

$12,677,000

Summary of Changes

• Wage and Benefit Settlements (net)	($980,000)
• Mpls Resident Care Staff adj. – 42FTE - Nursing	($4,027,000)
• Budget Increases prior to study	($1,095,000)
• HD Study Recommendations	($1,351,000)
• Repair and Betterment	($2,380,000)
• Energy Cost Surge	($870,000)
• Revenue Decline	($1,868,000)
• Reserve increase	($1,080,000)

Original Anticipated balance at the end of the biennium, before additional costs below		$ 920,000	
Subsequent modifications to expenditures and revenues:			
Expected VA per diems increase		$ 248,000	
Expected resident payments reduction		(2,445,000)	
Expected other revenues increase		210,000	
Opening unspent balance increase		119,000	
Anticipated Funds Available Reduction			(1,868,000)
Budgeted salaries reduction		$ 922,000	
Budgeted non-salary costs reduction		246,000	
Anticipated costs reduction			1,168,000
Wage settlements		($3,353,000) *	
Budgeted repairs and maintenance - not bondable		(2,380,000)	
Mpls.Nursing Adj. - Resident. Acuity		(4,027,000)	
Energy Cost Surge		(870,000)	
Budget Increases prior to study:		(1,095,000)	
HD Study Recommendations		(1,351,000)	
Budget Increases post study:			
Doctor MS3	($23,000)		
Momentus Program Mgr. RN Sup.	(96,000)		
Affirmative Action Officer	(75,000)		
		(194,000)	
Health Insurance Savings over original budget		2,373,000 **	
Total subsequent modifications			(10,897,000)
The Board has authorized maintenance of a reserve for contingencies of $2,000,000			(2,000,000)
Estimated total funds needed (Supplementary Funds From the Legislature)			($12,677,000)

(Failure to obtain supplementary funding would require significant reductions in capability to deliver services to residents, or reduction in resident beds)

* 2% across the board contractual increases, effective 7/1/05 and 7/1/06
Salary categories: full time; part time;and overtime.

	Base	% applied	Cost
FY06	39,600,000	2%	792,000
FY07	39,600,000	4.04%	1,600,000
			2,392,000
Additional cost of state's final MNA offer			961,000
Total wage settlements			3,353,000

** Calculated from the Department of Finance's original projections of 14.5% increases expected in 01/06 and 01/07 versus actual 0.0%/9.5%.

	Orig. est.	rev. est.	Savings
FY06	9,921,000	9,243,000	678,000
FY07	11,376,000	9,681,000	1,695,000
			2,373,000

Anticipated costs changes: The difference between the original cost estimates made in 9/2004 and the actual budgets finalized Original estimates were roughly based on flat % increases. Actual budgets were developed using the Department of Finance's agency guidelines including Finance's position cost projections.

Resident payments reduction: There has been a negative fluctuation in the level of income and assets available for resident payn With time, more assets have been exhausted. Less residents have been paying the full cost of care. More spouses have beer

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Changes made prior to HD Study	
Governor's System-wide Review	($150,000)
Minneapolis Resident Worker min. wage	(46,000)
First Minneapolis Painter 1FTE	(80,000)
Mpls temporary painters	(25,000)
Mpls. RN Educator	(110,000)
Hastings Receptionist 1.4 FTE	(84,000)
Luverne Night RN	(150,000)
Mpls. Lifts	(36,000)
Mpls. HST recertification	(15,000)
Fergus Falls 1.4 FTE part time	(99,000)
Interim management staff and study of board office relocation	(300,000)

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(Failure to obtain supplementary funding would require significant reductions in capability to deliver services to residents, or reduction in resident beds)

Minneapolis Nursing Staff Supplement – 42 FTE

1.5 FTE Registered Nurses

5.5 FTE Licensed Practical Nurses

35 FTE Health Service Technicians

Anticipated costs changes: The difference between the original cost estimates made in 9/2004 and the actual budgets finalized Original estimates were roughly based on flat % increases. Actual budgets were developed using the Department of Finance's agency guidelines including Finance's position cost projections.

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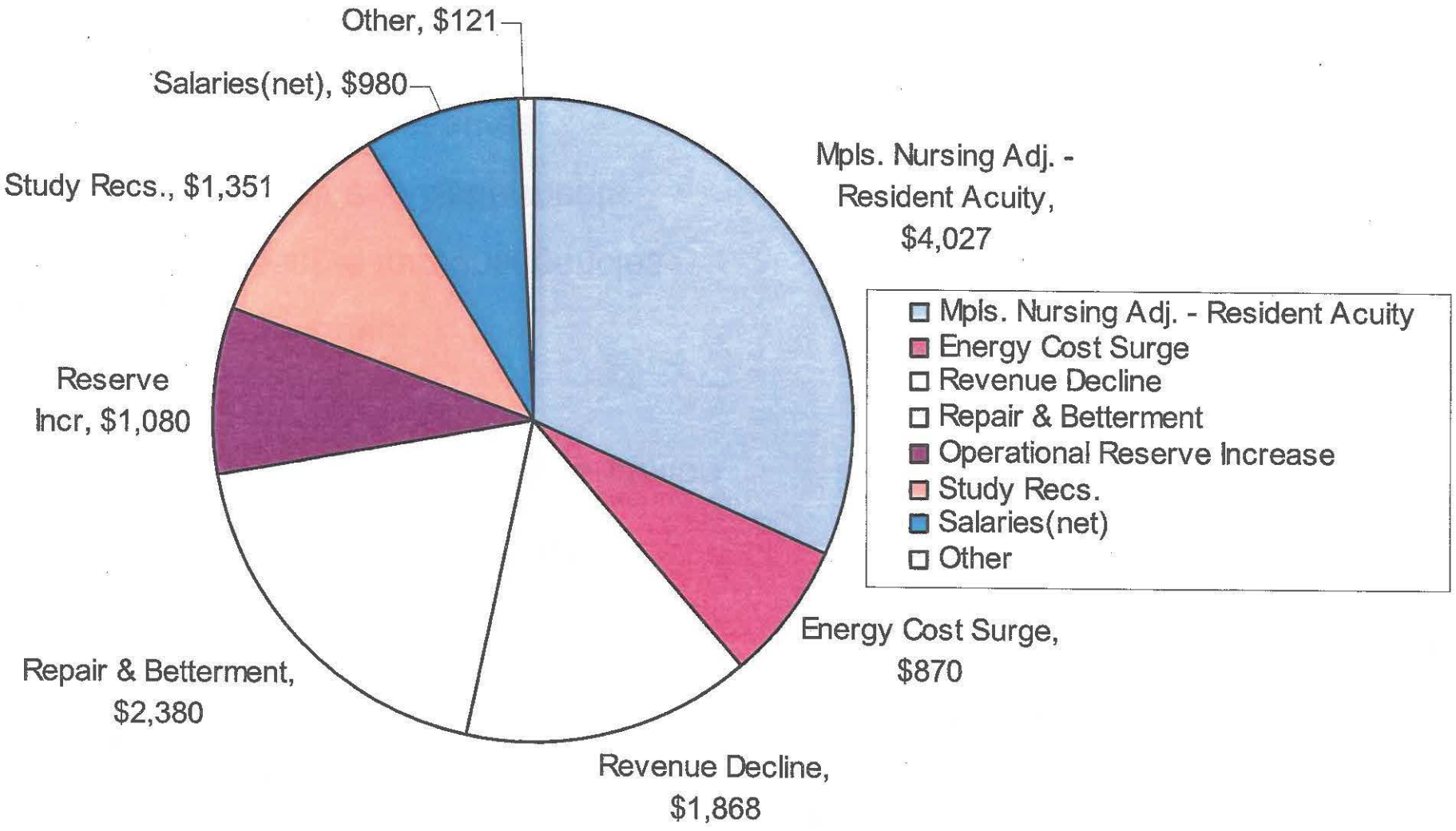
MVH Estimated Funds Needed -$12.677 million



Supplemental Budget Request/Governor's Recommendation

MVHB Supplemental Request		$12,677,000
Governor's Recommendation	$7,426,000	

Not Recommended:

Reserve for contingencies	$2,000,000
Repair and Betterments	$2,380,000
Energy Cost surge	$870,000

Consequences of Partial Funding

- Without a reserve, increases risk of not being able to meet unanticipated needs or adjust to revenue fluctuation (decreases) without asking for additional funds.

- May require moratorium on new admissions, with the potential of closing beds and beginning to eliminate special programs (i.e. homeless dual diagnosis program)

- Repair and betterment items continued to be delayed increasing deferred maintenance. Some repairs may need to be accomplished.

- Investigate the possibility of having to reduce the number of spouses of veterans we are able to admit.

Funding Offset

VA State Home Construction Grant Reimbursement	$12,964,634
FY2006 Bonding Bill	(2,200,000)
To General Fund	***$10,764,634***

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Supplemental Request	$12,677,000
Net Request	***$1,912,366***

Thank you

Senate Counsel, Research, and Fiscal Analysis

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Senate
State of Minnesota

S.F. No. 3016 - Welfare Reform/Foreign Operating Corporation Tax Bill

Author: Senator Linda Berglin

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

Date: March 13, 2006

Article 1 - Welfare Reform Article

Section 1 (Minnesota Statutes 2005 Supplement, section 119B.09, subdivision 1) changes the eligibility for child care assistance, allowing households that have an income less than or equal to 200 percent of the federal poverty guidelines, instead of 175 percent, to be eligible for child care assistance.

Section 2 (proposed coding, section 119B.095) reinstates the child care co-payment schedule that was effective prior to the 2003 legislative session.

Section 3 (Minnesota Statutes 2004, section 119B.13, adding subdivision 8) provides a two percent cost of living increase to child care provider rates.

Section 4 (Minnesota Statutes 2005 Supplement, section 256D.03, subdivision 3) reinstates emergency services under the general assistance medical care (GAMC) program for undocumented noncitizens and nonimmigrants.

Section 5 (Minnesota Statutes 2005 Supplement, section 256D.03, subdivision 4) eliminates GAMC co-payments

Section 6 (Minnesota Statutes 2005 Supplement, section 256J.21, subdivision 2) strikes a cross reference to a provision that is being repealed.

Section 7 (Minnesota Statutes 2004, section 256J.24, adding subdivision 5b) provides a ten percent cost of living increase to the MFIP transitional standard.

Section 8 provides repealers.

Paragraph (a), Minnesota Statutes, section 256B.0631, subdivisions 2 and 4, repeals Medical Assistance co-payments; section 256J.37, subdivision 3a, repeals the MFIP housing penalty; and section 256L.04, subdivision 10, repeals MinnesotaCare ineligibility provisions for noncitizens..

Paragraph (b), Minnesota Statutes, section 256B.0631, subdivisions 1 and 3, repeal Medical Assistance co-payments; and section 256J.37, subdivision 3b, repeals the MFIP SSI penalty.

Paragraph (c) repeals the existing child care fee schedule.

Article 2 - Tax Article

Article 2 contains tax provisions related to foreign operating corporations.

JW:mvm

Preliminary

Fiscal Note – 2005-06 Session

Bill #: S3016-0 **Complete Date:**

Chief Author: BERGLIN, LINDA

Title: WELFARE REFORM & TAX ARTICLES

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

Agency Name: Human Services Dept

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

Dollars (in thousands)	FY05	FY06	FY07	FY08	FY09
Expenditures					
General Fund		0	38,091	69,890	119,434
Health Care Access Fund					1,066
Less Agency Can Absorb					
-- No Impact --					
Net Expenditures					
General Fund		0	38,091	69,890	119,434
Health Care Access Fund					1,066
Revenues					
-- No Impact --					
Net Cost <Savings>					
General Fund		0	38,091	69,890	119,434
Health Care Access Fund					1,066
Total Cost <Savings> to the State		0	38,091	69,890	120,500

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

Preliminary

NARRATIVE: SF 3016/SF 3015

Bill Description

NOTE: This fiscal note includes costs for changes in MFIP and Child Care Assistance portions of the bill only.
This bill would make changes in program eligibility, copayments and provider rates in the Child Care Assistance programs. It would increase the program entry level for transition year and basic sliding fee (BSF) child care assistance programs from 175% of the Federal Poverty Guideline (FPG) to 200% of the FPG, would reduce the copayment fees for families with incomes that exceed the federal poverty guidelines (FPG) and would increase provider rates by a 2% cost of living adjustment. The Department would implement the cost of living rate increase as an ongoing annual increase effective July 1 each year.

The bill restores emergency General Assistance Medical Care (GAMC) eligibility for undocumented immigrants and nonimmigrants and ongoing GAMC for undocumented immigrants and nonimmigrant children under age 18, aged, blind and disabled individuals and Cuban and Haitian entrants and eliminates MA and GAMC Copayments.

Finally, the bill provides for a 10% cost of living adjustment to the Minnesota Family Investment Program (MFIP) and the Diversionary Work Program (DWP) transitional standard. Due to the need for initial Federal approval the Department would implement the cost of living rate increase as on ongoing annual increase effective August 1, 2006 and July 1 each year thereafter.

Money is appropriated from the tax relief account for the biennium ending June 30 2007 to the commissioner of human services for the purposes of sections 1 to 4 and 6.

Assumptions
See Attached

Expenditure and/or Revenue Formula
See attached
One-time systems costs to implement the MFIP COLA are estimated at $31,000 state share, to implement the repeal of the SSI and subsidized housing policies together $9900 state share.

Long-term Fiscal Considerations

Local Government Costs

References/Sources
Susan Snyder
Reports & Forecasts Division
MN Dept of Human Services
651.431.2947

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  Minnesota
MFIP and CCAP
Fiscal Analysis of SF3016
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Section 1: 200% FPG Entry

TY Entry From 175-200% FPG
This section establishes income eligibility for transition year child care for families up to 200% FPG.
The effect of this change is to add eligibility for families who exit MFIP with income above the current
TY entry level of 175% FPG and below 200% FPG.

Based on department data, it is estimated that about 2% of MFIP exits in a given month result from
income between  175-200% FPG.  It is further estimated that about one-fifth of these exits had no prior
subsidized child care usage.  Without prior use of MFIP child care, these cases would need to satisfy an
initial income test and would be denied TY eligibility under current law.  Finally, we assume about
 30% of these former MFIP cases would apply for subsidized child care, and that each case would use an
average of nine months of TY child care if eligible.

Since these additional families have average incomes higher than the overall TY caseload, they will pay
higher average copays.  Thus, the average monthly CCAP payment for these cases will be lower than the
overall projections under current law.  Based on department caseload data and the proposed copay
schedule, the average CCAP payment for these additional cases is projected to be about $75 per month
less than the overall TY caseload average.
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This section assumes the proposed maximum rate schedule and copay schedule in sections 2 and 3.

The effective date is July 1, 2006. A twelve-month phase-in is assumed due to initial eligibility determination, and billing lags.

	FY 2006	FY 2007	FY 2008	FY 2009
Average monthly MFIP exits	2,820	2,820	2,820	2,820
Estimated pct 175%-200% FPG	2%	2%	2%	2%
Avg monthly MFIP exits between 175-200% FPG	62	62	62	62
Percent with no prior child care	20%	20%	20%	20%
Avg monthly MFIP exits 175-200% FPG with no prior child care	12	12	12	12
Pct applying for TY child care	30%	30%	30%	30%
Avg mthly MFIP exits currently denied TY child care	4	4	4	4
Avg no. TY months per case	9	9	9	9
Avg monthly TY child care pmt (with copay adjustments)	$809	$787	$812	$838
Phase-in effect	0%	50%	100%	100%
TY direct service cost	$0	$159,320	$328,814	$339,294
Administrative allowance	$0	$7,966	$16,441	$16,965
Total TY cost	$0	$167,286	$345,255	$356,259

BSF Entry From 175-200% FPG
This section also eliminates the requirement that families have income less than 175% FPG to become eligible for the Basic Sliding Fee (BSF) program. Under current law, families must be below 175% FPG to enter the BSF program. However, once eligible, they can remain in the program until the family reaches 250% FPG. This policy change would allow additional families to become eligible for the BSF program with application incomes between 175-200% FPG.

During FY2003, the BSF program operated under an entry and exit income threshhold of 300% FPG. This fiscal analysis assumes a similar income distribution to the FY2003 historical experience for families with incomes between 175-200% FPG. The fiscal analysis also recognizes that families who satisfy initial income eligibility can then remain BSF eligible until they reach 250% FPG. Thus, there is also a projected increase in BSF families with incomes between 200-250% FPG under this proposal.

Based on sample data used in federal reporting, it is estimated that about 12% of the current average monthly BSF caseload has income between 175-200% FPG. It is further estimated that about 17% of the FY2003 average monthly BSF caseload had income between 175-200% FPG. This difference can be interpreted as the additional expected caseload with incomes between 175-200% FPG if the 175% FPG income requirement were changed to 200% FPG for initial eligibility determination. Based on the projected average monthly BSF caseload in FY2007, this translates into an additional 535 average monthly BSF cases with incomes between 175-200% FPG. Further, these families with application incomes between 175-200% FPG are BSF eligible until their income reaches 250% FPG. It is estimated that this results in an additional 178 average monthly families in BSF with incomes between 200-250% FPG.

Since these additional BSF families have average incomes higher than the overall BSF caseload, they will pay higher average copays. Thus, the average monthly CCAP payment for these cases will be lower than the overall projections under current law. Based on department BSF caseload data and the proposed copay schedule, the average CCAP payment for these additional cases is projected to be about $73 per month less than the overall BSF caseload average.

BSF is a capped appropriation that is allocated to counties.If BSF funding is not adjusted to reflect the costs in this fiscal note or the actual demand for BSF eligibility among families with application incomes between 175-200% FPG exceeds these projections, it will result in a larger waiting list.

This section assumes the proposed maximum rate schedule and copay schedule in sections 2 and 3.

The effective date is July 1, 2006. A twelve-month phase-in is assumed due to county allocation adjustments, initial eligibility determination, and billing lags.

	FY2006	FY2007	FY2008	FY2009
Additional avg mo. BSF cases	713	713	713	713

Average monthly BSF payment (with copay adjustments)	$713	$698	$724	$751
Phase-in effect	0%	50%	100%	100%
BSF direct service cost	$0	$2,988,781	$6,199,638	$6,429,487
Administrative allowance	$0	$149,439	$309,982	$321,474
Total BSF Cost	$0	$3,138,220	$6,509,620	$6,750,962
Total Cost of Section 1	$0	$3,305,506	$6,854,875	$7,107,221

Section 2: Copayment Change

This section repeals the current law CCAP copayment schedule and replaces it with a new schedule. The current law schedule charges no copay for families with income under 75% FPG, charges a copay of $5/month for families with incomes between 75% and 100% FPG, and charges a sliding scale copay amount starting at 3.23% of income for families between 100%-125% FPG and ending with 18% income for families between 245%-250% FPG. The new copay schedule would charge no copay for families with incomes under 100% FPG and specifies a sliding scale copay amount starting at 2.20% of income for families with 35% of State Median Income (SMI) and ending with 20% of income for families between 74.5 and 75% SMI.

Based on department data and the published copayment tables for FY2006, it is estimated that the average monthly MFIP/TY copay would decrease by about $9/month (from $30/month to $21/month) under the new schedule, and the average monthly BSF copay would decrease by about $30/month (from $98/month to $68/month).

This section assumes the proposed maximum rate schedule in section 3.

The effective date is July 1, 2006. This copay change will impact individual CCAP cases as their income is redetermined, leading to a 6-month phase-in.

MFIP/TY Child Care	FY2006	FY2007	FY2008	FY2009
Avg mo. MFIP/TY cases (fcst)	8,568	8,846	8,786	8,791
Additional MFIP/TY cases (from max rate change)	0	64	71	71
Avg monthly MFIP/TY cases	8,568	8,910	8,856	8,862
Avg mo. copay reduction	$9	$9	$9	$9
Phase-in	0%	75%	100%	100%
MFIP/TY direct service cost	$0	$728,207	$965,154	$965,717
County administrative allowance	$0	$36,410	$48,258	$48,286
Total MFIP/TY cost	$0	$764,617	$1,013,411	$1,014,003

BSF Child Care	FY2006	FY2007	FY2008	FY2009
Avg monthly BSF cases	8,394	8,254	8,304	8,408
Avg mo. copay reduction	$30	$30	$30	$30
Phase-in	0%	75%	100%	100%
BSF direct service cost	$0	$2,217,815	$2,975,153	$3,012,350
County administrative allowance	$0	$110,891	$148,758	$150,617
Total BSF cost	$0	$2,328,706	$3,123,910	$3,162,967
Total Cost of Section 2	$0	$3,093,323	$4,137,322	$4,176,970

Section 3: Reimbursement Rates Adjustment

Maximum reimbursement rates for child care providers were frozen July 1, 2003 at the levels that were set in 2002. Some maximum rates in rural counties were increased July 1, 2005, and on Jan 1, 2006, most maximum rates were increased to the lesser of the 75th percentile of the most recent market rates survey (2005) or the frozen rates inflated by 1.75%.

This section provides a 2% cost of living increase to maximum reimbursement rates for child care providers. The language in the bill is ambiguous as to whether the increase is one-time or to occur

annually, and also as to how the increase in rates is to be implemented. We assume for the purpose of this analysis that the increase is an annual 2% adjustment to maximum reimbursement rates.

The fiscal impact of this policy change results from a) an expected MFIP child care caseload increase; b) an average payment increase that affects the MFIP, TY, and BSF programs; and c) a small adjustment in the cost of accelerated payments due to the implementation of the MEC2 system. Phase-in of rates is built into the estimated payment and caseload increases.

The relationship between average CCAP caseload and published maximum reimbursement rates is used to estimate the effect of increased reimbursement rates on MFIP child care caseload. Based on historical experience, and assuming phase-in of new cases, it is estimated that between 64 and 71 additional average monthly MFIP child care cases will result in FY07-09 because of the increased reimbursement rates.

The relationship between historical average CCAP payments and published maximum reimbursement tables is used to estimate the effect of the maximum rate increase on payments. These effects are also adjusted for expected phase-in of implementation. In FY07 avg. monthly payments are expected to increase between $11 and $15 per case. Average monthly payments are expected to increase between $26 and $35 in FY08 and between $41 and $56 in FY09.

BSF is a capped appropriation that is allocated to counties. This fiscal analysis uses a "base forecast" which assumes a caseload in the BSF program based on the number of cases that are expected to be served given the average payments projected in the February 2006 forecast.

MFIP Caseload Effect	FY2006	FY2007	FY2008	FY2009
Average monthly MFIP child care caseload increase	0	64	71	71
Average monthly MFIP payment	$971	$1,010	$1,045	$1,082
Months	0	12	12	12
Direct service cost	$0	$771,644	$888,543	$916,262
Administrative allowance	$0	$38,582	$44,427	$45,813
MFIP cost due to caseload increase	$0	$810,226	$932,970	$962,075

MFIP Average Payment Effect	FY2006	FY2007	FY2008	FY2009
Avg mo. MFIP CCAP caseload	5,765	6,032	5,997	6,010
Avg mo. MFIP payment increase	$0	$15	$35	$56
Number of months	0	12	12	12
Total direct service cost	$0	$1,054,556	$2,517,287	$4,068,201
Administrative allowance	$0	$52,728	$125,864	$203,410
MFIP cost due to avg payment	$0	$1,107,284	$2,643,151	$4,271,611

TY Average Payment Effect	FY2006	FY2007	FY2008	FY2009
Avg mo. TY caseload	2,802	2,814	2,789	2,781
Avg mo. TY payment increase	$0	$12	$29	$47
Months	0	12	12	12
Direct service cost	$0	$410,024	$971,142	$1,553,989
Administrative allowance	$0	$20,501	$48,557	$77,699
TY cost due to average payment	$0	$430,525	$1,019,699	$1,631,688

BSF Average Grant Effect	FY2006	FY2007	FY2008	FY2009
Avg mo. BSF caseload	8,394	8,254	8,304	8,408
Avg mo. BSF payment increase	$0	$11	$26	$41
Months	0	12	12	12
Direct service cost	$0	$1,059,549	$2,559,676	$4,179,057
Administrative allowance	$0	$52,977	$127,984	$208,953
BSF total cost due to avg pmt	$0	$1,112,527	$2,687,660	$4,388,009

Increased Billing During System Transition	FY2006	FY2007	FY2008	FY2009
MFIP/TY direct service cost due to system transition	$0	$41,929	$54,712	$0
Administrative allowance	$0	$2,096	$2,736	$0

MFIP/TY cost	$0	$44,026	$57,448	$0
BSF direct service cost due to system transition	$0	$19,867	$31,996	$0
Administrative allowance	$0	$993	$1,600	$0
BSF cost	$0	$20,860	$33,596	$0

	FY2006	FY2007	FY2008	FY2009
Total MFIP/TY Cost	$0	$2,392,060	$4,653,268	$6,865,374
Total BSF Cost	$0	$1,133,387	$2,721,256	$4,388,009
Total Cost of Section 3	$0	$3,525,447	$7,374,524	$11,253,383

Section 6: MFIP Transitional Standard COLA

This section increases the MFIP transitional standard with a 10% increase to the cash portion of the transitional standard. It is assumed that the Family Wage Level (FWL) will remain at 110% of the new transitional standard, and that the Earned Income Disregard (currently at 37%) will be adjusted to maintain the MFIP exit level at 115% of FPG.

The language in the bill is ambiguous as to whether the increase is one-time or to occur annually. We assume for the purpose of this analysis that the increase is an annual 10% adjustment to the cash portion of the transitional standard.

This change will increase MFIP cash grants through the higher transitional standard (for families without earnings) or the family wage level (for families with earnings). DWP cash grants may be increased because the grant is capped at the MFIP transitional standard. Both MFIP and DWP grants can also be affected through the change in the earned income disregard. In addition, new MFIP & DWP cases are subject to an initial income eligibility test which is based on the transitional standard; cases that are currently ineligible may become eligible with the higher transitional standards.

In FY06, the COLA will increase the transitional standard for a family of size 3 from its current level of $884 to $938, and the corresponding FWL from $972 to $1,032. To maintain the MFIP exit level at 115% of FPG, at 2006 FPG levels, the earned income disregard would decrease from 37% to 35%.

Using DHS data, we estimate that in the first year of the 10% COLA, MFIP average grants will increase by $43 per month, and DWP average grants will increase by $19 per month.

It is also estimated that there will be a small number of new cases that are not eligible under the current law because they fail the initial income eligibility test, but would be eligible under the higher transitional standard. These are cases with earned income and from DHS data are estimated to have average grants of $130 per month.

The effective date for this section is July 1, 2006. Due to the requirement that DHS receive prior approval from the US Department of Agriculture, this section is projected to be implemented August 1, 2006. Subsequent rate increases will occur July 1 each year thereafter.

	FY 2006	FY 2007	FY 2008	FY 2009
Average monthly MFIP cases	34,507	34,882	34,966	34,992
Average grant increase	$0	$43	$90	$143
Number of months	0	11	12	12
MFIP Cost of Increased Grants	$0	$16,391,533	$37,877,063	$60,156,154
Average monthly DWP cases	3,661	3,651	3,651	3,640
Average grant increase	$0	$19	$35	$51
Number of months	0	11	12	12
DWP Cost of Increased Grants	$0	$746,842	$1,554,917	$2,212,163
Avg monthly MFIP/DWP cases	38,168	38,534	38,616	38,631
Percent previously ineligible	0	0.11%	0.21%	0.32%
Avg monthly additional MFIP/DWP cases	0	40	81	122
Average grant	$130	$130	$130	$130
Phase-in	0	75%	100%	100%
Cost of Additional Cases	$0	$43,394	$126,506	$189,835
Total Cost of Section 6	$0	$17,181,769	$39,558,486	$62,558,151

Section 8: Repeal of SSI/Housing Budgeting

This section repeals the requirement to budget up to $50 as unearned income for certain MFIP cases who receive subsidized housing. Excluded from this current law budgeting requirement are: 1) cases which include a person who is: a) age 60 or older, b) ill or incapacitated, c) required in the home because another member of the household is disabled; or 2) cases that contain a parental caregiver who receives supplemental security income (SSI). This section will have the effect of increasing cash grant amounts for non-excluded cases by up to $50 for each affected household.

Based on MAXIS data, it is projected that roughly 14% of MFIP cases are impacted by the subsidized housing budgeting requirement in a given month. It is further estimated that on average about $44 per case is budgeted off the cash portion of the MFIP grant for affected cases.

Note, also, that the average grant effect in this fiscal analysis assumes the simultaneous repeal of the SSI budgeting. This includes additional costs (of about $12K per year) due to the fact that a handful of families budgeting both subsidized housing and SSI have excess SSI in the budget (i.e. some of the SSI in the budget is not actually counted since the cash grant has already been reduced to zero). If only the subsidized housing budget is repealed, such cases wouldn't receive the full $50 increase since at least some of the excess SSI would then be counted instead of the subsidized housing.

The effective date for this section is July 1, 2006. Due to the requirement that DHS receive prior approval from the US Department of Agriculture, this section is projected to be implemented August 1, 2006.

This section assumes the proposed MFIP COLA of section 5.

	FY 2006	FY 2007	FY 2008	FY 2009
Average monthly MFIP cases	38,168	38,534	38,616	38,631
Pct of MFIP cases with budgeted subsidized housing deduction	14%	14%	14%	14%
Average monthly MFIP cases with subs. housing deduction	5,192	5,242	5,253	5,255
Avg monthly budgeted amount	$44	$44	$44	$44
Months	0	11	12	12
Cost for Repeal of Subsidized Housing Budget	$0	$2,539,001	$2,775,736	$2,776,842

This section would also repeal the requirement to budget up to $125 per case as unearned income for certain MFIP cases that include at least one SSI recipient in the household. Affected MFIP cases are those in which the SSI recipient is a mandatory assistance unit member and is MFIP ineligible solely due to SSI recipient status.
Excluded from this current law budgeting requirement are MFIP cases in which a relative caregiver (including a grandparent) could elect to be included in the MFIP assistance unit, unless the caregiver's children or stepchildren are also included in the unit. This proposal will have the effect of increasing cash grants for non-excluded cases by up to $125/month.

Based on MAXIS data, it is projected that roughly 18% of MFIP cases are impacted by the SSI budgeting requirement. It is further estimated that on average $111 per case is budgeted off the cash portion of the MFIP grant.

The effective date for this section is July 1, 2006. Due to the requirement that DHS receive prior approval from the US Department of Agriculture, this section is projected to be implemented August 1, 2006.

This section assumes the proposed MFIP COLA of section 5.

	FY 2006	FY 2007	FY 2008	FY 2009
Average monthly MFIP cases	38,168	38,534	38,616	38,631
Estimated percent of MFIP cases with SSI deduction	18%	18%	18%	18%
Estimated avg mo. MFIP cases with SSI deduction	6,806	6,871	6,886	6,889
Avg monthly budgeted amount	$111	$111	$111	$111
Months	0	11	12	12
Cost for Repeal of SSI Budget	$0	$8,405,264	$9,188,965	$9,192,627

Total Cost of Section 8	$0	$10,944,265	$11,964,701	$11,969,468

Fiscal Summary	FY2006	FY2007	FY2008	FY2009
		(in thousands)		
CCAP				
MFIP/TY				
Increase entry level	$0	$167	$345	$356
Copay Schedule	$0	$765	$1,013	$1,014
Maximum Reimbursement Rates	$0	$2,392	$4,653	$6,865
MFIP/TY Total Cost	$0	$3,324	$6,012	$8,236
BSF				
Increase entry level	$0	$3,138	$6,510	$6,751
Copay Schedule	$0	$2,329	$3,124	$3,163
Maximum Reimbursement Rates	$0	$1,133	$2,721	$4,388
BSF Total Cost	$0	$6,600	$12,355	$14,302
CCAP Total Cost	$0	$9,924	$18,367	$22,538
MFIP/DWP				
Increase grant	$0	$17,182	$39,558	$62,558
Repeal SSI/Housing Budgeting	$0	$10,944	$11,965	$11,969
MFIP/DWP Total Cost	$0	$28,126	$51,523	$74,528
TOTAL COST	$0	$38,050	$69,890	$97,065

Minnesota
General Assistance Medical Care
Fiscal Analysis of a Proposal to
Restore Coverage of Certain Undocumented Individuals
Senate File 3015, Section 4
Effective January 2009

This section restores regular GAMC coverage of undocumented children, elderly, and disabled individuals, and certain Cuban and Haitian entrants. It also restores emergency GAMC coverage of other undocumented individuals. We believe, however, that the requirement to have a Social Security number in the current law (256D.03h for GAMC; 256L.04, subd. 1a for MinnesotaCare) will continue to bar most undocumented individuals from regular GAMC and MinnesotaCare eligibility. A Social Security number is not required for emergency GAMC, so the full effect of that change is included in these estimates.

We estimate the enrollment effects of this change starting from the effects of the relevant eligibility cuts effective July 2003, which are estimated to have reduced GAMC enrollment at that time by 3025 regular enrollees and 275 emergency GAMC enrollees. We trend both enrollment numbers forward using the actual and forecasted enrollment for women covered under Minnesota's SCHIP prenatal coverage, most of whose enrollees are undocumented. Then we assume that 90% of undocumented individuals will be excluded from eligibility because they generally are unable to obtain Social Security numbers.

We use the projected average monthly cost for GAMC-only enrollees for the regular GAMC projection. For the emergency GAMC projection, we use the average monthly cost per enrollee from January to June 2003, trended forward at 5% per year.

Regular GAMC	July 2003	FY 2006	FY 2007	FY 2008	FY 2009
SCHIP Prenatal					
Avg. monthly enrollees	1,961	2,565	2,722	2,900	3,077
GAMC Undocumented Children, Eld., Disabled					
Potential avg. mo. enrollees	3,025	3,956	4,199	4,473	4,747
Proportion with Soc. Sec. number		10.00%	10.00%	10.00%	10.00%
Projected avg. mo. enrollees					475
Avg. monthly cost		595.69	669.18	709.34	718.58
Average months / year					10.5
Total GAMC cost (gross)		$0	$0	$0	$3,581,285
Proportion shifted to MinnesotaCare					30.00%
		FY 2006	FY 2007	FY 2008	FY 2009
Offset to GAMC from shift to MinnesotaCare:					

GAMC avg. enrollment			0	0	-142
GAMC payments			$0	$0	-$1,074,386
Net Regular GAMC Cost					
GAMC avg. enrollment			4,199	4,473	4,604
GAMC payments			$0	$0	$2,506,900
MinnesotaCare					
Avg. enrollment			0	0	142
Payments			$0	$0	$1,074,386
Premium revenue			$0	$0	$8,544
Net state cost			$0	$0	$1,065,842
Emergency GAMC					
Avg. monthly enrollees	275	360	382	407	432
Avg. monthly cost	$1,792	$2,024	$2,126	$2,232	$2,344
Average months			0.0	0.0	10.5
Total GAMC cost			$0	$0	$10,618,187
Grand total GAMC cost		$0	$0	$0	$14,199,472
Net state MinnesotaCare cost		$0	$0	$0	$1,065,842

Medical Assistance and General Assistance Medical Care
A Fiscal Analysis of a Proposal to
Eliminate All MA and GAMC copayments
Effective January 2009

Based on actuarial estimates, current managed care rates include a reduction for copayments. For MA and GAMC that reduction is 1.345% and 4.403%. Of the GAMC adjustment .995% is for the GAMC restorative dental copayment.

Based on actual offsets from January 2004 to June 2004, it is estimated that eliminating copayments in MA and GAMC would increase the FFS forecast for MA Families and Children by 0.24%, MA Elderly and Disabled by 0.52% and GAMC by 1.02%

Costs in MA Elderly and Disabled are adjusted to account for the impact of Medicare Part D.

Assumes a July 2006 implementation date; January 2007 for HMO.

	HMO	FFS
MA Fam	1.345%	0.19%
MA E&D	0.027%	0.36%
GAMC HMO	4.403%	0.75%

	FY 2006	FY007	FY 2008	FY 2009
February 2006 Forecast (in 000s)				
HMO				
MA elderly and disabled	$368,576	$348,195	$391,196	$435,272
MA families and children	$847,398	$897,490	$1,010,723	$1,167,748
GAMC	$199,939	$180,820	$127,337	$137,050
FFS				
MA Elderly and Disabled	$891,131	$837,342	$920,495	$997,942
MA families and children	$311,191	$353,321	$426,577	$460,466
GAMC	$91,022	87,836	80,866	80,262
Impact of elimination of copayments (in 000s)				
MA Elderly and Disabled HMO	$0	$0	$0	$49
MA Elderly and Disabled FFS	$0	$0	$0	$2,994
Total	$0	$0	$0	$3,043
Federal Share	$0	$0	$0	$1,521
State Share	$0	$0	$0	$1,521
MA Families and Children HMO	$0	$0	$0	$6,544
MA Families and Children FFS	$0	$0	$0	$723
Total	$0	$0	$0	$7,267
Federal Share	$0	$0	$0	$3,633
State Share	$0	$0	$0	$3,633
GAMC HMO	$0	$0	$0	$2,514
GAMC FFS	$0	$0	$0	$501
GAMC Total	$0	$0	$0	$3,015

Total GF	$0	$0	$0	$8,170

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

Preliminary

Fiscal Note – 2005-06 Session

Bill #: S3016-0 **Complete Date:** 03/14/06

Chief Author: BERGLIN, LINDA

Title: WELFARE REFORM & TAX ARTICLES

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

Agency Name: Revenue Dept

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

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

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

Preliminary

Bill Description – The proposed bill significantly changes the qualifications for Foreign Operating Corporations (FOC's). The tax provisions in Article 2 of SF 3016 would result in a revenue increase to the state's general fund.

There will be a positive revenue impact to the state's general fund if the proposed bill passes. However, the revenue impact is not included in this fiscal note at this time.

There will not be a fiscal impact to the Department of Revenue if the proposed bill passes.

Revenue Analysis Assumptions

Fiscal Impact Assumptions

Revenue Analysis Formula

Fiscal Impact Formula

Long-Term Fiscal Considerations
None

Local Government Costs
None

References/Sources

FN Coord Signature: JOHN POWERS
Date: 03/14/06 Phone: 556-4054

EBO Comments

A revenue analysis was not included with this fiscal note.

EBO Signature: ALEXANDRA BROAT
Date: 03/14/06 Phone: 296-1700

Senators Berglin; Pogemiller; Johnson, D.E.; Koering and Dille introduced–

S.F. No. 3016: Referred to the Committee on Finance.

A bill for an act

relating to human services; making changes to child care provider rates and parent fees; eliminating certain health care co-pays; increasing the MFIP transitional standard; reinstating health care benefits for certain noncitizens; repealing MFIP housing and SSI penalties; modifying foreign operating corporation tax provision; appropriating money from the tax relief account; amending Minnesota Statutes 2004, sections 119B.13, by adding a subdivision; 256J.24, by adding a subdivision; 290.34, subdivision 1; Minnesota Statutes 2005 Supplement, sections 119B.09, subdivision 1; 256D.03, subdivisions 3, 4; 256J.21, subdivision 2; 289A.38, subdivision 6; 290.01, subdivisions 6b, 19c, 19d; proposing coding for new law in Minnesota Statutes, chapter 119B; repealing Minnesota Statutes 2004, sections 256B.0631, subdivisions 2, 4; 256J.37, subdivision 3a; 256L.04, subdivision 10; Minnesota Statutes 2005 Supplement, sections 256B.0631, subdivisions 1, 3; 256J.37, subdivision 3b; Laws 2005, First Special Session chapter 4, article 3, section 19.

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

ARTICLE 1

WELFARE REFORM ARTICLE

Section 1. Minnesota Statutes 2005 Supplement, section 119B.09, subdivision 1, is amended to read:

Subdivision 1. **General eligibility requirements for all applicants for child care assistance.** (a) Child care services must be available to families who need child care to find or keep employment or to obtain the training or education necessary to find employment and who:

(1) have household income less than or equal to 250 percent of the federal poverty guidelines, adjusted for family size, and meet the requirements of section 119B.05; receive MFIP assistance; and are participating in employment and training services under chapter 256J or 256K; or

Senators Berglin; Pogemiller; Johnson, D.E.; Koering and Dille introduced–

S.F. No. 3016: Referred to the Committee on Finance.

A bill for an act

relating to human services; making changes to child care provider rates and parent fees; eliminating certain health care co-pays; increasing the MFIP transitional standard; reinstating health care benefits for certain noncitizens; repealing MFIP housing and SSI penalties; modifying foreign operating corporation tax provision; appropriating money from the tax relief account; amending Minnesota Statutes 2004, sections 119B.13, by adding a subdivision; 256J.24, by adding a subdivision; 290.34, subdivision 1; Minnesota Statutes 2005 Supplement, sections 119B.09, subdivision 1; 256D.03, subdivisions 3, 4; 256J.21, subdivision 2; 289A.38, subdivision 6; 290.01, subdivisions 6b, 19c, 19d; proposing coding for new law in Minnesota Statutes, chapter 119B; repealing Minnesota Statutes 2004, sections 256B.0631, subdivisions 2, 4; 256J.37, subdivision 3a; 256L.04, subdivision 10; Minnesota Statutes 2005 Supplement, sections 256B.0631, subdivisions 1, 3; 256J.37, subdivision 3b; Laws 2005, First Special Session chapter 4, article 3, section 19.

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(1) have household income less than or equal to 250 percent of the federal poverty guidelines, adjusted for family size, and meet the requirements of section 119B.05; receive MFIP assistance; and are participating in employment and training services under chapter 256J or 256K; or

(2) have household income less than or equal to ~~175~~ 200 percent of the federal poverty guidelines, adjusted for family size, at program entry and less than 250 percent of the federal poverty guidelines, adjusted for family size, at program exit.

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

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

Sec. 2. **[119B.095] CO-PAYMENT FEE FOR FAMILIES WITH ANNUAL INCOMES THAT EXCEED THE FEDERAL POVERTY LEVEL.**

(a) The monthly family co-payment fee for families with annual incomes greater than the federal poverty level, adjusted for family size, is determined in paragraphs (b) and (c):

(b) The family's annual gross income is converted into a percentage of state median income (SMI) for a family of four, adjusted for family size, by dividing the family's annual gross income by 100 percent of the SMI for a family of four, adjusted for family size. The percentage must be carried out to the nearest 100th of a percent.

(c) If the family's annual gross income is less than or equal to 75 percent of the SMI for a family of four, adjusted for family size, the family's monthly co-payment fee is the fixed percentage established for the family's income range in clauses (1) to (60), multiplied by the highest possible income within that income range, divided by 12, and rounded to the nearest whole dollar.

	Percent of SMI	Percent
(1)	less than 35.01	2.20
(2)	35.01 to 42.00	2.70
(3)	42.01 to 43.00	3.75
(4)	43.01 to 44.00	4.00
(5)	44.01 to 45.00	4.25
(6)	45.01 to 46.00	4.50
(7)	46.01 to 47.00	4.75
(8)	47.01 to 48.00	5.00
(9)	48.01 to 49.00	5.25

	(10)	49.01 to 50.00	5.50
	(11)	50.01 to 50.50	5.75
	(12)	50.51 to 51.00	6.00
	(13)	51.01 to 51.50	6.25
	(14)	51.51 to 52.00	6.50
	(15)	52.01 to 52.50	6.75
	(16)	52.51 to 53.00	7.00
	(17)	53.01 to 53.50	7.25
	(18)	53.51 to 54.00	7.50
	(19)	54.01 to 54.50	7.75
	(20)	54.51 to 55.00	8.00
	(21)	55.01 to 55.50	8.30
	(22)	55.51 to 56.00	8.60
	(23)	56.01 to 56.50	8.90
	(24)	56.51 to 57.00	9.20
	(25)	57.01 to 57.50	9.50
	(26)	57.51 to 58.00	9.80
	(27)	58.01 to 58.50	10.10
	(28)	58.51 to 59.00	10.40
	(29)	59.01 to 59.50	10.70
	(30)	59.51 to 60.00	11.00
	(31)	60.01 to 60.50	11.30
	(32)	60.51 to 61.00	11.60
	(33)	61.01 to 61.50	11.90
	(34)	61.51 to 62.00	12.20
	(35)	62.01 to 62.50	12.50
	(36)	62.51 to 63.00	12.80
	(37)	63.01 to 63.50	13.10
	(38)	63.51 to 64.00	13.40

(39)	64.01 to 64.50	13.70
(40)	64.51 to 65.00	14.00
(41)	65.01 to 65.50	14.30
(42)	65.51 to 66.00	14.60
(43)	66.01 to 66.50	14.90
(44)	66.51 to 67.00	15.20
(45)	67.01 to 67.50	15.50
(46)	67.51 to 68.00	15.80
(47)	68.01 to 68.50	16.10
(48)	68.51 to 69.00	16.40
(49)	69.01 to 69.50	16.70
(50)	69.51 to 70.00	17.00
(51)	70.01 to 70.50	17.30
(52)	70.51 to 71.00	17.60
(53)	71.01 to 71.50	17.90
(54)	71.51 to 72.00	18.20
(55)	72.01 to 72.50	18.50
(56)	72.51 to 73.00	18.80
(57)	73.01 to 73.50	19.10
(58)	73.51 to 74.00	19.40
(59)	74.01 to 74.50	19.70
(60)	74.51 to 75.00	20.00

Sec. 3. Minnesota Statutes 2004, section 119B.13, is amended by adding a subdivision to read:

Subd. 8. **Cost of living increase.** In addition to the provider rates specified under this section, the commissioner shall provide a two percent cost of living rate increase to providers.

Sec. 4. Minnesota Statutes 2005 Supplement, section 256D.03, subdivision 3, is amended to read:

Subd. 3. **General assistance medical care; eligibility.** (a) General assistance medical care may be paid for any person who is not eligible for medical assistance under chapter 256B, including eligibility for medical assistance based on a spenddown of excess income according to section 256B.056, subdivision 5, or MinnesotaCare as defined in paragraph (b), except as provided in paragraph (c), and:

(1) who is receiving assistance under section 256D.05, except for families with children who are eligible under Minnesota family investment program (MFIP), or who is having a payment made on the person's behalf under sections 256I.01 to 256I.06; or

(2) who is a resident of Minnesota; and

(i) who has gross countable income not in excess of 75 percent of the federal poverty guidelines for the family size, using a six-month budget period and whose equity in assets is not in excess of $1,000 per assistance unit. Exempt assets, the reduction of excess assets, and the waiver of excess assets must conform to the medical assistance program in section 256B.056, subdivision 3, with the following exception: the maximum amount of undistributed funds in a trust that could be distributed to or on behalf of the beneficiary by the trustee, assuming the full exercise of the trustee's discretion under the terms of the trust, must be applied toward the asset maximum;

(ii) who has gross countable income above 75 percent of the federal poverty guidelines but not in excess of 175 percent of the federal poverty guidelines for the family size, using a six-month budget period, whose equity in assets is not in excess of the limits in section 256B.056, subdivision 3c, and who applies during an inpatient hospitalization; or

(iii) the commissioner shall adjust the income standards under this section each July 1 by the annual update of the federal poverty guidelines following publication by the United States Department of Health and Human Services.

(b) Effective for applications and renewals processed on or after September 1, 2006, general assistance medical care may not be paid for applicants or recipients who are adults with dependent children under 21 whose gross family income is equal to or less than 275 percent of the federal poverty guidelines who are not described in paragraph (e).

(c) Effective for applications and renewals processed on or after September 1, 2006, general assistance medical care may be paid for applicants and recipients who meet all eligibility requirements of paragraph (a), clause (2), item (i), for a temporary period beginning the date of application. Immediately following approval of general assistance medical care, enrollees shall be enrolled in MinnesotaCare under section 256L.04, subdivision 7, with covered services as provided in section 256L.03 for the rest of the six-month eligibility period, until their six-month renewal.

(i) County agencies are authorized to use all automated databases containing information regarding recipients' or applicants' income in order to determine eligibility for general assistance medical care or MinnesotaCare. Such use shall be considered sufficient in order to determine eligibility and premium payments by the county agency.

(j) General assistance medical care is not available for a person in a correctional facility unless the person is detained by law for less than one year in a county correctional or detention facility as a person accused or convicted of a crime, or admitted as an inpatient to a hospital on a criminal hold order, and the person is a recipient of general assistance medical care at the time the person is detained by law or admitted on a criminal hold order and as long as the person continues to meet other eligibility requirements of this subdivision.

(k) General assistance medical care is not available for applicants or recipients who do not cooperate with the county agency to meet the requirements of medical assistance.

(l) In determining the amount of assets of an individual eligible under paragraph (a), clause (2), item (i), there shall be included any asset or interest in an asset, including an asset excluded under paragraph (a), that was given away, sold, or disposed of for less than fair market value within the 60 months preceding application for general assistance medical care or during the period of eligibility. Any transfer described in this paragraph shall be presumed to have been for the purpose of establishing eligibility for general assistance medical care, unless the individual furnishes convincing evidence to establish that the transaction was exclusively for another purpose. For purposes of this paragraph, the value of the asset or interest shall be the fair market value at the time it was given away, sold, or disposed of, less the amount of compensation received. For any uncompensated transfer, the number of months of ineligibility, including partial months, shall be calculated by dividing the uncompensated transfer amount by the average monthly per person payment made by the medical assistance program to skilled nursing facilities for the previous calendar year. The individual shall remain ineligible until this fixed period has expired. The period of ineligibility may exceed 30 months, and a reapplication for benefits after 30 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired. The period of ineligibility begins in the month the transfer was reported to the county agency, or if the transfer was not reported, the month in which the county agency discovered the transfer, whichever comes first. For applicants, the period of ineligibility begins on the date of the first approved application.

(m) When determining eligibility for any state benefits under this subdivision, the income and resources of all noncitizens shall be deemed to include their sponsor's income and resources as defined in the Personal Responsibility and Work Opportunity

Reconciliation Act of 1996, title IV, Public Law 104-193, sections 421 and 422, and subsequently set out in federal rules.

(n) (1) An undocumented ~~noncitizens and nonimmigrants are~~ noncitizen or a nonimmigrant is ineligible for general assistance medical care other than emergency services. For purposes of this subdivision, a nonimmigrant is an individual in one or more of the classes listed in United States Code, title 8, section 1101(a)(15), and an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the Immigration and Naturalization Service.

(2) This paragraph does not apply to a child under age 18; to a Cuban or Haitian entrant as defined in Public Law 96-422, section 501(e)(1) or (2)(a); or to a noncitizen who is aged, blind, or disabled as defined in Code of Federal Regulations, title 42, sections 435.520, 435.530, 435.531, 435.540, and 435.541, who cooperates with United States Citizenship and Immigration Services to pursue any applicable immigration status, including citizenship, that would qualify the individual for medical assistance with federal financial participation.

(3) For purposes of this paragraph, "emergency services" has the meaning given in Code of Federal Regulations, title 42, section 440.255(b)(1), except that it also means services rendered because of suspected or actual pesticide poisoning.

(o) Notwithstanding any other provision of law, a noncitizen who is ineligible for medical assistance due to the deeming of a sponsor's income and resources, is ineligible for general assistance medical care.

~~(p) Effective July 1, 2003, general assistance medical care emergency services end.~~

Sec. 5. Minnesota Statutes 2005 Supplement, section 256D.03, subdivision 4, is amended to read:

Subd. 4. **General assistance medical care; services.** (a)(i) For a person who is eligible under subdivision 3, paragraph (a), clause (2), item (i), general assistance medical care covers, except as provided in paragraph (c):

(1) inpatient hospital services;

(2) outpatient hospital services;

(3) services provided by Medicare certified rehabilitation agencies;

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

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

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

(7) hearing aids;

(8) prosthetic devices;

(9) laboratory and X-ray services;

(10) physician's services;

(11) medical transportation except special transportation;

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

(13) podiatric services;

(14) dental services as covered under the medical assistance program;

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

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

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

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

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

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

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

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

(23) mental health telemedicine and psychiatric consultation as covered under section 256B.0625, subdivisions 46 and 48.

(ii) Effective October 1, 2003, for a person who is eligible under subdivision 3, paragraph (a), clause (2), item (ii), general assistance medical care coverage is limited to inpatient hospital services, including physician services provided during the inpatient hospital stay. A $1,000 deductible is required for each inpatient hospitalization.

(b) Effective August 1, 2005, sex reassignment surgery is not covered under this subdivision.

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

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

~~(1) $25 for eyeglasses;~~

~~(2) $25 for nonemergency visits to a hospital-based emergency room;~~

~~(3) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $12 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness; and~~

~~(4) 50 percent coinsurance on restorative dental services.~~

~~(e) Co-payments shall be limited to one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital-based emergency room. Recipients of general assistance medical care are responsible for all co-payments in this subdivision.~~

~~The general assistance medical care reimbursement to the provider shall be reduced by the amount of the co-payment, except that reimbursement for prescription drugs shall not be reduced once a recipient has reached the $12 per month maximum for prescription drug co-payments. The provider collects the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment, except as provided in paragraph (f).~~

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

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

~~(h)~~ (e) Chemical dependency services that are reimbursed under chapter 254B must not be reimbursed under general assistance medical care.

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

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

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

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

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

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

~~(o) Fee-for-service payments for nonpreventive visits shall be reduced by $3 for services provided on or after January 1, 2006. For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, advance practice nurse, audiologist, optician, or optometrist.~~

~~(p) Payments to managed care plans shall not be increased as a result of the removal of the $3 nonpreventive visit co-payment effective January 1, 2006.~~

Sec. 6. Minnesota Statutes 2005 Supplement, section 256J.21, subdivision 2, is amended to read:

Subd. 2. **Income exclusions.** The following must be excluded in determining a family's available income:

(1) payments for basic care, difficulty of care, and clothing allowances received for providing family foster care to children or adults under Minnesota Rules, parts 9555.5050 to 9555.6265, 9560.0521, and 9560.0650 to 9560.0655, and payments received and used for care and maintenance of a third-party beneficiary who is not a household member;

(2) reimbursements for employment training received through the Workforce Investment Act of 1998, United States Code, title 20, chapter 73, section 9201;

(3) reimbursement for out-of-pocket expenses incurred while performing volunteer services, jury duty, employment, or informal carpooling arrangements directly related to employment;

(4) all educational assistance, except the county agency must count graduate student teaching assistantships, fellowships, and other similar paid work as earned income and, after allowing deductions for any unmet and necessary educational expenses, shall count scholarships or grants awarded to graduate students that do not require teaching or research as unearned income;

(5) loans, regardless of purpose, from public or private lending institutions, governmental lending institutions, or governmental agencies;

(6) loans from private individuals, regardless of purpose, provided an applicant or participant documents that the lender expects repayment;

(7)(i) state income tax refunds; and

(ii) federal income tax refunds;

(8)(i) federal earned income credits;

(ii) Minnesota working family credits;

(iii) state homeowners and renters credits under chapter 290A; and

(iv) federal or state tax rebates;

(9) funds received for reimbursement, replacement, or rebate of personal or real property when these payments are made by public agencies, awarded by a court, solicited through public appeal, or made as a grant by a federal agency, state or local government, or disaster assistance organizations, subsequent to a presidential declaration of disaster;

(27) income earned by a caregiver under age 20 who is at least a half-time student in an approved elementary or secondary education program;

(28) MFIP child care payments under section 119B.05;

(29) all other payments made through MFIP to support a caregiver's pursuit of greater economic stability;

(30) income a participant receives related to shared living expenses;

(31) reverse mortgages;

(32) benefits provided by the Child Nutrition Act of 1966, United States Code, title 42, chapter 13A, sections 1771 to 1790;

(33) benefits provided by the women, infants, and children (WIC) nutrition program, United States Code, title 42, chapter 13A, section 1786;

(34) benefits from the National School Lunch Act, United States Code, title 42, chapter 13, sections 1751 to 1769e;

(35) relocation assistance for displaced persons under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970, United States Code, title 42, chapter 61, subchapter II, section 4636, or the National Housing Act, United States Code, title 12, chapter 13, sections 1701 to 1750jj;

(36) benefits from the Trade Act of 1974, United States Code, title 19, chapter 12, part 2, sections 2271 to 2322;

(37) war reparations payments to Japanese Americans and Aleuts under United States Code, title 50, sections 1989 to 1989d;

(38) payments to veterans or their dependents as a result of legal settlements regarding Agent Orange or other chemical exposure under Public Law 101-239, section 10405, paragraph (a)(2)(E);

(39) income that is otherwise specifically excluded from MFIP consideration in federal law, state law, or federal regulation;

(40) security and utility deposit refunds;

(41) American Indian tribal land settlements excluded under Public Laws 98-123, 98-124, and 99-377 to the Mississippi Band Chippewa Indians of White Earth, Leech Lake, and Mille Lacs reservations and payments to members of the White Earth Band, under United States Code, title 25, chapter 9, section 331, and chapter 16, section 1407;

(42) all income of the minor parent's parents and stepparents when determining the grant for the minor parent in households that include a minor parent living with parents or stepparents on MFIP with other children;

(43) income of the minor parent's parents and stepparents equal to 200 percent of the federal poverty guideline for a family size not including the minor parent and the minor

parent's child in households that include a minor parent living with parents or stepparents not on MFIP when determining the grant for the minor parent. The remainder of income is deemed as specified in section 256J.37, subdivision 1b;

(44) payments made to children eligible for relative custody assistance under section 257.85;

(45) vendor payments for goods and services made on behalf of a client unless the client has the option of receiving the payment in cash; and

(46) the principal portion of a contract for deed payment.

Sec. 7. Minnesota Statutes 2004, section 256J.24, is amended by adding a subdivision to read:

Subd. 5b. **Cost of living increase.** The commissioner shall provide a ten percent cost of living increase to the cash portion of the transitional standard.

Sec. 8. **REPEALER.**

(a) Minnesota Statutes 2004, sections 256B.0631, subdivisions 2 and 4; 256J.37, subdivision 3a; and 256L.04, subdivision 10, are repealed.

(b) Minnesota Statutes 2005 Supplement, sections 256B.0631, subdivisions 1 and 3; and 256J.37, subdivision 3b, are repealed.

(c) Laws 2005, First Special Session chapter 4, article 3, section 19, is repealed.

ARTICLE 2
TAX ARTICLE

Section 1. Minnesota Statutes 2005 Supplement, section 289A.38, subdivision 6, is amended to read:

Subd. 6. **Omission in excess of 25 percent.** Additional taxes may be assessed within 6-1/2 years after the due date of the return or the date the return was filed, whichever is later, if:

(1) the taxpayer omits from ~~gross~~ taxable income an amount properly includable in it that is in excess of 25 percent of the amount of ~~gross~~ taxable income ~~stated in the return~~ that would have been reported but for the omission;

(2) the taxpayer omits from a sales, use, or withholding tax return an amount of taxes in excess of 25 percent of the taxes reported in the return; or

(3) the taxpayer omits from the gross estate assets in excess of 25 percent of the gross estate reported in the return.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 2. Minnesota Statutes 2005 Supplement, section 290.01, subdivision 6b, is amended to read:

Subd. 6b. **Foreign operating corporation.** The term "foreign operating corporation," when applied to a corporation, means a domestic corporation with the following characteristics:

(1) it is part of a unitary business at least one member of which is taxable in this state;

(2) it is not a foreign sales corporation under section 922 of the Internal Revenue Code, as amended through December 31, 1999, for the taxable year;

(3) either (i) ~~the average of the percentages of its property and payrolls, including the pro rata share of its unitary partnerships' property and payrolls, assigned to locations outside the United States, where the United States includes the District of Columbia and excludes the commonwealth of Puerto Rico and possessions of the United States, as determined under section 290.191 or 290.20, is 80 percent or more; or (ii)~~ it has in effect a valid election under section 936 of the Internal Revenue Code; or (ii) at least 80 percent of the gross income from all sources of the corporation in the tax year is active foreign business income; and

(4) ~~it has $1,000,000 of payroll and $2,000,000 of property, as determined under section 290.191 or 290.20, that are located outside the United States. If the domestic corporation does not have payroll as determined under section 290.191 or 290.20, but it or its partnerships have paid $1,000,000 for work, performed directly for the domestic corporation or the partnerships, outside the United States, then paragraph (3)(i) shall not require payrolls to be included in the average calculation~~ for purposes of this subdivision, active foreign business income means gross income that is (i) derived from sources without the United States, as defined in subtitle A, chapter 1, subchapter N, part 1, of the Internal Revenue Code; and (ii) attributable to the active conduct of a trade or business in a foreign country.

EFFECTIVE DATE. This section is effective for taxable years beginning after December 31, 2005.

Sec. 3. Minnesota Statutes 2005 Supplement, section 290.01, subdivision 19c, is amended to read:

Subd. 19c. **Corporations; additions to federal taxable income.** For corporations, there shall be added to federal taxable income:

(1) the amount of any deduction taken for federal income tax purposes for income, excise, or franchise taxes based on net income or related minimum taxes, including but not limited to the tax imposed under section 290.0922, paid by the corporation to Minnesota, another state, a political subdivision of another state, the District of Columbia, or any foreign country or possession of the United States;

(2) interest not subject to federal tax upon obligations of: the United States, its possessions, its agencies, or its instrumentalities; the state of Minnesota or any other state, any of its political or governmental subdivisions, any of its municipalities, or any of its governmental agencies or instrumentalities; the District of Columbia; or Indian tribal governments;

(3) exempt-interest dividends received as defined in section 852(b)(5) of the Internal Revenue Code;

(4) the amount of any net operating loss deduction taken for federal income tax purposes under section 172 or 832(c)(10) of the Internal Revenue Code or operations loss deduction under section 810 of the Internal Revenue Code;

(5) the amount of any special deductions taken for federal income tax purposes under sections 241 to 247 of the Internal Revenue Code;

(6) losses from the business of mining, as defined in section 290.05, subdivision 1, clause (a), that are not subject to Minnesota income tax;

(7) the amount of any capital losses deducted for federal income tax purposes under sections 1211 and 1212 of the Internal Revenue Code;

(8) the exempt foreign trade income of a foreign sales corporation under sections 921(a) and 291 of the Internal Revenue Code;

(9) the amount of percentage depletion deducted under sections 611 through 614 and 291 of the Internal Revenue Code;

(10) for certified pollution control facilities placed in service in a taxable year beginning before December 31, 1986, and for which amortization deductions were elected under section 169 of the Internal Revenue Code of 1954, as amended through December 31, 1985, the amount of the amortization deduction allowed in computing federal taxable income for those facilities;

(11) the amount of any deemed dividend from a foreign operating corporation determined pursuant to section 290.17, subdivision 4, paragraph (g). The deemed dividend shall be reduced by the amount of the addition to income required by clauses (19), (20), (21), and (22);

(12) the amount of a partner's pro rata share of net income which does not flow through to the partner because the partnership elected to pay the tax on the income under section 6242(a)(2) of the Internal Revenue Code;

(13) the amount of net income excluded under section 114 of the Internal Revenue Code;

(14) any increase in subpart F income, as defined in section 952(a) of the Internal Revenue Code, for the taxable year when subpart F income is calculated without regard to the provisions of section 614 of Public Law 107-147;

(15) 80 percent of the depreciation deduction allowed under section 168(k)(1)(A) and (k)(4)(A) of the Internal Revenue Code. For purposes of this clause, if the taxpayer has an activity that in the taxable year generates a deduction for depreciation under section 168(k)(1)(A) and (k)(4)(A) and the activity generates a loss for the taxable year that the taxpayer is not allowed to claim for the taxable year, "the depreciation allowed under section 168(k)(1)(A) and (k)(4)(A)" for the taxable year is limited to excess of the depreciation claimed by the activity under section 168(k)(1)(A) and (k)(4)(A) over the amount of the loss from the activity that is not allowed in the taxable year. In succeeding taxable years when the losses not allowed in the taxable year are allowed, the depreciation under section 168(k)(1)(A) and (k)(4)(A) is allowed;

(16) 80 percent of the amount by which the deduction allowed by section 179 of the Internal Revenue Code exceeds the deduction allowable by section 179 of the Internal Revenue Code of 1986, as amended through December 31, 2003;

(17) to the extent deducted in computing federal taxable income, the amount of the deduction allowable under section 199 of the Internal Revenue Code; ~~and~~

(18) the exclusion allowed under section 139A of the Internal Revenue Code for federal subsidies for prescription drug plans~~.~~;

(19) an amount equal to the interest and intangible expenses, losses, and costs paid, accrued, or incurred by any member of the taxpayer's unitary group to or for the benefit of a corporation that is a member of the taxpayer's unitary business group that qualifies as a foreign operating corporation. For purposes of this clause, intangible expenses and costs include:

(i) expenses, losses, and costs for, or related to, the direct or indirect acquisition, use, maintenance or management, ownership, sale, exchange, or any other disposition of intangible property;

(ii) losses incurred, directly or indirectly, from factoring transactions or discounting transactions;

(iii) royalty, patent, technical, and copyright fees;

(iv) licensing fees; and

(v) other similar expenses and costs.

For purposes of this clause, "intangible property" includes stocks, bonds, patents, patent applications, trade names, trademarks, service marks, copyrights, mask works, trade secrets, and similar types of intangible assets.

This clause does not apply to any item of interest or intangible expenses or costs paid, accrued, or incurred, directly or indirectly, to a foreign operating corporation with respect to such item of income to the extent that the income to the foreign operating corporation is income from sources without the United States as defined in subtitle A, chapter 1, subchapter N, part 1, of the Internal Revenue Code;

(20) except as already included in the taxpayer's taxable income pursuant to clause (19), any interest income and income generated from intangible property received or accrued by a foreign operating corporation that is a member of the taxpayer's unitary group. For purposes of this clause, income generated from intangible property includes:

(i) income related to the direct or indirect acquisition, use, maintenance or management, ownership, sale, exchange, or any other disposition of intangible property;

(ii) income from factoring transactions or discounting transactions;

(iii) royalty, patent, technical, and copyright fees;

(iv) licensing fees; and

(v) other similar income.

For purposes of this clause, "intangible property" includes stocks, bonds, patents, patent applications, trade names, trademarks, service marks, copyrights, mask works, trade secrets, and similar types of intangible assets.

This clause does not apply to any item of interest or intangible income received or accrued by a foreign operating corporation with respect to such item of income to the extent that the income is income from sources without the United States as defined in subtitle A, chapter 1, subchapter N, part 1, of the Internal Revenue Code;

(21) the dividends attributable to the income of a foreign operating corporation that is a member of the taxpayer's unitary group in an amount that is equal to the dividends paid deduction of a real estate investment trust under section 561(a) of the Internal Revenue Code for amounts paid or accrued by the real estate investment trust to the foreign operating corporation; and

(22) the income of a foreign operating corporation that is a member of the taxpayer's unitary group in an amount that is equal to gains derived from the sale of real or personal property located in the United States.

EFFECTIVE DATE. This section is effective for taxable years beginning after December 31, 2005.

Sec. 4. Minnesota Statutes 2005 Supplement, section 290.01, subdivision 19d, is amended to read:

Subd. 19d. **Corporations; modifications decreasing federal taxable income.** For corporations, there shall be subtracted from federal taxable income after the increases provided in subdivision 19c:

(1) the amount of foreign dividend gross-up added to gross income for federal income tax purposes under section 78 of the Internal Revenue Code;

(2) the amount of salary expense not allowed for federal income tax purposes due to claiming the federal jobs credit under section 51 of the Internal Revenue Code;

(3) any dividend (not including any distribution in liquidation) paid within the taxable year by a national or state bank to the United States, or to any instrumentality of the United States exempt from federal income taxes, on the preferred stock of the bank owned by the United States or the instrumentality;

(4) amounts disallowed for intangible drilling costs due to differences between this chapter and the Internal Revenue Code in taxable years beginning before January 1, 1987, as follows:

(i) to the extent the disallowed costs are represented by physical property, an amount equal to the allowance for depreciation under Minnesota Statutes 1986, section 290.09, subdivision 7, subject to the modifications contained in subdivision 19e; and

(ii) to the extent the disallowed costs are not represented by physical property, an amount equal to the allowance for cost depletion under Minnesota Statutes 1986, section 290.09, subdivision 8;

(5) the deduction for capital losses pursuant to sections 1211 and 1212 of the Internal Revenue Code, except that:

(i) for capital losses incurred in taxable years beginning after December 31, 1986, capital loss carrybacks shall not be allowed;

(ii) for capital losses incurred in taxable years beginning after December 31, 1986, a capital loss carryover to each of the 15 taxable years succeeding the loss year shall be allowed;

(iii) for capital losses incurred in taxable years beginning before January 1, 1987, a capital loss carryback to each of the three taxable years preceding the loss year, subject to the provisions of Minnesota Statutes 1986, section 290.16, shall be allowed; and

(iv) for capital losses incurred in taxable years beginning before January 1, 1987, a capital loss carryover to each of the five taxable years succeeding the loss year to the extent such loss was not used in a prior taxable year and subject to the provisions of Minnesota Statutes 1986, section 290.16, shall be allowed;

(6) an amount for interest and expenses relating to income not taxable for federal income tax purposes, if (i) the income is taxable under this chapter and (ii) the interest and expenses were disallowed as deductions under the provisions of section 171(a)(2), 265 or 291 of the Internal Revenue Code in computing federal taxable income;

(7) in the case of mines, oil and gas wells, other natural deposits, and timber for which percentage depletion was disallowed pursuant to subdivision 19c, clause (11), a reasonable allowance for depletion based on actual cost. In the case of leases the deduction must be apportioned between the lessor and lessee in accordance with rules prescribed by the commissioner. In the case of property held in trust, the allowable deduction must be apportioned between the income beneficiaries and the trustee in accordance with the pertinent provisions of the trust, or if there is no provision in the instrument, on the basis of the trust's income allocable to each;

(8) for certified pollution control facilities placed in service in a taxable year beginning before December 31, 1986, and for which amortization deductions were elected under section 169 of the Internal Revenue Code of 1954, as amended through December 31, 1985, an amount equal to the allowance for depreciation under Minnesota Statutes 1986, section 290.09, subdivision 7;

(9) amounts included in federal taxable income that are due to refunds of income, excise, or franchise taxes based on net income or related minimum taxes paid by the corporation to Minnesota, another state, a political subdivision of another state, the District of Columbia, or a foreign country or possession of the United States to the extent that the taxes were added to federal taxable income under section 290.01, subdivision 19c, clause (1), in a prior taxable year;

(10) 80 percent of royalties, fees, or other like income accrued or received from a foreign operating corporation or a foreign corporation which is part of the same unitary business as the receiving corporation, unless the income resulting from such payments or accruals is income from sources within the United States as defined in subtitle A, chapter 1, subchapter N, part 1, of the Internal Revenue Code;

(11) income or gains from the business of mining as defined in section 290.05, subdivision 1, clause (a), that are not subject to Minnesota franchise tax;

(12) the amount of handicap access expenditures in the taxable year which are not allowed to be deducted or capitalized under section 44(d)(7) of the Internal Revenue Code;

(13) the amount of qualified research expenses not allowed for federal income tax purposes under section 280C(c) of the Internal Revenue Code, but only to the extent that the amount exceeds the amount of the credit allowed under section 290.068;

(14) the amount of salary expenses not allowed for federal income tax purposes due to claiming the Indian employment credit under section 45A(a) of the Internal Revenue Code;

(15) the amount of any refund of environmental taxes paid under section 59A of the Internal Revenue Code;

(16) for taxable years beginning before January 1, 2008, the amount of the federal small ethanol producer credit allowed under section 40(a)(3) of the Internal Revenue Code which is included in gross income under section 87 of the Internal Revenue Code;

(17) for a corporation whose foreign sales corporation, as defined in section 922 of the Internal Revenue Code, constituted a foreign operating corporation during any taxable year ending before January 1, 1995, and a return was filed by August 15, 1996, claiming the deduction under section 290.21, subdivision 4, for income received from the foreign operating corporation, an amount equal to 1.23 multiplied by the amount of income excluded under section 114 of the Internal Revenue Code, provided the income is not income of a foreign operating company;

(18) any decrease in subpart F income, as defined in section 952(a) of the Internal Revenue Code, for the taxable year when subpart F income is calculated without regard to the provisions of section 614 of Public Law 107-147;

(19) in each of the five tax years immediately following the tax year in which an addition is required under subdivision 19c, clause (15), an amount equal to one-fifth of the delayed depreciation. For purposes of this clause, "delayed depreciation" means the amount of the addition made by the taxpayer under subdivision 19c, clause (15). The resulting delayed depreciation cannot be less than zero; and

(20) in each of the five tax years immediately following the tax year in which an addition is required under subdivision 19c, clause (16), an amount equal to one-fifth of the amount of the addition.

EFFECTIVE DATE. This section is effective for taxable years beginning after December 31, 2005.

Sec. 5. Minnesota Statutes 2004, section 290.34, subdivision 1, is amended to read:

Subdivision 1. **Business conducted in such a way as to create losses or improper taxable net income.** (a) When any corporation liable to taxation under this chapter conducts its business in such a manner as, directly or indirectly, to benefit its members

or stockholders or any person or corporation interested in such business or to reduce the income attributable to this state by selling the commodities or services in which it deals at less than the fair price which might be obtained therefor, or buying such commodities or services at more than the fair price for which they might have been obtained, or when any corporation, a substantial portion of whose shares is owned directly or indirectly by another corporation, deals in the commodities or services of the latter corporation in such a manner as to create a loss or improper net income or to reduce the taxable net income attributable to this state, the commissioner of revenue may determine the amount of its income so as to reflect what would have been its reasonable taxable net income but for the arrangements causing the understatement of its taxable net income or the overstatement of its losses, having regard to the fair profits which, but for any agreement, arrangement, or understanding, might have been or could have been obtained from such business.

(b) When any corporation engages in a transaction or series of transactions whose primary business purpose is the avoidance of tax, or engages in a transaction or series of transactions without economic substance, that transaction or series of transactions shall be disregarded and the commissioner shall determine taxable net income without regard for any such transaction or series of transactions.

Sec. 6. **INTENT OF LEGISLATURE.**

Section 5 does not change Minnesota law, but merely clarifies the legislature's intention with respect to transactions without economic substance or business purpose.

256B.0631 MEDICAL ASSISTANCE CO-PAYMENTS.

Subdivision 1. **Co-payments.** (a) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following co-payments for all recipients, effective for services provided on or after October 1, 2003:

(1) $3 per nonpreventive visit. For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(2) $3 for eyeglasses;

(3) $6 for nonemergency visits to a hospital-based emergency room; and

(4) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $12 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness.

(b) Recipients of medical assistance are responsible for all co-payments in this subdivision.

Subd. 2. **Exceptions.** Co-payments shall be subject to the following exceptions:

(1) children under the age of 21;

(2) pregnant women for services that relate to the pregnancy or any other medical condition that may complicate the pregnancy;

(3) recipients expected to reside for at least 30 days in a hospital, nursing home, or intermediate care facility for the mentally retarded;

(4) recipients receiving hospice care;

(5) 100 percent federally funded services provided by an Indian health service;

(6) emergency services;

(7) family planning services;

(8) services that are paid by Medicare, resulting in the medical assistance program paying for the coinsurance and deductible; and

(9) co-payments that exceed one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital-based emergency room.

Subd. 3. **Collection.** The medical assistance reimbursement to the provider shall be reduced by the amount of the co-payment, except that reimbursement for prescription drugs shall not be reduced once a recipient has reached the $12 per month maximum for prescription drug co-payments. The provider collects the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment, except as provided in subdivision 4.

Subd. 4. **Uncollected debt.** If it is the routine business practice of a provider to refuse service to an individual with uncollected debt, the provider may include uncollected co-payments under this section. A provider must give advance notice to a recipient with uncollected debt before services can be denied.

256J.37 TREATMENT OF INCOME AND LUMP SUMS.

Subd. 3a. **Rental subsidies; unearned income.** (a) Effective July 1, 2003, the county agency shall count $50 of the value of public and assisted rental subsidies provided through the Department of Housing and Urban Development (HUD) as unearned income to the cash portion of the MFIP grant. The full amount of the subsidy must be counted as unearned income when the subsidy is less than $50. The income from this subsidy shall be budgeted according to section 256J.34.

(b) The provisions of this subdivision shall not apply to an MFIP assistance unit which includes a participant who is:

(1) age 60 or older;

(2) a caregiver who is suffering from an illness, injury, or incapacity that has been certified by a qualified professional when the illness, injury, or incapacity is expected to continue for more than 30 days and prevents the person from obtaining or retaining employment; or

(3) a caregiver whose presence in the home is required due to the illness or incapacity of another member in the assistance unit, a relative in the household, or a foster child in the household when the illness or incapacity and the need for the participant's presence in the home has been certified by a qualified professional and is expected to continue for more than 30 days.

(c) The provisions of this subdivision shall not apply to an MFIP assistance unit where the parental caregiver is an SSI recipient.

(d) Prior to implementing this provision, the commissioner must identify the MFIP participants subject to this provision and provide written notice to these participants at least 30

days before the first grant reduction. The notice must inform the participant of the basis for the potential grant reduction, the exceptions to the provision, if any, and inform the participant of the steps necessary to claim an exception. A person who is found not to meet one of the exceptions to the provision must be notified and informed of the right to a fair hearing under section 256J.40. The notice must also inform the participant that the participant may be eligible for a rent reduction resulting from a reduction in the MFIP grant and encourage the participant to contact the local housing authority.

Subd. 3b. **Treatment of Supplemental Security Income.** The county shall reduce the cash portion of the MFIP grant by up to $125 for an MFIP assistance unit that includes one or more SSI recipients who reside in the household, and who would otherwise be included in the MFIP assistance unit under section 256J.24, subdivision 2, but are excluded solely due to the SSI recipient status under section 256J.24, subdivision 3, paragraph (a), clause (1). If the SSI recipient or recipients receive less than $125 of SSI, only the amount received shall be used in calculating the MFIP cash assistance payment. This provision does not apply to relative caregivers who could elect to be included in the MFIP assistance unit under section 256J.24, subdivision 4, unless the caregiver's children or stepchildren are included in the MFIP assistance unit.

256L.04 ELIGIBLE PERSONS.

Subd. 10. **Citizenship requirements.** Eligibility for MinnesotaCare is limited to citizens of the United States, qualified noncitizens, and other persons residing lawfully in the United States as described in section 256B.06, subdivision 4, paragraphs (a) to (e) and (j). Undocumented noncitizens and nonimmigrants are ineligible for MinnesotaCare. For purposes of this subdivision, a nonimmigrant is an individual in one or more of the classes listed in United States Code, title 8, section 1101(a)(15), and an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the Immigration and Naturalization Service.

Laws 2005, First Special Session chapter 4, article 3, section 19

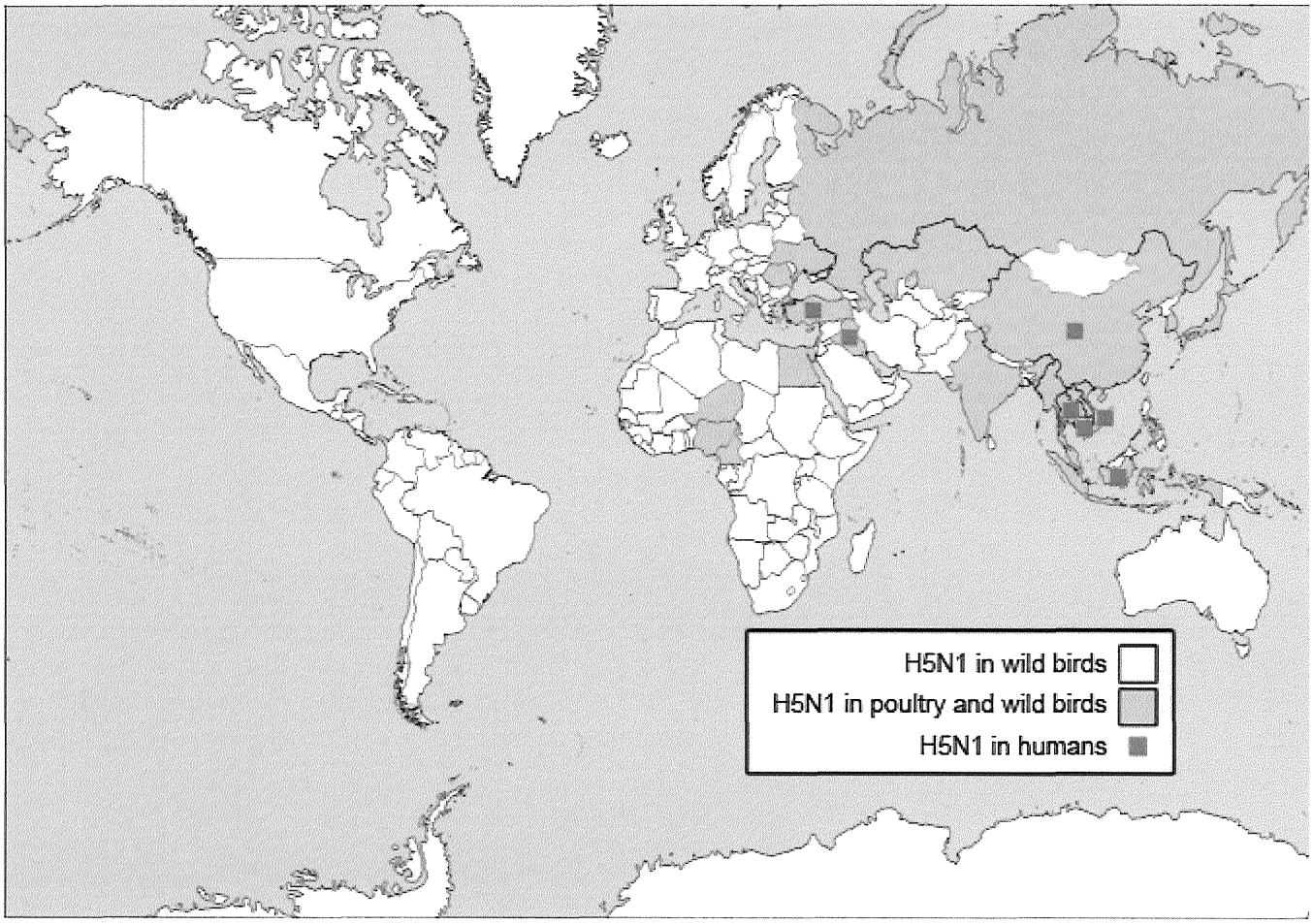
Sec. 19. [PARENT FEE SCHEDULE.]

(a) Notwithstanding Minnesota Rules, part 3400.0100, subpart 4, the parent fee schedule is as follows: <u>Income Range (as a</u> <u>Co-payment (as a percent of the federal</u> <u>percentage of adjusted poverty guidelines)</u> <u>gross income)</u> <u>0-74.99%</u> <u>$0/month 75.00-99.99%</u> <u>$5/month 100.00-104.99%</u> <u>3.23% 105.00-109.99%</u> <u>3.23% 110.00-114.99%</u> <u>3.23% 115.00-119.99%</u> <u>3.23% 120.00-124.99%</u> <u>3.60% 125.00-129.99%</u> <u>3.60% 130.00-134.99%</u> <u>3.60% 135.00-139.99%</u> <u>3.60% 140.00-144.99%</u> <u>3.97% 145.00-149.99%</u> <u>3.97% 150.00-154.99%</u> <u>3.97% 155.00-159.99%</u> <u>4.75% 160.00-164.99%</u> <u>4.75% 165.00-169.99%</u> <u>5.51% 170.00-174.99%</u> <u>5.88% 175.00-179.99%</u> <u>6.25% 180.00-184.99%</u> <u>6.98% 185.00-189.99%</u> <u>7.35% 190.00-194.99%</u> <u>7.72% 195.00-199.99%</u> <u>8.45% 200.00-204.99%</u> <u>9.92% 205.00-209.99%</u> <u>12.22% 210.00-214.99%</u> <u>12.65% 215.00-219.99%</u> <u>13.09% 220.00-224.99%</u> <u>13.52% 225.00-229.99%</u> <u>14.35% 230.00-234.99%</u> <u>15.71% 235.00-239.99%</u> <u>16.28% 240.00-244.99%</u> <u>17.37% 245.00-249.99%</u> <u>18.00% 250%</u> <u>ineligible</u>

(b) This schedule is effective January 1, 2006, and shall be implemented at or before the participant's next eligibility redetermination. The parent fee schedule in Laws 2003, First Special Session chapter 14, article 9, section 36, shall remain in effect until the schedule in this section is fully implemented.

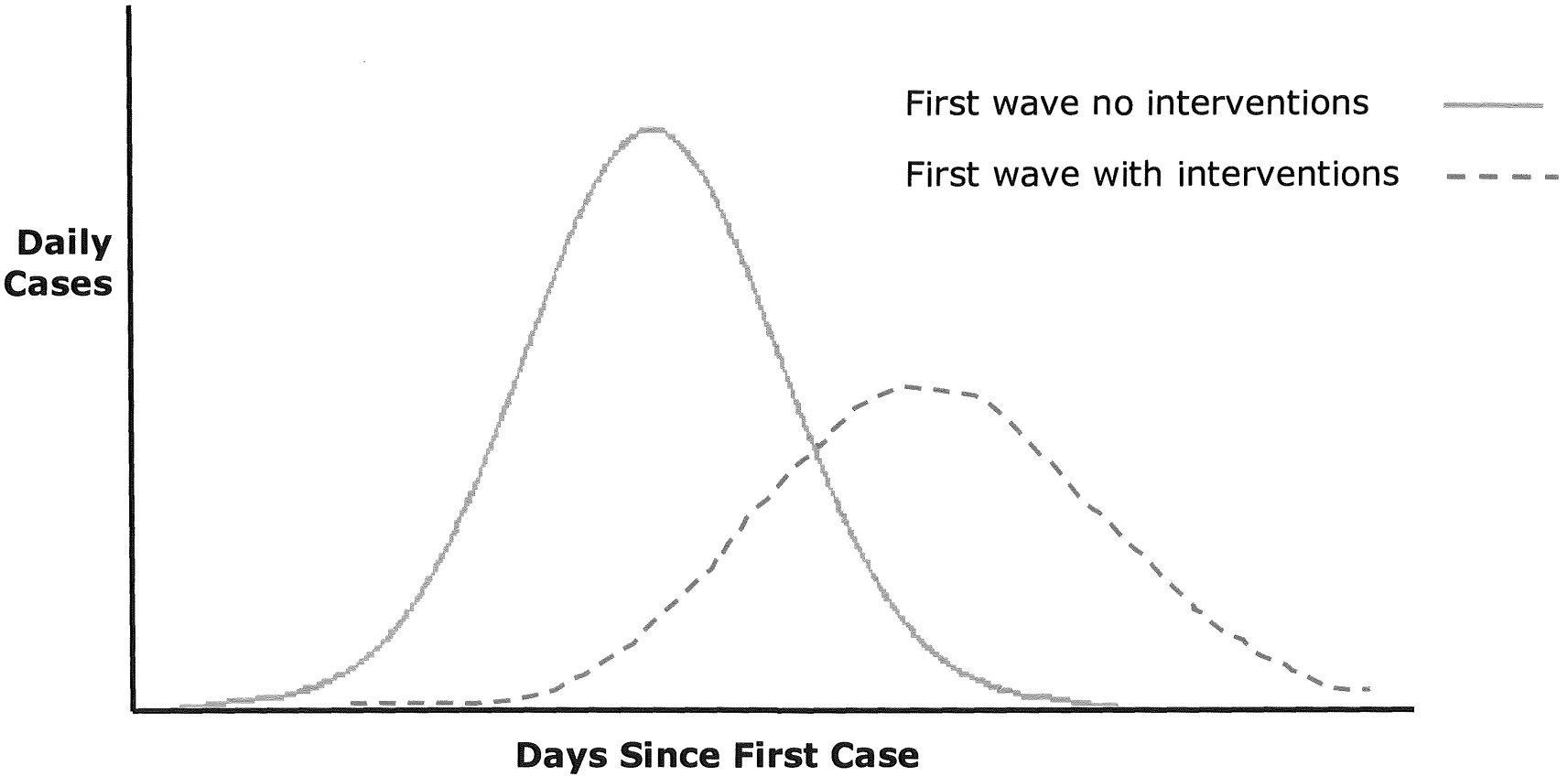
(c) A family's monthly co-payment fee is the fixed percentage established for the income range multiplied by the highest possible income within that income range.

Nations With Confirmed Cases
H5N1 Avian Influenza (March 13, 2006)



Close

Why Plan?

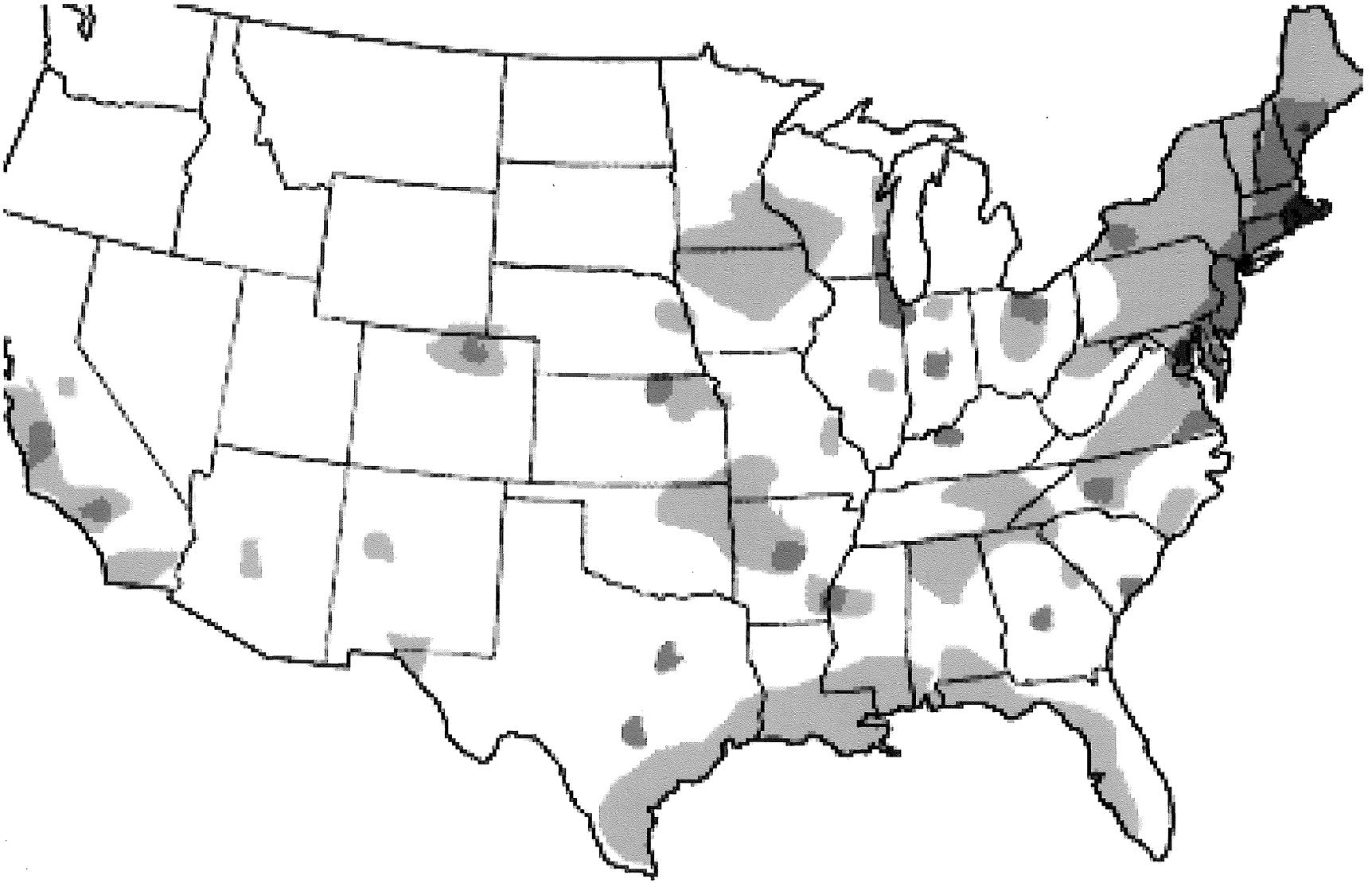

First wave no interventions
First wave with interventions
Daily Cases
Days Since First Case

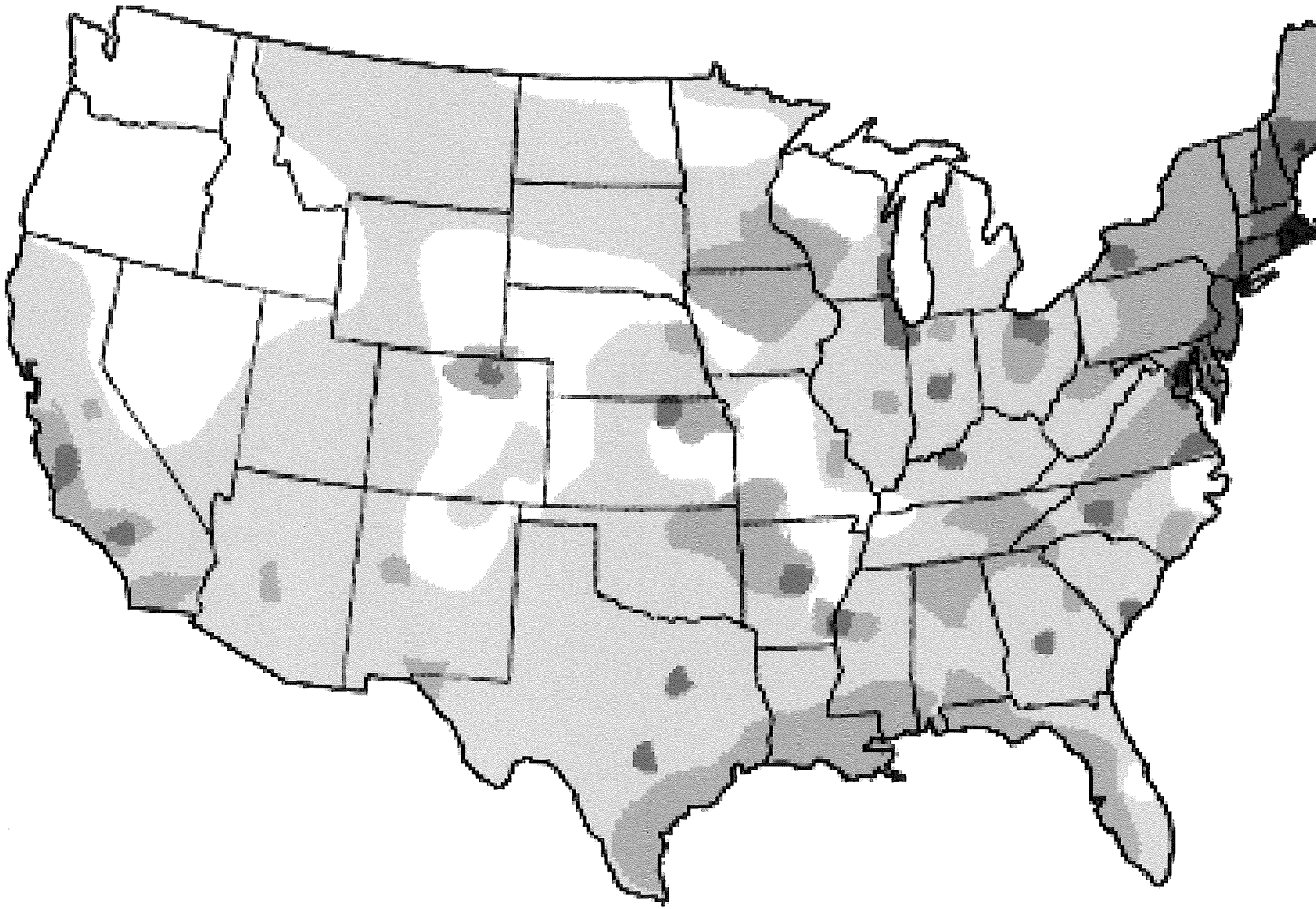
Approximate beginning of the epidemic, 1918

before sept. 14	between sept. 14 - 21	between sept. 21 - 28	between sept. 28 - oct. 5	after oct. 5

Source: America's Forgotten Pandemic - The Influenza of 1918 - 1989

before sept. 14	between sept. 14 - 21	between sept. 21 - 28	between sept. 28 - oct. 5	after oct. 5


before
sept. 14
between
sept. 14 - 21
between
sept. 21 - 28
between
sept. 28 - oct. 5
after
oct. 5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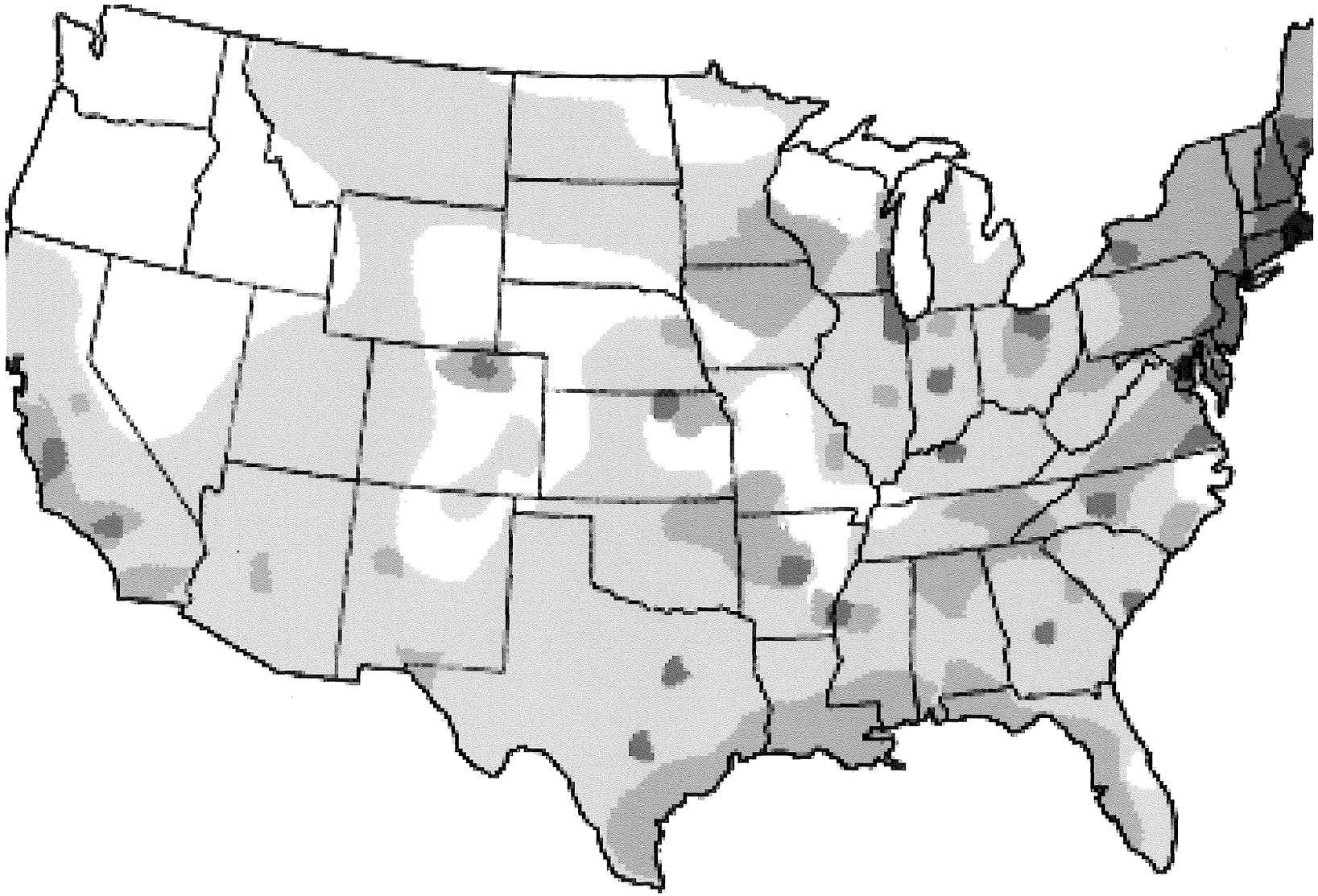

before sept. 14	between sept. 14 - 21	between sept. 21 - 28	between sept. 28 - oct. 5	after oct. 5

Minnesota Department of **Human Services**

Fast Facts:
2006 Legislative Session

Governor's mental health initiative:
Improving care for children and adults with mental illness

Issue:

- Many Minnesotans with mental illness do not receive the care they need, when they need it. They often must become very sick before they receive appropriate services.
- The current system is fragmented, with varying levels of access and care coordination. There is little incentive for early identification and intervention and many opportunities for cost shifting and cost avoidance.
- People often have both physical and mental health problems at the same time, yet the current health care system artificially separates their treatment.
- Mental health treatment needs to move into the mainstream of health care delivery rather than exist on the margins.

Proposal:

Based on the recommendations of the Minnesota Mental Health Action Group, the governor's initiative would reform the financing and delivery of publicly funded mental health care services for children and adults to improve access, quality and care coordination and to encourage identification and intervention. The proposal includes $50 million in new investments and $59 million in redirected government investments. Key components are:

Adoption of a comprehensive mental health benefit set across publicly funded health care programs *($26.8 million over three years; offset by $22.8 million redirected adult mental health grant funds)*

- Evidence-based mental health services currently available under the Medical Assistance fee-for-service program will be added to General Assistance Medical Care and MinnesotaCare for consistency across programs.
- Services that are now available on an "as funds are available" basis through state and county grants will become part of the mental health benefit set and available based on need. Variations in access from county to county will be eliminated.

Integration of mental and physical health care and the effective coordination of health care with social services and education *($32.5 million over three years; offset by $28.4 million redirected state grant funds)*

- Certain services which are now only available through MA fee-for-service (mental health case management and children's residential treatment) will be available in Prepaid Medical Assistance Plans for individuals already enrolled in those plans.
- Integrated care networks will be established through a request for proposals process in consultation with consumers, advocates and other stakeholders.
- Enrollment will be phased in region by region as integrated care networks are approved.
- Clear accountability for performance based on client outcomes is established through an integrated payment and service model.

Targeting investments to support an effective mental health infrastructure, including:

- Shore up children's school-based mental health services infrastructure for uninsured and under-insured children *($17.4 million)*
- Develop statewide mental health crisis intervention and stabilization infrastructure as a first-line safety net for children and adults *($13.5 million offset by $8.2 million redirected from increase in county share for commitments to state operated hospitals)*
- Monitor and track availability of mental health services *($253,000)*
- Develop and support evidence-based practices *($5.7 million)*
- Address workforce shortages, including psychiatrists and other critical mental health professionals *($7.5 million)*
- Develop capacity to address the mental health care needs of specialty populations *($5 million)*
- Create a system for measuring mental health service outcomes *($323,000).*

Benefits:

- Making a single entity responsible for the entire continuum of mental health services allows for a more holistic approach to a consumer's health and improves accountability for performance.
- Promoting early intervention will help assure consumers receive services before they are very ill.
- Involving large provider networks associated with managed care will give consumers more choice and more opportunity for consistency in access to care across geographic areas.
- Investing in an expanded mental health benefit set for public sector clients will demonstrate the efficacy of offering an expanded benefit set to private sector clients.

Fiscal impact:

- FY 2007: $3.4 million net cost, $3.6 million redirected from existing mental health grants.
- FY 2008: $24 million net cost, $15.2 million redirected from existing mental health grants.
- FY 2009: $22 million net cost, $32.3 million redirected from existing mental health grants.

Funds redirected from existing mental health grants will follow clients to new payers. The amount of redirected mental health grant funding ($51 million) represents about 21 percent of county mental health grants ($243 million total). The balance of redirected funds in the proposal ($8.2 million) is from an increase in the county share for commitments to state operated hospitals.

Number of people affected:

- 108,040 adults in state's publicly funded health care programs receiving mental health services
- 41,524 children in state's publicly funded health care programs receiving mental health services

Timeline:

- CY 2006: Establish workgroup, including advocates and stakeholders, to develop and issue a request for proposals for regional projects featuring integrated care networks.
- CY 2007: Increase benefit set for publicly funded Minnesota health care programs to match that of Medical Assistance; select regional projects/integrated care networks.
- CY 2008: Implement regional projects/integrated care networks and begin enrollment phase-in.

Related information:

- Finance Web site at www.finance.state.mn.us.

DHS Communications: March 2006

Minnesota Department of **Human Services**

Governor's Mental Health Initiative: Questions and Answers

Overview

What are the key elements of the Governor's mental health initiative?
The Governor is proposing over three years to invest $50 million in new Health Care Access Fund investments and redirect $59 million in existing funds to finance the transformation of the mental health system. The key elements to be financed include:

- Adopting a comprehensive mental health benefit set with proven treatment across all publicly funded health care programs *($26.8M; offset by $22.8M in redirected grants)*.
- Requiring the integration of mental and physical health care and the effective coordination of health care with social services and education *($32.5M; offset by $28.4M in redirected state grants)*; and,
- Targeting significant investments to support an effective mental health infrastructure *($49.6M; offset by $8.2M in redirected revenues)*.

Bipartisan legislation has been introduced to implement this initiative. To view the latest version, go to www.leg.state.mn.us/leg/legis.asp and enter HF3630 or SF3290.

What is the purpose of the Governor's Mental Health Initiative?
The purpose of the mental health initiative is to improve access, quality, and accountability in the delivery of mental health services for children and adults. We want mental illnesses to be recognized as health issues that can be successfully treated. We know that when mental health care and physical health care are integrated, the outcomes for both are improved.

Mental health treatment needs to move into the mainstream of the health care delivery and financing structures rather than existing on their margins. This will improve care and result in more equitable statewide access to mental health services. It will provide incentives to deliver care to people before their mental health issue becomes a major mental illness. It is a major step toward achieving mental health parity in our publicly funded health care system.

What is meant by improving "access, quality, and accountability?
The mental health initiative is based on the vision and recommendations of the Minnesota Mental Health Action Group (MMHAG). MMHAG was first organized in the autumn of 2003 under a vision of "a comprehensive mental health system that is accessible and responsible to consumers, guided by clear goals and outcomes, and grounded in public / private partnerships." Its membership includes consumers, families, advocacy organizations, mental health providers, hospitals, health plans, counties, and state agencies.

In the document "Road Map for Mental Health System Reform in Minnesota", MMHAG identified the following desired outcomes:

- Public / private partnerships to assure that all aspects of the mental health system are working to serve consumers and families.

- A new 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, 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 the consumers and families to navigate and they receive the right combination of services to achieve the desired health and social outcomes.

The mental health initiative's framework for access, quality, and accountability is taken from MMHAG's recommendations for a new mental health payment model. These recommendations include the following list of key policy objectives:

Access and 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 of mental health services.
- Minimizes uncompensated care
- Supports the development of a sustainable infrastructure

Quality and 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 efficiently
- Clarifies public / private health care payer responsibilities
- Builds a continuous evaluation of the effectiveness of the mental health system in achieving desired policy objectives
- Discourages cost and risk shifting
- Provides clear and continuous accountability

How will the Mental Health Initiative affect consumers?

As indicated above, the basic direction of the Mental Health Initiative is to make services more accessible, more accountable and more responsive to individual consumers' needs. During the past year, about 108,000 adults and 41,000 children received publicly funded mental health services. The Mental Health Initiative takes great care to recognize the huge variation in need and circumstances which is reflected by the current clients as well as by those who need services and are not now receiving them. A number of provisions (described below) have been included to address individual circumstances and particularly to ensure that nobody loses needed services as a result of the proposed changes.

One of the objectives is to integrate physical and mental health care. Since consumers now receive their physical health care (and their health care coverage in general) in a variety of ways and through a variety of payers, much of the complexity of the Mental Health Initiative results from trying to address and simplify existing variations in health care coverage.

Adopting a Comprehensive Mental Health Benefit Set For All Public Health Care Programs

What is meant by adopting a comprehensive mental health benefit?
Minnesota's medical assistance (MA) fee-for-service program offers mental health services that are not available in our General Assistance Medical Care (GAMC) program, MinnesotaCare, and the Prepaid Medical Assistance Program (PMAP). Many of these services have been added to the MA fee for service program over the past 5 years and are considered evidence-based and proven to be effective for treating and supporting people with mental illnesses.

This proposal adds mental health services to GAMC, MinnesotaCare, and PMAP so that all of Minnesota's publicly financed health programs offer the same, comprehensive outpatient mental health benefit set. These services include:

1. Assertive Community Treatment (ACT);
2. Intensive Residential Treatment Services (IRTS);
3. Adult Rehabilitative Mental Health Services (ARMHS);
4. Adult Crisis Services; and,
5. Case Management or Care Coordination;

Who benefits?
Some individuals now enrolled in GAMC and MinnesotaCare have access to these services only to the extent that funds are available through capped state grants, county funds, or a combination of both. For this reason, access to mental health services varies from region to region and county to county.

By adding these services to the GAMC and MinnesotaCare standard benefit set, all enrollees in Minnesota's health care programs will have access based on need. This will improve access for current enrollees and future enrollees. This may also provide incentives for persons with mental health issues to enroll and stay enrolled in these programs, which in turn, will result in better access to preventive physical and mental health care.

What is the cost of adding these benefits?
The total cost of the comprehensive benefit set is expected to be $26.8 million over the next three years. This cost is offset by the redirection of $22.8 million from capped, state mental health grants. The redirected funds represent money following the clients from the current payer (counties) to the new payer (state health programs). The amount of redirected funds is based on the value of these services now paid by state and county grants that in the future will be paid as part of the health care programs' standard benefit set. The services and the provider do not change, but the payer will.

Why is the cost of adding these benefits $4 million more than the amount of redirected grants?
Four million dollars in new funds are needed because access to these services will improve. The current payer (counties) provides these services within the limits of capped state and county grants. The new payer (public health programs) must offer these services to anyone who requires them.

How will the Mental Health Initiative affect Supported Employment?
Supported Employment is currently funded mostly through the Department of Employment and Economic Development, and the Mental Health Initiative will not affect that. Federal law places strict limits on the use of MA for supported employment. We do use MA for Adult Mental Health Rehabilitative Services (ARMHS) to do skills training to help clients learn how to deal with their mental illness in a variety of settings, including employment settings. The Mental Health Initiative uses some of the proposed new funding to expand GAMC and MnCare to include ARMHS, so in that sense the Governor's Initiative will assist Supported Employment.

What will happen with case management under the Mental Health Initiative?
For the majority of publicly funded mental health clients (those who are MA-disabled), nothing will change unless and until we receive a proposal from a health plan - county partnership for an integrated network that meets the requirements of the proposed new RFP. Our intention is to incorporate into that RFP the work that is being done by the MMHAG Service Access and Care Coordination Workgroup. The group has broad representation and is looking for creative ways to accomplish case management functions in a way that is more effective for clients. As far as funding for case management, we are assuming that state and county funding for case management will continue at least at current levels. Not enough information is available yet to predict the future of federal case management funding, but we believe this proposal puts Minnesota into a better position to deal with potential federal reductions to Targeted Case Management revenues.

Does the Mental Health Initiative support a psycho-social rehabilitation model of care?
Yes, the inclusion of services such as ACT, IRT and ARMHS in the standard benefit set for all publicly funded health care programs is a clear indication of the state's support for the psycho-social rehabilitative model of care. New research is increasingly showing mental illness as an illness, and services such as ACT have been proven to be effective when they are provided according to fidelity standards. The traditional medical model is evolving to embrace new research in mental health and DHS intends to support this change. We believe that integration of psycho-social rehabilitation with an evolving model of physical health care will be more effective than implementation of either model alone.

Requiring the Integration of Mental and Physical HealthCare

Why is the integration of mental health care and physical health care so important?
Physical and mental health problems co-occur. There are high rates of mental illness that accompany certain physical diseases and conditions such as diabetes, hypertension, obesity, breast cancer, and hepatitis B. Depressive disorders have been related to increased risk for developing coronary health disease, increased insulin resistance, increased risk of developing some cancers, and accelerated progression of HIV infection to AIDS.

Consumers of mental health services are under-treated. Studies show that only 11% of individuals with a serious mental illness received preventative physical care during a visit with a psychiatrist, and 48% of women's health issues were undiagnosed by psychiatrists. Consumers report that the issues they raise about physical health care concerns are often dismissed as psychosomatic. Surveys also indicate that children with special health needs are at significantly increased risk of mental health disorders.

A recent study of children and adolescents receiving services in Minnesota Health Care programs found that 60% of those prescribed psychotropic medications received these without any accompanying mental health service. Health plans in Minnesota report that primary care providers are prescribing up to 80% of the psychotropic prescriptions for both children and adults covered by private insurance.

The benefits of integrated care models are proven in a number of studies. One showed that 74% of people with major depression in an integrated treatment plan showed significant symptom reduction compared with only 44% of patients who had physician treatment and referral to mental health services at a separate site.

With primary care physicians serving as the first point of contact for most children, bifurcated physical and mental health treatment often results in the neglect of early diagnosis and treatment at early stages. This is clearly the case for children with pediatrics playing the central role in caring for common and emerging mental health problems.

Communication, co-location, and shared responsibility among primary care providers and mental health clinicians are all critical elements of better treatment and improved outcomes.

What is the strategy for achieving the integration of mental health treatment with other health care services?
The primary strategies for integrating the mental health care treatment with other health care services are to integrate the payment and require the development of integrated service models. This includes the removal of the "opt out" provision for individuals who qualify for enrollment into the Prepaid Medical Assistance Program (PMAP), and the enrollment of individuals who are disabled as the result of serious mental illnesses into health networks that include the choice of at least one "preferred integrated care network". The end of the "opt out" provision and enrollment of persons who are disabled would be thoughtfully phased in region by region. The first phase is anticipated to be implemented in January, 2008 and is projected to reach 20% of the state's potential enrollees. This is a projection for the pace of phasing in enrollment. Actual enrollment may be more or less than 20%.

What is a "preferred integrated care network"? What will determine the pace of the phase in period?
A "preferred integrated care network" is a mental and physical health care network that has been specifically designed to effectively integrate mental health care and physical health care and to coordinate these services with social services and education. "Preferred integrated care networks" will be identified through an RFP process. Consumers, advocates and other primary stakeholders with no direct financial interest will participate in the development of the RFP. The successful selection of these networks will be the primary determinant of the pace of phasing in enrollment.

Who can respond to the RFP and what will be the requirements for a successful bidder?
Approved projects will be based on locally defined partnerships that include at least one health plan or county-based purchasing entity, and the county or counties within the region.

The bidder will need to demonstrate the ability to accept and manage risk for the cost of physical and mental health services. "Preferred integrated care networks" will also need to demonstrate:

- The capacity to deliver effective care and treatment across the spectrum of physical and mental health care needs;
- The ability and commitment to integrate care across health care, social services, and education systems;

- An effective strategy for care coordination within and across systems of care;
- The ability to foster and maintain working relationships with varied partners, including counties, schools, Children's Mental Health Collaboratives, and Adult Mental Health Initiatives;
- An understanding and commitment to the application of best practices for mental health treatment;
- The ability to comply with reporting requirements and meet identified outcome standards;
- The ability to administer client protections and safeguards; and,
- The ability to bill third party payers including Medicare.

Will the counties have a voice on who is selected as a "preferred integrated care network?
Yes, the ability to coordinate mental and physical health care with social services will be a requirement of any bidder. This cannot be accomplished without a prearranged relationship with the counties covered in the region.

How will standards for access and care be established for "integrated care networks" and how will these standards be enforced?
Contract standards to be applied to the integrated care networks will be developed with significant input from consumers and advocates. These standards will address the specific needs and interests of persons with mental illnesses. Examples include:

- Standards of care and treatment;
- Requirements and incentives for developing and applying current and emerging best practices;
- Performance standards, outcome measures, and reporting requirements;
- Standards for behavioral service utilization reporting;
- Standards for access to mental health professionals and services;
- Care coordination standards;
- Requirements for coordination and integration with social services and education systems;
- Due process provisions for patient complaints; and,
- Requirements for continuity of care to assure that individuals can continue to receive services from qualified providers.

Does the proposal require all persons to enroll? Will there be the guarantees for continuity of care?
The proposal presumes enrollment into the care networks; however, exceptions will be made to allow an "opt out" for individuals who have previously established therapeutic relationships with specific providers who are not part of the integrated care network.

Will people be able to choose among all available health provider networks or will they be required to enroll in the "preferred integrated care network"?
Everyone will have the choice of enrolling in any available health networks. If no choice is made, the person will be enrolled in the "preferred" network. All health networks must provide the complete mental health benefit set and must work with counties to coordinate health care with social services. Counties must provide required social services to individuals regardless of what health network is chosen.

Will consumers have to go through a managed care plan to get their services?
The answer depends on your health care eligibility:

If you receive your physical health care through a managed care plan now, you already receive some of your mental health services through that plan. After January 1, 2007, GAMC, MnCare and PMAP plans will also include coverage for Assertive Community Treatment (ACT), Intensive Residential Treatment (IRT), Adult Rehabilitative Mental Health Services (ARMHS) and crisis services. After January 1, 2008, these plans will include coverage for mental health case management. These changes will help ensure more consistent, statewide access to these services, and better coordination with your physical health care.

If you are currently on MA fee-for-service (usually this is the same as "MA-disabled"), you will continue to receive both your physical and your mental health services through fee-for-service until the state has approved an integrated care network for your county. As indicated above, an integrated care network must demonstrate a working partnership between a county, a health network, and probably other agencies. It won't happen if the state determines that the partnership is unable to meet the criteria for integrated care (see above). The earliest date for integrated care networks to begin is January 1, 2008. Only 20% of the state is expected to qualify by that date. Other areas will begin later.

Receiving your health care through a managed care plan does not require approval for every service. In recent years, managed care plans have streamlined their service authorization requirements, thus allowing direct access to service providers in most situations.

What if I have a previously established therapeutic relationship with a specific provider under MA fee-for-service, and that provider is not included when the new integrated care network is developed?
The state will require the new integrated care networks to include a broad network of providers, so it's very unlikely that your provider would not be included. However, if that should occur, you would then have the option of staying in fee-for-service and continuing with your current provider.

Why does this Initiative include the health plans?
Our focus is on integration of physical health care, mental health care and social services in order to meet clients' needs. Most physical health care is currently provided through public or private health plans, while most social services are provided by counties. Currently there is an ineffective dichotomy between these systems, and this is not good for clients. In some areas, counties have begun this integration process through public health plans (county-based purchasing) and are reporting very promising results. Background regarding the need for integrated care is described in a paper available on the DHS website at www.dhs.state.mn.us/MHInitiative.

How will DHS monitor and manage health plan performance?
DHS uses several levels of monitoring including internal DHS staff and external sources. Each contract is assigned to a contract manager who is responsible for review of all plan materials and network changes, tracking of required reports and submissions and for tracking and ensuring resolution of service delivery, access or payment issues.

DHS works closely with the Minnesota Department of Health (MDH) in their regulatory and oversight process. If MDH identifies deficiencies or makes recommendations, DHS reviews those items to determine whether there is an impact on contract compliance. DHS monitors for resolution of deficiencies or may separately require that the plan develop and complete a corrective action plan.

The plans are also subject to review by an external quality review organization (EQRO), which reviews systems in place to assure access, timeliness and quality of services. If there are issues, a corrective

action plan may be required. The EQRO reviews for completion of the required corrective action plan at a subsequent visit. The EQRO also does special studies as designated by DHS related to access, timeliness and quality of services.

Prior to the implementation of the integrated care networks we will develop additional contract standards that are designed to address unique service and protection interests of people with mental illnesses. We have committed to seeking the input of consumers and consumer representatives in the development of these additional standards.

What due process and client protections will be in place?
Clients will have the same access to the state fair hearing (DHS appeal) process that they now have under fee for service. In addition, they will also have access to complaint and grievance processes at the plans as required by state and federal law. Minnesota Health Care Program enrollees in managed care plans have access to assistance from the Department of Human Services Managed Care Ombudsman for complaints and grievances. In addition, managed care plan enrollees may file complaints with the Minnesota Department of Health.

In fact, due process will improve significantly for persons enrolled in GAMC and MinnesotaCare. Once these programs include the expanded mental health benefit set, appeals will be determined solely on the individual's need for services. Today, counties do not have to provide these services if it can be demonstrated that there is a lack of available funding.

Under the proposal, are there limits or caps on the services that I can use?
Under a contract, the entity must provide all the services that are medically necessary. There are no "caps" or "limits" on services except for the inpatient cap already in place under the MinnesotaCare Limited Benefit (MLB) set. The governor's proposal adds the ACTs, IRTS, ARMHS and crisis services to the GAMC and MinnesotaCare benefit sets. We are also proposing to amend the MinnesotaCare Limited Benefit (MLB) set to allow reimbursement of all appropriate mental health provider types. However, MLB enrollees will still be subject to the $10,000 inpatient cap which is a combined limit for all types of MLB inpatient including psychiatric and non-psychiatric.

The contracted entities may require periodic review of treatment plans and may periodically authorize services, but they may not arbitrarily limit services.

What funding changes are necessary to finance the integration of mental health and physical health care?
Movement of clients and services from fee-for-service into managed care has two types of fiscal impacts: 1) the one-time cash flow cost of pre-payment; and 2) state assumption of non-federal match that is currently paid by counties for MH-TCM and Rule 5 Children's Residential services for persons in PMAP, GAMC and MnCare. State assumption of local match currently paid by counties will be offset by a reduction in county grants. The legislation proposes discontinuation of the state grants offsetting the local share of mental health targeted case management as the primary source of offsetting funds. The cost of these changes both statewide and within the regional projects is projected at $32.5 million; offset by $28.4million in redirected state grants.

How does this proposal relate to the Adult Mental Health Initiatives (AMHIs)?
The AMHIs began about 10 years ago in response to concerns that were similar to the concerns being addressed by this Mental Health Initiative. However, the AMHIs were focused on adults with serious and persistent mental illness, whereas the current initiative attempts to improve accessibility and quality

for all publicly funded mental health services, including adults and children, as well as improving continuity and parity with broader health care coverage, including public and private coverage. This Mental Health Initiative builds on the numerous successes that have been achieved by the AMHIs and uses the AMHI structure to further improve mental health infrastructure for adults (as well as the children's collaboratives for children).

This initiative does not affect the employment status of state staff assigned to the AMHIs.

Targeting Significant New Investments to Support an Effective Mental Health Infrastructure

What new mental health infrastructure investments are being recommended?

- Developing statewide mental health crisis intervention and stabilization infrastructure as a first line safety net for children and adults*($13.5M; offset by $8.2M available from increases in the county share for commitments to state operated hospitals);*
- Developing and supporting best practices *($5.7M)*;
- Developing capacity to address the mental health care needs of specialty populations *($5M)*;
- Shoring up children's school-based mental health services through local collaboratives *($17.4M)*;
- Reducing workforce shortages, including psychiatrists and other professionals by improved rate setting *($7.5M)*;
- Monitoring and tracking the availability of psychiatric hospital beds and other community-based mental health services *($253,000)*; and,
- Developing performance-based systems for accountability that focus on client outcomes *($323,000)*;

See separate document, Governor's Mental Health Initiative: Investments in the Mental Health Service Infrastructure, available at www.dhs.state.mn.us/MHInitiative

Financing

If the Governor proposes $50 million in new investments over 3 years, what is proposed as the annual amount of new investment?

The amount of new funding on an ongoing basis will be approximately $22 million per year by SFY 2009. Since some of these investments are for increased benefits in the publicly funded health care programs, they will be adjusted each year according to how much enrollment and use is projected for each program. Net startup costs for the initiative amount to $3.4 million in SFY2007.

Why is the Health Care Access Fund (HCAF) being used to finance mental health services?

This initiative and the accompanying transformation of mental health services are based on the principle that mental illness is a health care issue. Providing care and treatment for mental health issues is a health care responsibility. While MinnesotaCare is financed by the HCAF, so are many other activities designed to support access to health care. The access challenges faced by people with mental illnesses are clearly documented.

Simply stated, we believe that improving access to critical mental health services is an appropriate and necessary use of the HCAF because we believe that mental illness should be viewed and treated as a health care issue.

Where does this money come from? Does the HCAF have surplus funding available?
Currently, the HCAF is showing significant surpluses in the fund balance statement. By the end of state fiscal year (SFY) 2009, the HCAF is expected to have over $175 million in surplus funds and a structural balance (annual amount of revenues exceeding expenditures) of over $42 million. The mental health initiative requires $50 million of new funding from the HCAF by the end of SFY 2009 and has an on-going annual cost of $22 million per year. After fully financing the mental health initiative there still remains $125 million in surplus funds at the end of SFY 2009 and a structural balance of $20 million per year. This remains available for other uses that may be proposed during the 2006 session.

Using the HCAF to finance the mental health initiative will have no impact on the current MinnesotaCare program or other existing HCAF investments.

If this proposal redirects approximately $59 million of existing investments, are you taking away mental health money from one service to fund another?
The redirection of mental health grants simply allows the money to follow the clients to new payers. It does not require the services or the provider to change. For example, once we add mental health benefits to GAMC and MinnesotaCare, the same services that are now being provided on an "as funds are available" basis become part of the standard mental health benefit set. Not only does this support the integration of mental health services with other health care, but it makes these services available to all enrollees who need them. Today, these mental health services might be available to GAMC and MinnesotaCare enrollees, but only to the extent that counties have state grant funds or county funds in an amount sufficient to pay for the cost.

This initiative moves only the amount of the state grant dollars from counties to the public health programs equal to the value of the services that are moving from one payer to another. The amount of redirected mental health grant funding ($51 million over three years) represents about 21 percent of state mental health grants ($243 million total). The balance of redirected funds in the proposal ($8.2 million) is from an increase in the county share for commitments to state operated hospitals.

We are also proposing new funding for the GAMC and MinnesotaCare programs that is in addition to the redirected grants, because we know that access to mental health services will improve once they become part of a standard benefit set.

Will you be taking financial support away from local programs that are critical to people with mental illness?
No. This proposal does not make funding less available to current uses. We strongly support the continuation of programs such as club house models and other innovative services models and do not see the availability of these changing as a result of this proposal. We do hope that earlier intervention can prevent more intensive levels of service. The payer of the service may change if the service is one that is added to the benefit set of the public funded health care programs. The application of a county maintenance of effort will also benefit local programs to the extent that the programs rely on local financing. However, while there will be a floor applied to the amount of county investment, counties still have discretion on where to invest these local funds in mental health services. Counties also have this discretion today.

Which programs and funding sources are not affected by this proposal?
As indicated elsewhere in this Q&A, this proposal, as introduced, does not affect the employment status of current state staff in the Adult MH Initiatives and it does not affect state appropriations for Supported

Employment through the Department of Employment and Economic Development. Likewise, it does not affect appropriations for the Regional Treatment Centers, Community Behavioral Health Hospitals, Bridges housing subsidies, Group Residential Housing (GRH), home and community-based waiver programs such as CADI, CAC and TBI, home health and PCA services, mental health grants for American Indians, compulsive gambling programs, crisis housing and 45-day contract beds.

Changes to the County Role

Does the mental health initiative significantly change the county role in the administration of the mental health system?
Counties will continue to have a primary role in the delivery of social services. Counties in partnership with the state will be responsible for supporting a viable mental health infrastructure and for the provision of mental health care for people who are uninsured or underinsured. Beyond this, DHS intends to engage counties and stakeholders in a dialogue about the future role of counties in the public mental health system. The experience of the regional projects will inform that dialogue. Broad changes to the Mental Health Acts will not be proposed until a full discussion has occurred. In the short term, we'll propose clarifying that counties are not responsible for mental health services which are legally the responsibility of health plans.

Are there other changes being proposed that directly affect counties?
Counties, which now contribute considerable resources toward funding mental health services, will be expected to maintain current levels of funding so that the new investments are not used to supplant existing resources.

Increases in the county share for state operated hospital commitments are also being proposed. This is to align financial incentives to encourage the development and use of community-based alternatives to reduce unnecessary institutional placements. The incentives are carefully constructed so the *necessary* hospital placements are not discouraged. These county share increases are not expected to increase total county cost, since increases to the county share will be applied to the county maintenance of effort requirements. The new revenues generated from the increased county share are used to offset the cost of increasing statewide crisis capacity, and this in turn should reduce state hospital commitments and unnecessary use of community psychiatric hospital beds.

How will these changes and investments affect the counties' ability to address the service needs of the uninsured and underinsured?
Those who are currently uninsured or underinsured realize the greatest benefit from the infrastructure investments in this proposal. Nearly all of the new investments are directed at improving access to effective mental health treatment by qualified professionals. As previously mentioned, the expansion of the model mental health benefit set to the GAMC and MinnesotaCare programs means that the same individuals plus many more will have access to these services. The availability of mental health benefits may also serve as an incentive for people to enroll and stay enrolled in the public health programs. This in turn could result in improved access to preventative care.

Those who are underinsured or uninsured are also expected to be the greatest beneficiaries of the investments in crisis services, school-based treatment, the monitoring and tracking of psychiatric bed and community service capacity, improvement to current workforce shortages of mental health professionals, developing services for specialty populations, and developing best practices.

Does this proposal turn a county-based mental health system into a state run system?
A key objective of this initiative is to improve statewide access to mental health treatment and to gain more equity in service access from county to county and across the state. This requires a stronger state commitment to mental health services which this initiative represents. This especially applies to the state's commitment to people with mental illness who qualify for service through the state funded health care programs (GAMC, Medical Assistance, and MinnesotaCare).

About $51M dollars over three years are moving from state grants directed to counties to state funded health programs. Again, this represents the value of the services now funded through county contracts that will move to state health programs due to the addition of mental health service to the benefit sets of all health programs. This change provides guaranteed access to needed mental health treatment for all GAMC and MinnesotaCare enrollees and the integration of mental health treatment with other health care services.

The funds redirected from county grants to health programs are significantly offset by the $50M in new investments. A significant portion of the new infrastructure investments will be issued through county contracts.

A Work in Progress

Is the work on this initiative complete and final?
No, it is a work in progress. The mental health initiative is based upon the non-partisan work, recommendations, and input of the many consumers, advocates, counties, providers, hospitals, health plans, and state agencies who participate on the MMHAG steering committee, workgroups and advisory committees. These groups are still active and we are committed to continue to seek a broad range of input as the proposal progresses to the implementation phase.

What issues are still being addressed by MMHAG members and the Department of Human Services ?
The development of the "preferred integrated care networks" relies heavily on the development of an RFP as well as the development and enforcement of clear contract standards. Consumers, advocates, and other stakeholders who have no direct financial interest as bidders will participate in drafting both products. Standards are expected to include performance measures based on client outcomes as well as requirements for care coordination and management. Both of these elements are subjects of active MMHAG workgroups which are expected to complete their work over the next few months. Some examples of specific issues still being addressed include:

- Ensuring continuity of services and access to qualified providers;
- Developing standard reporting requirements related to outcome measures and encounter data;
- Identifying care coordination and management standards based on critical functions;
- Ensuring adequate client protections and due process;
- Changes to the Mental Health Acts to reflect changes in state and county roles, and
- Access to "preferred integrated care networks" by new enrollees.

We expect that many of these issues can be addressed in the RFP and service contracts. Any additional law changes can be addressed in the 2007 Legislative Session prior to the implementation of the first phase of enrollment that is slated for January, 2008.

Minnesota Department of **Human Services**

Governor's Mental Health Initiative: Investments in the Mental Health Service Infrastructure

Statewide Crisis Mental Health Services Intervention and Stabilization Infrastructure

Service Description:

Mobile mental health crisis response teams composed of a mental health professional and one or more practitioner level staff. The team provides crisis intervention and assessment services. Crisis stabilization services may be provided on site, or in crisis beds that are part of a residential program.

Issues to be addressed:

Even though crisis services are a top priority under the Mental Health Act, the state has struggled for years to develop and maintain an adequate capacity for these services. A number of factors make it difficult to put together a crisis services program that is economically viable without a source of operating subsidy:

- A large portion of those needing crisis services are uninsured – especially among adults. This is no surprise as the uninsured have minimal access to preventative care.
- By its nature, the demand for crisis services is sporadic and any effort to maintain 24/7 availability will have a significant amount of time that is not providing direct service and therefore not "billable time."
- It is doubly difficult to operate crisis services in rural areas. A region large enough to generate a reasonable client base is frequently too large to allow acceptable response time for the mobile crisis services.

Proposed Funding Mechanism:

Counties, Adult Mental Health Initiatives, Children's Mental Health and Family Service Collaboratives and tribes will be eligible apply for competitive grants to subsidize crisis services delivery. Regional applications will receive preference. Grants will operate on a quarterly "settle-up" basis to offset uncompensated time to the limit of the grant award. Grant funds may also be used to follow-up with crisis services users and assist them in gaining ongoing health care coverage.

Expected Outcomes:

- Reduced unnecessary use of emergency room resources for mental health crisises.
- Reduced demand for psychiatric hospital resources.
- Clients will retain more of their existing housing.

Minnesota Examples:

- In the St. Could area, CentraCare, local schools, and the 4 area counties (Benton, Sherburne, Stearns, Wright) have cooperated in a public/private partnership to develop the "Children's Emergency Assessment System." This mobile crisis response unit provides on-site crisis response services to children in schools and childcare providers and builds on an earlier local effort that established co-located child psychiatry services in CentraCare pediatric clinics and other local primary care sites.

- A public-private partnership of representatives from hospitals, county social service departments, health plans and DHS Mental Health Divisions has developed comprehensive crisis service models to divert children and adults who are experiencing a mental health crisis from unnecessary emergency room visits and inpatient hospital stays. For adults, the East Metro Adult Crisis Stabilization program has been in existence for 2 ½ years and has served over 1000 adults. Follow up data seven months after discharge from the program indicate that the overwhelming majority of these individuals have not been hospitalized. Of note, 30 percent of those who received services were uninsured and were covered by time limited grant funding. Similarly, the "Metro Children's Crisis System" provides a first line safety net for children with emotional disturbance and their families, and supplies critical linkages to community-based services.

Monitor and Track Available Mental Health Service Capacity

Description:

Develop a statewide, web-based, resource to track and provide real-time information regarding the current, staffed psychiatric acute care capacity for children, adolescents and adults within the state. The system will track both the beds currently in use and those available for new admissions. Over time, expand this to track the availability of other key mental health services.

Issues to be addressed:

A Minnesota Department of Health, Health Economics Issues Brief released in August 2005 stated: *"In recent years, there has been increasing concern about the availability of mental health and chemical dependency beds. Anecdotal evidence and media reports have suggested high occupancy rates and long waiting periods for inpatient mental health and chemical dependency beds, especially in the Twin Cities. To date, however, systematic information on capacity and occupancy rates for inpatient chemical dependency and mental health services has not been available."* Further, it reported: *"The occupancy rates reported for mental health beds ranged from 0 to 100 percent, with more than half of the hospitals reporting occupancy rates of 75 percent or higher. The occupancy rates reported for pediatric mental health beds ranged from 63 percent to 100 percent with a median of 91 percent."*

With these high occupancy rates, people in psychiatric crisis need a resource to help direct them to near by hospitals with available capacity in order to avoid unnecessary travel time, long emergency room stays and delays in admission. In addition, administrators and policy makers need improved information to determine the appropriate means of addressing the apparent crisis in acute care capacity.

Proposed Funding Mechanism:

Tracking of available service capacity will be an administrative activity of the Department of Human Services. In order to be available as a 24/7 statewide resource, DHS will either contract with an outside vendor for this activity, operate the system from its central office, or incorporate it within the centralized intake and admissions system under development for state operated community behavioral health hospitals.

Expected Outcomes:

- Improved timely access to psychiatric acute care and other mental health services, through improved information regarding service availability for crisis services providers, law enforcement, emergency room staff and hospital admissions staff.
- Improved targeting and coordination of state, county, health plan and provider efforts to free up resources in short supply when they are being used inappropriately.
- Concrete information to inform policy changes to address the apparent shortage of psychiatric acute care capacity.

School-Based Mental Health Services

Service Description:

Day treatment programs and co-located mental health professionals in schools to provide assessment, crisis intervention services and psychotherapy. Also included will be mental health support for home visiting, maternal & child health, and pre-school programs.

Issues to be addressed:

All of the above services can be critical to the educational success of many children with emotional problems. Unfortunately, access to these services is in peril due to recent federal policy for Title IV-E and Medicaid administrative claiming. This funding mechanism was the basis for the Local Collaborative Time Study (LCTS), the primary funding source for children's collaboratives. LCTS will lose an estimated $40 million annually due to these changes – more than 2/3rds of their annual funding. Children's collaboratives have historically expended over $9 million annually on these services.

Proposed Funding Mechanism:

Funds will be made available initially to Children's Mental Health and Family Service Collaboratives on a competitive grant basis. Once comparable data is available across grantees, the allocation of funds among grantees will be in proportion to the number of children they serve adjusted for the portion that cannot access third party coverage.

Expected Outcomes:

- Fewer classroom disruptions and improved attendance, classroom participation and grades among children served.
- Healthy child development and improved school readiness.
- Sustain a viable system of co-located mental health services in schools.

Minnesota Examples:

- Northern St. Louis County Family Services Collaborative – contracts with the Range Mental Health Center to provide mental health services on-site in 12 schools. Providing assessments, psychotherapy and rehabilitative services in the schools saves parents travel time and better coordinates the mental health care with the educational and special education programs. The result for children is improved school performance and greater stability in their lives.
- The Carver County Integrated Services Council has arranged to have a county mental health case manager in the schools. This improves access and coordination of mental health, social services and special education service for children with mental health problems and their families.

Address Critical Shortages of Qualified Mental Health Professionals

Service Description:

Provide an increased rate in MA, GAMC and MinnesotaCare for certain outpatient mental health services which currently have long waiting lists and other access problems. The concept is similar to what was proposed in 2005 in SF 2211 and what is done now for hospitals and dental providers.

Issues to be addressed:

Currently, 70 of Minnesota's 87 counties meet federal criteria as mental health professional shortage areas. The shortage of mental health professionals has far reaching effects on the state's mental health system. It limits access to quality assessments, up-to-date treatment planning and medication monitoring. Historically poor reimbursement rates in public mental health programs has often been cited as contributing to the problems of attracting and retaining mental health professionals.

Proposed Funding Mechanism:

Under this proposal, a 20-25% rate increase is provided to psychiatrists, advanced practice registered nurses (APRNs) with a psychiatric specialty, and "Critical Access Providers" when they provide the following services:

- CTSS group skills training, psychotherapy, medication management, evaluation and management, diagnostic assessment, explanation of findings, psychological testing, neuropsychological services, direction of behavioral aides and inpatient consultation

- "Critical Access Providers" eligible for the rate increase include community mental health centers (CMHCs) and providers who are certified by the Department of Health as Essential Community Providers and who do not already receive higher (or cost-based) rates through other provisions. Therefore, this proposal does not affect Indian Health Services, Federally Qualified Health Centers and Rural Health Centers.

This proposal does not include adult day treatment, partial hospitalization, Crisis Response services, ARMHS, ACT, IRTS, Rule 5 or MH-TCM, most of which have cost-based rates or which received significant rate increases in 2004.

MHCP rates (other than cost-based rates) are generally recognized as being less than the average actual cost of the services. This proposal would bring these rates closer to, but not over, actual cost.

It is assumed that the process of obtaining federal approval and implementing differential rates will delay implementation until 7/1/07.

Expected Outcomes:

- Attract more mental health professionals to serving public sector clients or to increase the portion of public sector clients they serve.
- Reduced waiting times for publicly funded clients to see psychiatrists or other MH professionals
- Reduced travel time and expense for clients to access psychiatrists or other MH professionals
- Provision of more appropriate, more effective services

Minnesota Examples:

- None related directly to mental health. The state has pursued this strategy to increase access to dental care for enrollees in the states health care programs.

Develop and Support Evidence-Based Practices and Best Practices

Service Description:

Grants will support and leverage the local implementation of evidence based mental health treatment practices including:

- Integrated Dual Diagnosis (MI/CD) Treatment across the service delivery system;
- Assertive Community Treatment (ACT) teams in the 7 county metro area;
- Models of integrated care including co-location of MH services in primary care settings and schools;
- Application of treatment research in daily clinical decision making for children and adolescents (Hawaii Project);
- Use of technology to aid in effective treatment planning; and,
- Housing with support services

Issues to be addressed:

The mental health field is changing rapidly with advances in both physiological and psycho-sociological approaches to treatment. As the pace of change accelerates, it becomes increasingly important to devote resources to staying current in order to provide quality, effective care. There are many barriers to adopting and embracing change. These grants are to provide incentives to try new approaches and to offset the costs associated with implementing them.

Proposed Funding Mechanism:

Grants will be awarded on a competitive basis to counties, Adult Mental Health Initiatives, collaboratives, tribes and mental health provider organizations. The grants will generally be short term, to offset start-up costs associated with adopting new technology in mental health treatment.

Expected Outcomes:

- Reduced demand for regional treatment center capacity by metro area clients;
- Improved quality of mental health care provided through primary care clinics;
- Improved quality of treatment planning based on client diagnosis and demographic information.

Minnesota Examples:

- A key best practice in the children's mental health field is to identify and treat emotional problems before they are compounded by more intractable behavioral problems. Ramsey County has provided strong leadership in pulling together local Head Start programs, schools, pediatric clinics and mental health providers in a strategic planning effort to foster early identification and brief, effective early intervention for children.

- Recognizing the need for a more seamless service for persons who were experiencing difficulty in managing their independence in the community and who were served by either the public or private sector, St. Louis County Social Services, Human Development Center, Range Mental Health Center , DHS- Mental Health Division and Medica- United Behavioral Health developed an Assertive Community Treatment Team to serve public and privately funded clients in need of this intensive

evidence-based service. Follow up data indicate a marked reduction in Emergency Room use, improved community tenure and improved client satisfaction with services.

- Given the shortage of mental health providers in the area and the large rural geographic region, the 10 county South Central Adult Mental Health Initiative is in the process of establishing 36 telehealth sites that will be able to be used by all the mental health providers, county social service agencies, and others to improve communication, conduct client assessments and provide other medically necessary services via this technology. This is expected to help with improving access to needed services.

Cultural Specific and other Specialty Services

Service Description:

This proposal provides competitive grants to counties, Adult Mental Health Initiatives, tribes, collaboratives, and mental health providers to address special treatment populations and service-delivery infrastructure that falls outside the expertise or capacity off the existing locally available service infrastructure. The grants will fund costs related to provider training, co-location of specialty providers, recruitment of specialty providers, development of professional consultation and tele-health, and client outcomes data collection and evaluation. Grants will develop care delivery infrastructure for medically necessary services that are eligible for reimbursement through Minnesota Health Care Programs and private payers.

Issues to be addressed:

Some mental health disorders, such as eating disorders or treatment resistant psychoses, require highly specialized treatment that either cannot be effectively delivered by mainstream mental health service providers, or are difficult to make economically viable due to the low incidence of the disorders.

Some populations, such as people from racial and ethnic minorities or those who are deaf, hard-of-hearing, or deaf and blind are most effectively treated by persons with the specialized skills necessary to communicate with them and the knowledge to draw on the context and strengths of their culture. Racial and ethnic minorities—including both immigrants and well-established minority populations—continue to experience mental health care outcomes that are substandard by comparison with the general population. Too many mental health providers lack the expertise to distinguish cultural variation from psychopathology and lack training in using cultural strengths as an effective treatment tool.

Proposed Funding Mechanism:

This proposal would fund a strategically-coordinated series of competitive grants, issued via RFP's, to encourage innovative approaches and gap-filling infrastructure. Eligible applicants would be counties, tribes, collaboratives, and mental health providers. Grantees must show how their proposed approach will meet the needs of the target group and how it will coordinate with existing service infrastructure and access third party payment whenever possible. Grantees must be willing to serve as models from which the rest of the state can learn. Preference will be given to regional or multi-jurisdictional proposals that define a service area based on the natural incidence of its target population, rather than by political subdivisions. Proposals based on short-term start-up funds and / or ongoing funding support will be accepted.

Expected Outcomes:

- Treatment outcomes among racial and ethnic minority populations will achieve parity with outcomes of all Minnesotans
- People with highly specialized or challenging treatment needs will receive high quality care inside Minnesota.

Minnesota Examples:

- Community University Health Care Clinic in Minneapolis and AH Wilder Southeast Asian program in St. Paul receive grant funding from DHS to develop culturally competent mental health services to the growing Somali and Southeast Asian communities. Both programs employ staff from the respective communities who are knowledgeable about the cultures and specific approaches to mental health treatment.

- 25 percent of the federal mental health block grant (about $1.5 million) is dedicated to providing community-based mental health services to American Indians. These funds are awarded to 9 tribes and 4 urban programs. We are also working with the tribes to become Medicaid providers.

- The PACT 4 children's collaborative serves Kandiyohi, Meeker, Renville, and Yellow Medicine counties and the Upper Sioux Community in west central Minnesota. The collaborative has been contracting with two metro area providers, CLUES (Comunidades Latinas Unidas en Servicio) and the La Familia Guidance Center to help bring culturally competent mental health services to the Chicano/Latino population in west central Minnesota.

- DHS funded creation of the Multi-Cultural Specialty Providers Network to increase the provider pool of culturally and linguistically competent providers. This association of culturally diverse children's metal health providers mentored new ethnically-diverse community-based providers in obtaining managed care provider contracts and developed a training curriculum to increase the cultural competence of the state's children's mental health providers. The goal is to eliminate the disparities in mental health outcomes between cultural groups.

Minnesota Department of **Human Services**

Governor's Mental Health Initiative: Background on Integrated Care

Integrated physical and mental health care is emerging as a needed, promising and soon to be standard model of service delivery. In August, 2005, a coalition of 24 health care provider, public health and consumer groups comprising *The Health Care for the Whole Person Collaborative* issued a joint statement calling for the integration of behavioral and mental health services into the nation's primary and public health systems. The *Collaborative*, whose member organizations include the American Psychological Association, the American Public Health Association, the American College of Obstetricians and Gynecologists, The American Nurses Association, the National Association of Community Health Centers, Families USA and the Consumers Union, among others, said that "the current model of health care in the United States artificially separates emotional and mental health from physical health leading to higher health care costs and negative effects on health care access and outcomes."

Recent studies from the Bazelon Center for Mental Health Law (2004), the National Institute for Health Care Management (NIHCM, 2005), and numerous academic research groups have argued the case for integrated care and demonstrated specific ways in which integration can be achieved.

I. Physical and Mental Health Problems Co-Occur

Integration is a needed model because physical and mental health problems are not separable, and previous models which have treated them in isolation have actually exacerbated both. The Bazelon study particularly demonstrates that people with serious mental illnesses have poor physical health, including:

- High rates of diabetes [prevalence rates of 15% for those with major mood disorders; 16-25% for those with schizophrenia; 25% for bipolar disorder; and 50% for schizoaffective disorder]
- Significant hypertension [34% among those with serious mental illnesses] and cardiac disease [16%]
- High rates of obesity
- Elevated risks of breast cancer [9.5 times higher in women with SMI], HIV infection [eight times U.S. prevalence], and hepatitis B and C [five and eleven times the U.S. prevalence, respectively]

In addition to these specific risks, depressive disorders have been related to an increased risk of developing coronary heart disease; increased insulin resistance; increased risk of developing some cancers; and accelerated progression of HIV infection to AIDS (Health Resources and Services Administration [HRSA], 2001).

Despite these high rates of physical disease, consumers of mental health services are undertreated. In two studies reported by Bazelon, only 11% of individuals with a serious mental illness received preventive physical care during a visit to a psychiatrist, and 48% of women's health issues were undiagnosed by psychiatrists. Consumers interviewed by Bazelon staff reported that too often "they

have raised issues related to physical illness with their mental health provider, only to have their complaints dismissed as psychosomatic or the result of their mental illness" [p. 11].

Conversely, the mental health needs of children and adults with acute and chronic illnesses are also underestimated and undertreated in systems which have carved apart physical and mental health care. A triennial national survey of children with special health care needs (CSHCN) has repeatedly demonstrated that these children and adolescents are at significantly increased risk of mental health disorders, with common children's mental health diagnoses occurring at up to twice the rate of non-CSHCN children. Minnesota Student Survey data similarly shows that children who identify themselves as having special health needs have elevated levels of depressed mood and suicidal ideation.

For adults, data from the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services clearly demonstrates the ubiquity of mental health problems – usually unidentified and untreated – among persons with chronic health conditions:

- Depression occurs in 35-45% of patients who have had a heart attack, and depression may be an independent risk factor for death in patients who have experienced heart attack and others with coronary heart disease.
- 10-15% of people with diabetes have depression, and almost 80% of these have a re-occurrence of depression during a five-year follow-up period.
- Almost half of all cancer patients have a mental health disorder, with adjustment disorders and depressive disorders being the most common.
- Between 22-32% of HIV-infected patients have depression.

II. Primary Care is the Locus of Most Mental Health Care

Despite the current bifurcation of physical and mental health service delivery, the majority of mental health care is delivered in the context of primary care. The *Health Care for the Whole Person Collaborative* reports that the ten most common problems which adult patients bring to primary health care services, including chest pain, fatigue, dizziness, headaches, back pain and insomnia, account for 40 per cent of all primary care visits – but only 26 per cent of these problems have a confirmed biological cause. Not surprisingly, primary care providers often respond to these visits by initiating pharmacological treatment. A recent study of children and adolescents receiving services under Minnesota Health Care programs found that 60% of those prescribed psychotropic medications received these without any accompanying mental health services. Health plans in Minnesota report that primary care providers may prescribe up to 80% of psychotropic prescriptions for both children and adults covered by private insurance.

NIHCM's study noted that primary care is playing a substantial and growing role in mental health treatment for children and youth: from the mid-1980s to the late 1990s, the percentage of children's physician visits that included a mental health diagnosis nearly tripled, and nearly all of this increase was for visits at which psychotropic medications were prescribed (p. 13).

Primary care was similarly noted by the Surgeon General's Report on Mental Health (1999) to be a "pivotal setting for the identification and treatment of mental disorders in older people" (p. 68). This report noted studies which had found a preference among the elderly to receive mental health treatment in primary care, and argued that primary care offers the elderly the potential advantages of proximity, affordability, convenience, and coordination of care for mental and somatic disorders, "given that comorbidity is typical" (p. 68).

III. Integrated Behavioral and Primary Care Improves Care Effectiveness

The rapid growth of mental health treatment in primary care has raised awareness of both the limitations of current practice and the opportunities that exist to enhance practice through integration. Primary care providers have been noted to misdiagnose mental health conditions, have less than optimal outcomes with medications, and generally not provide or refer to psychosocial services along with medication (NIHCM, p. 14). However, the addition of consulting mental health professionals to primary care practices has led to substantial improvements in practice and outcomes, as demonstrated, for example, by Unity Health System in Rochester, NY, and Kaiser Permanente in California (NIHCM, p. 14).

In addition to the benefits of mental health consultation, specific advantages accrue when mental health and primary care providers work side-by-side in the same clinics. Katon (1992, 1995) and his collaborators at the University of Washington have provided some of the most closely controlled studies on interventions that can help primary care physicians manage mental health disorders, and particularly depression, more effectively. Katon's integrated protocol for depression included patient education and brief treatment with a psychiatrist or psychologist who was co-located within the primary care setting; patient visits with the biomedical provider alternated with visits with the mental health provider. The results associated with this protocol were significant and substantial: 74% of the people with major depression in the integrated treatment plan showed significant symptom reduction while only 44% of the patients who had physician treatment and referral to mental health services at a separate site showed similar improvement. Katon's work as a whole has shown that "a model of collaborative management...dramatically improves adherence, satisfaction with treatment, and depressive outcomes" (Katon, 1995, p. 364).

IV. Primary Care is Uniquely Situated to Provide Early Identification and Intervention

One of the most salient consequences of the bifurcated physical and mental health treatment system is a focus of mental health resources on children and adults with the most complicated and serious needs, to the neglect of early identification of disorders and optimal treatment at early, tractable stages. This is clearly the case for children, as noted by the Commonwealth Fund in its analysis of the central role of pediatrics in caring for common and emerging mental health problems. Similarly, NIHMC notes that primary care providers remain the first point of contact for most children, particularly in infancy and the preschool years: "In those years especially, when prevention and early intervention can have significant long-term impact, primary care providers and organizations have a critical role to play in developmental and behavioral screening, parent counseling, and referral to community resources" (p. 13).

A similar case can be made for screening for depression and other common mental health disorders in adults, as recommended by the New Freedom Commission Report on Mental Health (2004), and particularly for older adults (Surgeon General, 1999). The Surgeon General's report argued that older adults, who commonly present with medical disorders which may affect their mental health, either through a disease process or via multiple medications that may affect mental functioning, are more likely to have their symptoms detected and treated if primary care is structured to do so.

Early identification and intervention within primary care is also more tractable than in other systems such as education or social services because of greater assurance of confidentiality, reduced stigmatization associated with location or service type, and the provider's ability to simultaneously consider both physical and mental etiology. For example, a group of parents of diverse ethnicity in a local early childhood system expressed reservations about mental health screening in an educational

setting, but agreed that they would readily complete the same instrument if their doctor recommended it. This acceptance was also noted by the Rural Health Advisory Committee's Task Force on Mental Health and Primary Care (2004), which recommended primary care as the optimal setting for mental health care provision in underserved areas of the state.

V. A Variety of Models of Integrated Care Are Being Developed and Tested

The Bazelon study (2004) referenced above demonstrated that there is not a single model for integrated care, but that a variety of emerging models demonstrate the advantages and challenges of different forms of integration. Bazelon grouped these models into four types and reported in detail on several examples of each type. These models, examples, advantages and challenges are briefly described in the sections below.

Model 1: Primary Care Embedded in a Mental Health Program

The embedding of primary care in a mental health program ensures strong linkages between primary care and mental health providers and may be particularly effective for adults with serious mental illnesses. Bazelon studied four examples of such programs:

- Center for Integrated Care, Chicago, IL. A collaboration between a psychiatric rehabilitation center and the College of Nursing at the University of Chicago, this program provides the primary care services of advance-practice nurses and a consulting family physician to psychiatric clients at the Center and satellite sites, including homeless shelters. Approximately 58% of the Center's 700 clients are regular users of primary care services, with an average of 4.3 visits per year for physical health care.
- Comprehensive Care Services, Pittsburg, PA. This program is operated by Western Psychiatric Institute at the University of Pittsburg Medical Center, and is staffed by a primary care physician, physician assistant and nurse. Primary care and pharmacy services are provided to approximately 850 individuals with serious mental illnesses per year. Consumers who choose to receive their primary care elsewhere may have that care coordinated through CCS.
- EXCEL Group, AZ: A nonprofit Medicaid health plan providing services to adults and children with serious mental illnesses has a small primary care clinic staffed by a family practice physician, physician assistant, nurse practitioner and medical assistants, located within a behavioral health service clinic. Primary care services are provided to individuals receiving outpatient mental health services, with approximately 50 patients seen each day for physical care; the medical staff also conducts daily rounds at an adult inpatient psychiatric facility and a children's residential treatment center.
- Massachusetts Behavioral Health Partnership: Three primary care projects are embedded in psychiatric day programs for seriously mentally ill adults in Springfield, Hyannis and Lawrence. One site is specialized to serve homeless adults with co-occurring mental health and substance abuse disorders.

Advantages of embedded primary care:

- Staffing patterns in these programs have been developed to allow for longer patient visits and more comprehensive assessments
- Working on-site at mental health programs allows the development of strong working relationships between health care and mental health providers. Both groups expanded their knowledge and skills as a result of reciprocal consultation, common training and continuing education.

- Integrated electronic medical records have facilitated communication and treatment planning in these programs. Client confidentiality and informed consent are closely monitored, and consumers are generally more comfortable with information exchange in these programs than they may be with exchange between agencies.
- Access to care, including preventive health care for problems which are common among persons with serious mental illnesses, was substantially improved in all these programs. Specialized diabetes care is an element of all the programs.

Challenges to embedded primary care:

- In all of these programs, the primary care staff is small and available for limited hours.
- All programs had continuing funding challenges, and needed sources of support beyond third party reimbursement for direct services.

Model 2: Unified Primary Care and Mental Health Programs

Combining publicly funded primary care and behavioral health into a unified approach was described by Bazelon as the most "seamless approach" of the models studied, integrating delivery of care, administration and financing. Bazelon studied three sites, each providing a full range of primary care and behavioral health services, utilizing multidisciplinary teams.

- Cherokee Health System, East Tennessee: A nonprofit organization operates both a community mental health center and a federally qualified health center (FQHC); it created its first integrated primary care and behavioral health clinic in 1984 and now provides integrated services in 21 sites and serves approximately 40,000 individuals annually. Full ranges of both primary care and mental health services are provided, including day programs, case management and substance abuse treatment.
- Washtenaw Community Health Organization, Michigan: A collaboration of the University of Michigan Health System, a Medicaid managed care health plan, a county and the state, this organization provides integrated mental health, substance abuse, and primary and specialty care health services to Medicaid, low income and indigent populations.
- Massachusetts Mental Health Services Program for Youth: A collaboration of all state-level child-serving agencies with the Neighborhood Health Plan, a managed care plan associated with Harvard Pilgrim Health Care, MMHSPY has been in operation since 1998. It provides integrated mental health and physical care to adolescents with serious emotional disorders and youth who are at risk of out of home placement, or who are returning from placements to their homes and communities. The program capacity is 30 youth at any one time.

Advantages of unified care:

- Financing flexibility allows corresponding flexibility in utilization of varied providers' time, and supports collaboration at the individual case level.
- There is some evidence that unified arrangements are economically efficient. The Massachusetts Youth Program, for example, reduced per client costs by 18% below the capitation rate while also improving service access.
- High levels of provider collaboration, based on unified treatment planning, characterize these programs.
- These programs were also noted to improve consumer satisfaction, improve care access, and provide better preventive care to recipients.

Challenges to unified care:

- Only the Cherokee Health System is of substantive size. Problems associated with moving from demonstration-level projects to scale for the most part remain to be discovered or analyzed.
- Recruitment of providers who are comfortable and willing to work across disciplinary boundaries is necessary, but can be challenging.

Model 3: Co-Location of Mental Health Specialists within Primary Care

Co-location of mental health professionals within primary care is a popular model of integration; it is used extensively in Minnesota by HealthPartners as well as in demonstration projects supported by other health plans. Bazelon notes that a number of research studies have demonstrated the effectiveness of this model, particularly for children and adults with less severe mental disorders. Bazelon references several examples of co-location:

- Multnomah County, OR: Mental health and substance abuse providers are located at several primary care clinics, primarily treating depression and anxiety disorders.
- Network Health, MA: This provider-sponsored, Medicaid-only managed care organization ended its carve-out and brought behavioral health services in-house. Members are followed by medical, behavioral and social case managers, and integrated team meetings are held weekly.
- Hackley Community Care Center, MI: The staff of this FQHC includes a social worker who assesses individuals' mental health, provides brief interventions for those with less serious problems, and refers those with serious mental illness to community mental health centers.
- Lifeways, MI: This community mental health program has located a psychiatrist at a local health center one day per week, where she provides psychiatric consultations and medication evaluations. The health center has also made case managers responsible for linking primary care clients with behavioral health issues to other needed services.

Advantages of co-location:

- Depression is prevalent among primary care patients, who often present with physical complaints. Co-location has been found to increase access to care, resolution of symptoms, and consumer satisfaction among these patients.
- Co-location projects also improve treatment for individuals with serious physical illnesses, who often have co-occurring depression or other mild to moderate mental health problems.
- This model can improve both the productivity and the skills of the primary care provider, by clarifying and supporting his or her scope of practice in managing mental health problems.
- Access to crisis evaluations and brief therapy is increased by having these services available at the primary care site.

Challenges of co-location:

- Clarifying the roles of the co-located mental health professional and the time that will be required for each (crisis evaluations, routine evaluations, therapy, consultation) is critical to success. An unsuccessful example provided by the Bazelon report involved a co-located psychologist whose schedule was so quickly filled with therapy appointments that he became unavailable for consultation with primary care providers.
- If the co-located mental health professional is employed by an agency other than the primary care clinic, fiscal and information sharing problems may pose barriers to optimal integration.

Model 4: Improving Collaboration between Separate Providers

Integration of care is difficult when providers practice independently and have separate administrative, information and funding systems; technically, the fourth model is not genuinely integrative. But because this approach causes the least disruption to traditional models of practice, it has numerous applications. Bazelon noted that Massachusetts, Michigan, Oregon and Oklahoma have introduced a number of strategies to increase collaboration, including:

- Special targeted programs;
- Financial incentives;
- Managed care contract requirements; and
- Provider education and training.

All of these strategies have provided some improvements in access to care. But collaboration can be difficult to establish or sustain without larger, systemic changes to make it a routine and viable way of doing business.

Governor's Mental Health Initiative: Implementation Timelines

March 16, 2006

Implementation Area	July 2006	January 2007	July 2007	January 2008	July 2008
Administration / Planning Activity	▫ Continue stakeholder meetings, with focus on implementation issues; criteria for regional projects RFP and future role of county in MH system. ▫ DHS supplies counties with projected grant changes for 2007 and estimated county share of RTC costs data.	▫ DHS releases RFP for regional projects. ▫ Continue stakeholder meetings – focus on implementation & transition issues. ▫ DHS reports to legislature on further recommendations & future role of counties in MH system.	▫ DHS selects regional project sites from RFP responses, begins working on transition with applicant counties and care networks. ▫ Stakeholder oversight of initiative progress and implementation continues. ▫ DHS calculates grant transfers for regional projects.	▫ Regional Projects begin. ▫ DHS provides TA and monitors local implementation. ▫ Stakeholder oversight of initiative progress and implementation continues. ▫ DHS releases RFP for second round of regional projects.	▫ DHS selects additional regional project sites from RFP responses, begins working on transition with applicant counties and care networks. ▫ Stakeholder oversight of initiative continues. ▫ DHS calculates grant transfers for new regional projects.
MHCP Benefit Changes	None.	▫ GAMC and MnCare begin coverage for ARMHS, ACT, IRTS, Crisis Services. ▫ These services made available through MHCP prepaid plans.	None.	▫ Case management and children's residential treatment move from fee-for-service only to also being available through prepaid plans.	None.
MHCP Enrollment Changes	None.	None.	None.	▫ Within approved regional projects, SED/SPMI persons on fee-for-services MA are transitioned to prepaid plans / preferred integrated care networks.	▫ Continue transition to preferred integrated care networks.
County Changes	▫ Counties begin CY2007 budget/service planning. ▫ Counties begin discussions w/ local prepaid plans about coordination issues.	▫ County share of AMRTC/CBHH placement cost increases.	▫ Counties begin CY2008 budget/service planning.		▫ Counties begin CY2009 budget/service planning.
Outcome Measurement	▫ MMHAG Outcomes measurement group finalizes its recommendations. ▫ DHS begins work on system requirements and design.	▫ DHS continues on system design. ▫ DHS pilots outcomes measurement system.		▫ Outcomes measurement system operational.	
Other	▫ DHS releases RFP for first round of MH Infrastructure Grants.	▫ MH Infrastructure Grants begin. ▫ Psychiatric bed tracking system operational.	▫ MHCP 23.7% rate increase for psychiatrists, APRNs, selected MH services and providers begins.	▫ DHS releases RFP for second round of MH Infrastructure Grants.	▫ Second round of MH Infrastructure Grants begin.