The 1930 lithograph of the Minnesota State Capitol used on the cover was originally created by Margaret Bradbury and reproduced with the permission of the Minnesota Historical Society

Protecting, maintaining and improving the health of all Minnesotans

February 18, 2003

The Minnesota Legislature
State Capitol
St. Paul, Minnesota

To the 2003 Minnesota Legislature:

On behalf of the Governor and the Minnesota Department of Health, I am pleased to submit the 2004-2005 biennial budget. The budget includes a total of $752.039 million in expenditures, which represents all funds available to the department. The recommended budget will allow us to focus on public health's core functions in order to protect, maintain, and improve the health of all Minnesotans. The 2004-2005 budget represents a $36.269 million reduction in spending over the previous FY 2002-03 biennium (a 4.6% reduction overall). Spending reductions of $87.643 million ($16,252 million in the General Fund, $7.783 million in the HCAF, $20 million in TANF funds, $41.607 million in Tobacco Use Prevention Endowment funds, and $1.106 million in other funds) are offset by increases in the MERC fund, State Government and Miscellaneous Special Revenue Funds, and Federal funds.

The Minnesota constitution affirms that protecting, maintaining and improving the public's health is a duty that falls on government. In Minnesota, that duty is shared in significant ways with local government. Together, we will focus on the core activities that protect or maintain the public's health while redirecting our efforts and emphasis to achieving results that advance the health status of individuals and communities.

The 2004-2005 budget is based on priorities that improve efficiencies in our program activities and it focuses our energies on results. We have some innovative recommendations that help us better achieve the goal of healthy communities. With this budget, we will continue to

- Protect the public from infectious disease outbreaks and food borne illnesses by taking quick, effective, and appropriate action when such problems arise
- Ensure that Minnesotans continue to receive high quality care through their HMOs, hospitals and nursing homes
- Strengthen the public health system's preparedness to deal with natural disasters, emergencies, and potential acts of terrorism
- Work to reduce injury, chronic disease, and address maternal and child health needs
- Improve access to health care for rural Minnesotans
- Assure that all newborn babies are screened for rare, treatable diseases and receive the care they need
- Work closely with communities and tribal governments to help reduce health disparities
- Support and work closely with local public health agencies to maintain a strong public health system across the state
- Continue operation of the state Poison Control Center as a source of information for both parents and health practitioners
- Help policy makers find ways to contain health care costs
- Distribute two-thirds of our funds to grantees—local units of government and local communities

Our budget reduction proposals help resolve the state's deficit while retaining those programs and services most critical to protecting the public's health. General Fund spending will be $16.252 million less in FY 2004-05 biennium, a 12.0% reduction over the previous biennium and Health Care Access Fund spending will be $7.783 million less than the previous biennium.

To accomplish these reductions, we will use the following strategies.

First, we redesigned the way in which we distribute grant funds. We will consolidate 13 grants into a single Local Public Health Grant and reduce or eliminate other grants. While this approach means a reduction in overall grant expenditures, ($10.608 million General Fund, $6 million TANF, and $500,000 HCAF), we also propose to eliminate many restrictions and requirements in how the grants are awarded and monitored, reducing MDH-based activity by $1.5 million General Fund. This approach will

- Allow greater local flexibility
- Eliminate "bureaucracy" at the state and local level
- Focus on accountability over process

Second, we streamline agency operations and further reduce expenditures by $6.764 General Fund and $601,000 HCAF. After reviewing all of our services and programs, we have reduced or eliminated activities that are lower priorities, limited in scope, or overlapping with other services. Reductions include management and support positions, consumer education and technical assistance, and direct services to the public.

By focusing on core activities, and streamlining and redesigning our operating processes, we will continue to support the Poison Control Center, providing immediate information about poisons and toxic exposures to individuals and health care professionals.

Third, we also make adjustments to several of our fee-based programs, to ensure fees support our activities, and that we are meeting fee-payers needs. Most importantly, we will enhance the Newborn Screening program to take advantage of recent advances in technology and improve the health outcome of all babies born in Minnesota.

Finally, funding for tobacco prevention activities and medical education will be fundamentally altered. With the elimination of the two endowments, the corresponding revenue streams to support these activities will be eliminated. We will continue to support medical education (MERC) by replacing the endowment revenues with current law cigarette tax revenues. We will also continue a limited and targeted tobacco prevention program for the next two years, to help some communities maintain the gains they have achieved in the past few years.

We look forward to working with you to put these recommendations in place.

Sincerely,

Dianne Mandernach
Commissioner

	FY 2004-05 Expenditures ($000s)		
	General Fund	**Other Funds**	**Total**
2003 Funding Level	145,016	710,344	855,360
February Forecast Adjustment	-12,580	162	-12,418
New Programs To Agency Base	420	0	420
One-Time Appropriations	2,840	-18,340	-15,500
Adjusted Base Funding	135,696	692,166	827,862
Change Items			
Agency Operations Reductions	-6,764	0	-6,764
Grant Redesign	-8,176	-6,000	-14,176
Grant Reductions	-3,932	0	-3,932
Hcaf Grant And Operations Reductions	0	-2,202	-2,202
Mdh-merc Impact Of Dhs Gamc/pmap Changes	0	-6,734	-6,734
Med Educ & Tobacco Endowment Changes	0	-51,950	-51,950
Health Improvement			
Poison Information System	2,300	0	2,300
Health Protection			
Newborn Screening System	0	5,772	5,772
Plumbing Plan Review	0	1,718	1,718
Swimming Pool Regulation	0	145	145
Governor's Recommendations	119,124	632,915	752,039
Biennial Change, 2002-03 to 2004-05	-16,252	-20,017	-36,269
Percent Change	-12%	-3%	-5%

Brief Explanation Of Budget Decisions:

The Department's FY 2002-03 funding level is the starting point for building the FY 2004-05 budget. Base adjustments are generally technical items and are discussed below.

Two February Forecast Adjustments reflect changes in Intergovernmental Transfer (IGT) revenue. Original estimates made during the 2001 legislative session based revenue on a 150% Medicare Upper Payment Limit (UPL) for Minnesota's Medicaid program. The UPL has since been reduced to 100%. This results in a decrease in revenues to the following:

- Community Clinic Grants (-$7.286 million, GF)
- Rural Hospital Capital Improvement Grants (-$5.294 million, GF)

A separate forecast adjustment is made to spending in the Medical Education Endowment, which supports teaching institutions. This increase of $162,000 is based on new estimates of the fair market value of the endowment fund, as forecast by the Department of Finance.

New programs to the agency base total $420,000 and are entirely due to the Health Professional Loan Program. This adjustment reflects the bi-annual costs of implementing the loan repayment program. This program was added to the Department's budget with the Laws of 2001.

One-time appropriations result in a net increase in general fund spending of $2.840 million. The components and a brief explanation are as follow:

⇒ Poison Information Center (-$2.720 million, GF) appropriations were for the FY 2002-03 biennium only.

⇒ Family Planning Grants ($1.380 million, GF) were reduced by $690,000 in FY 2003 only. This adjustment restores funding to the FY 2004-05 base budget.

⇒ Rural Hospital Capital Improvement Grants ($4.240 million GF; -$4.240 million, HCAF) were partially funded from the Health Care Access Fund in FY 2002-03. This adjustment reflects the legislature's intent to originate all funding from the General Fund.

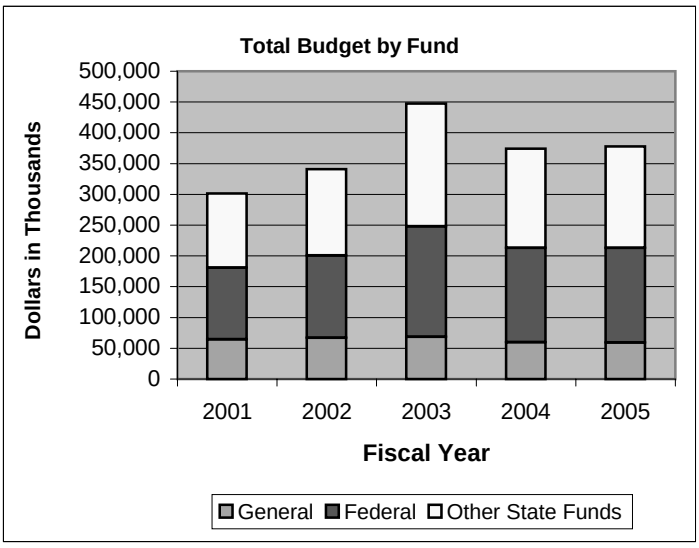
⇒ - LTC Reimbursement System (-$60,000, GF) originated in the Laws of 2001 and provided $60,000/year for three years to implement a new reimbursement system.

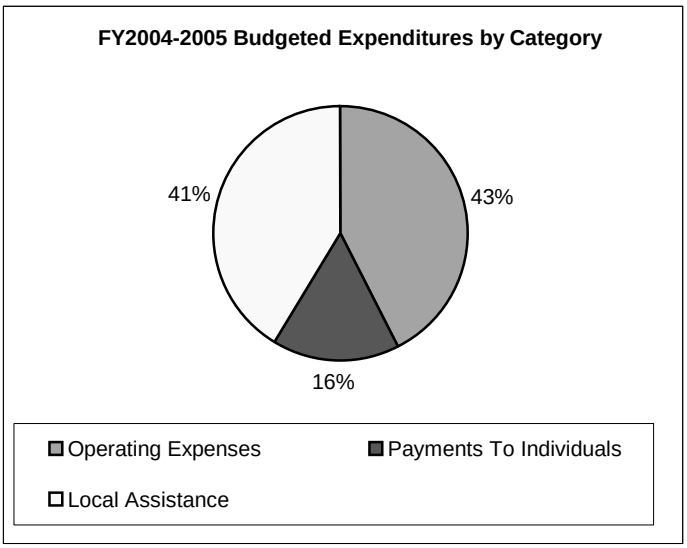
⇒ - Health Care Purchasing Alliances (-$100,000, HCAF) are grants to local activities and were appropriated only for the FY 2004-05 biennium.

⇒ - TANF Home Visiting (-$14.000 million, TANF) originated in the Laws of 2000 at $7.000 million/year for three years. The FY 2004-05 budget still includes $4.000 million each year for home visiting added by the Laws of 2001.

The Governor's recommended FY 2004-05 budget is based on a review of all MDH activities and retains those most critical to protecting and improving the health of Minnesotans. Budget reductions occur in both MDH-based activities and grants, and cross all divisions in the Department. Detailed explanations of changes items are described later in this document. Detailed information on the change items "MDH Impact of DHS 5% Ratable Reduction", and "MERC Impact of DHS GAMC/PMAP changes" can be found in the Department of Human Services budget.

	FY 2004-05 Revenues ($000s)		
	General Fund	**Other Funds**	**Total**
FY 2004-05 Current Law Revenues			
Dedicated Revenues—MERC Fund	0	171,514	171,514
Dedicated Revenues—MSR Fund	0	66,753	66,753
Non-dedicated Revenues	0	52,187	52,187
Change Items—Dedicated Revenue			
Health Quality and Access			
MDH--MERC Impact of DHS GAMC/PMAP changes	0	(6,734)	(6,734)
Medical Education and Tobacco Endowment changes	0	16,500	16,500
Change Items—Non-dedicated Revenue			
Health Improvement			
MDH Impact of DHS 5% Ratable Reduction	1,584	0	1,584
Health Protection			
Alcohol and Drug Counselor Regulation	0	461	461
Newborn Screening System	0	5,740	5,740
Swimming Pool Regulation	0	174	174
Occupational Therapist Fee Holiday	0	(440)	(440)
Hearing Instrument Dispenser Regulation	0	(20)	(20)
Plumbing Plan Review	0	1,970	1,970
FY 2004-05 Total Revenues			
Dedicated Revenues—MERC Fund	0	164,780	164,780
Dedicated Revenues—MSR Fund		83,253	83,253
Non-dedicated Revenues	1,584	60,072	61,656
Biennial Change 2002-03 to 2004-05	0	0	0
Dedicated Revenues—MERC Fund	0	36,398	36,398
Dedicated Revenues—MSR Fund		18,436	18,436
Non-dedicated Revenues	1,576	9,851	11,427
Percent Change			
Dedicated Revenues—MERC Fund	0	28.4%	28.4%
Dedicated Revenues—MSR Fund		28.4%	28.4%
Non-dedicated Revenues	>100%	19.6%	22.7%





Dollars in Thousands	Actual	Actual	Preliminary	Governor's Rec		Biennium
Expenditures by Fund	**FY2001**	**FY2002**	**FY2003**	**FY2004**	**FY2005**	**2004-05**
Direct Appropriations						
General	64,284	66,915	68,461	59,722	59,402	119,124
Minnesota Resources	117	15	0	0	0	0
State Government Special Revenue	23,118	21,770	31,714	32,880	32,617	65,497
Health Care Access	10,945	10,196	10,133	6,273	6,273	12,546
Federal Tanf	2,866	5,971	26,029	6,000	6,000	12,000
Solid Waste	213	158	242	0	0	0
Open Appropriations						
Medical Education & Research	31,565	48,920	90,346	71,484	75,862	147,346
Tobacco Use Prevention	14,587	19,363	22,248	0	0	0
Statutory Appropriations						
Drinking Water Revolving Fund	0	490	1,038	522	522	1,044
Special Revenue	39,860	39,141	43,361	49,649	49,547	99,196
Federal	113,537	127,991	153,547	147,615	147,619	295,234
Miscellaneous Agency	109	0	0	0	0	0
Gift	152	92	167	26	26	52
Total	**301,353**	**341,022**	**447,286**	**374,171**	**377,868**	**752,039**
Expenditures by Category						
Operating Expenses	135,304	134,754	183,990	159,540	159,355	318,895
Capital Outlay & Real Property	281	68	4	4	4	8
Payments To Individuals	57,026	61,139	59,200	60,791	60,391	121,182
Local Assistance	108,380	144,631	203,667	153,611	157,893	311,504
Other Financial Transactions	362	430	425	425	425	850
Transfers	0	0	0	-200	-200	-400
Total	**301,353**	**341,022**	**447,286**	**374,171**	**377,868**	**752,039**

Dollars in Thousands	Actual	Actual	Preliminary	Governor's Rec		Biennium
Expenditures by Program	**FY2001**	**FY2002**	**FY2003**	**FY2004**	**FY2005**	**2004-05**
Health Improvement	166,297	187,355	226,774	173,778	172,898	346,676
Health Quality And Access	59,337	75,848	122,262	107,485	111,809	219,294
Health Protection	54,842	57,651	75,000	70,288	70,547	140,835
Management & Support Services	20,877	20,168	23,250	22,620	22,614	45,234
Total	**301,353**	**341,022**	**447,286**	**374,171**	**377,868**	**752,039**
Revenue by Type and Fund						
Non Dedicated						
General	33	5	3	767	817	1,584
State Government Special Revenue	20,757	24,450	25,751	29,782	30,290	60,072
Health Care Access	0	20	0	0	0	0
Subtotal Non Dedicated	20,790	24,475	25,754	30,549	31,107	61,656
Dedicated						
Drinking Water Revolving Fund	0	490	1,038	522	522	1,044
General	18	0	0	0	0	0
Special Revenue	33,129	32,779	32,038	36,828	33,325	70,153
Federal	120,639	130,841	155,111	153,619	153,623	307,242
Medical Education & Research	41,382	54,871	73,511	80,388	84,392	164,780
Miscellaneous Agency	126	109	175	175	175	350
Gift	86	32	26	26	26	52
Subtotal Dedicated	195,380	219,122	261,899	271,558	272,063	543,621
Total Revenue	**216,170**	**243,597**	**287,653**	**302,107**	**303,170**	**605,277**
Full-Time Equivalents (FTE)	**1,246.2**	**1,236.8**	**1,371.8**	**1,360.3**	**1,358.8**	

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($3,182)	($3,582)	($3,582)	($3,582)
Revenues	0	0	0	0
Other Fund –				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact	($3,182)	($3,582)	($3,582)	($3,582)

Recommendation

The Governor recommends reducing agency-wide operational expenses by $3.182 million in FY 2004 and $3.582 in FY 2005. This includes a reduction of 20.3 FTEs.

Background

Each Bureau within the department has identified areas to reduce or eliminate administrative operations. Some of these reductions were first identified and implemented in response to the Laws of 2002, Chapter 374, in which the legislature required executive branch state agency operating budgets to be reduced by an aggregate amount of $58 million. MDH was allocated $1.738 million, and made these reductions in the General Fund in FYs 2002 and 2003. Additional operational reductions have been identified for the FY 2004-05 biennium.

Agency-wide management and support ($1.139 million each FY)—Management positions within Environmental Health; Infectious Disease Epidemiology, Prevention and Control; Health Promotion and Chronic Disease; Facility and Provider Compliance; the Executive Office; Human Resources; and District Office Oversight will be eliminated. The funds available to the Commissioner's Office for contracts will be reduced.

Vital Records System ($88,000 each FY)—Two positions that support "walk-up" customers seeking birth and death records will be eliminated and those citizens will be directed to the communities or the MDH web site for issuance of these documents.

Vaccine Outbreak Fund ($197,000 each FY)—Funds used as a "ready" resource to respond to a vaccine-preventable disease outbreak (e.g. measles, hepatitis A, meningitis) and, in the absence of outbreaks, for use in adult populations (e.g. hepatitis B vaccine for high risk adults seen in HIV/STD clinics) will be eliminated.

Food Safety Program ($313,000 each FY)—One position that supports curriculum development and technical assistance for schools will be eliminated. The development and distribution of consumer education materials will be eliminated. A half position that provides technical support for state and local food safety programs will be eliminated.

Fetal Alcohol Syndrome Program ($725,000 each FY)—One position and the research component to determine better diagnostic criteria for children will be eliminated. The public awareness campaign and professional educational activities will be significantly reduced. The grant component of this program is included in the grant redesign recommendation.

MCSHN Treatment and Operations ($720,000 in FY 2004, $1.12 million in FY 2005)— The Minnesota Children with Special Health Needs (MCSHN) Treatment program has a long history of serving children with special health needs and was one of the first safety net programs, preceding Medicaid by over twenty years. With subsequent Medicaid income eligibility expansions and the advent of other safety net programs, the focus of the treatment program moved from children with physical disabilities to supporting children with chronic illness or children who have significant one-time needs (such as hearing aids).

Increasing medical costs and a growing number of families requesting services have put continuous pressure on finite MCSHN treatment dollars, enabling this program to serve only 3% of the eligible population. In addition, providing direct reimbursement for medical care is more traditionally a service provided by the Department of Human Services.

Elimination of program funding is phased over two biennia since providers can bill up to one year after the date of services.

Relationship to Base Budget

This recommendation represents a 14% reduction in the department's operating budget. Operating reductions identified in the grant redesign recommendation bring the total to 17% of the FY 2004-05 operating base budget.

Key Measures

The activities being reduced in this proposal are administrative in nature—how staff support the activities of one another and the operations of the department. As FTEs are eliminated, but oversight functions remain, the overall output of the remaining staff will be reduced.

Several activities being reduced in this proposal will impact the way in which services are delivered to the public—specifically the "walk-up window" for vital records. The public will be inconvenienced until they become familiar with the new web-based system. (In addition, copies of all vital records may be obtained in each county.)

Several more activities being reduced in this proposal will impact the level of services delivered: less consumer education, less assistance to local units of government or other state agencies, less reimbursement for medical services.

Statutory Change: Not Applicable

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($4,088)	($4,088)	($4,088)	($4,088)
Revenues	0	0	0	0
Other Fund TANF				
Expenditures	(3,000)	(3,000)	(3,000)	(3,000)
Revenues	0	0	0	0
Net Fiscal Impact	($7,088)	($7,088)	($7,088)	($7,088)

Recommendation

The Governor recommends the grant administration and allocation process at the Department of Health be redesigned to build on partnerships with local public health, better target local priorities, and focus on results and accountability. 13 categorical grants will be consolidated into a single grant. Total grant funds will be reduced by $3.338 million in general funds and $3 million in TANF funds in each fiscal year. In addition, MDH-based activities will be reduced by $750,000 each fiscal year and 11.5 FTEs will be eliminated.

Background

The department administers a variety of grants whose primary purposes are related to meeting government responsibilities for public health protection and improving the health status of low-income and/or high-risk mothers and children. Consolidating 13 separate but related grants into one formula-based grant program will achieve streamlined administrative activities, reduce redundant and burdensome categorical grant requirements, and minimize the overall impact of funding reductions. The resulting flexibility will allow local public health agencies and tribal governments to direct limited but reduced resources to community-identified priorities and services. Existing statutory requirements of the Community Health Services (CHS) Subsidy and the Maternal and Child Health (MCH) Block Grant will provide the framework for this proposal. Accountability measures will shift from the current administrative requirements to a focus on results.

This proposal, the Local Public Health Grant, is based on the framework established in M.S. 145A [Local Public Health Act] and 145.88 [Maternal and Child Health].

The Community Health Service Subsidy was created in 1976 and distributes funding to Community Health Boards for activities designed to protect and promote the health of the general population. Program categories include disease prevention and control, emergency medical care, environmental health, family health, health promotion and home health care. Currently there are 51 Community Health Boards receiving $19,112,000 annually. Additional state, federal and local funds support local activities designed to protect the public from infectious disease outbreaks, public health threats from natural occurrences such as flooding or tornados and terrorist incidents**.** These local activities are aligned with complementary activities at the state level.

The Maternal and Child Health Special Projects grant program was created in 1985 to distribute Minnesota's share of the federal MCH Title V Block Grant. Currently a total of $7.5 million (approximately $6.5 million in federal MCH Block Grant funds and $1 million in state general revenue) is distributed through a formula to Community Health Boards (CHBs). These funds are targeted to improving the health and well being of Minnesota mothers and children. Funds are directed at the highest at-risk populations (particularly low-income and minority populations) in four specified areas: improving pregnancy outcomes, reducing unintended pregnancies, early identification and intervention for children with handicapping conditions/chronic illness, and reducing childhood injury.

The individual grant programs identified for consolidation in this grant are congruent with the priorities and purposes of community health boards as defined in the CHS Act and the MCH Block Grant. Funds will be distributed to Community Health Boards utilizing a single formula. $2,000,000 of the consolidated grant funds will be allocated directly to Tribal Governments for targeted health purposes.

Relationship to Base Budget

Current funding for the grant programs included in the consolidation proposal are identified below. In addition, $750,000 annually will be reduced from MDH-based activities and 11.5 FTEs will be eliminated.

Grant Program	General Fund 2004-2005	TANF 2004-2005	Federal 2004-2005	Total FY 2004-2005
CHS Subsidy	$38,224,000			$38,224,000
Bioterrorism			$10,165,000	$10,165,000
MCH Block Grant	$2,000,000		$13,000,000	$15,000,000
WIC	$7,380,000			$7,380,000
Infant Mortality	$200,000			$200,000
Lead Safe Housing	$50,000			$50,000
Family Home Visiting	$2,088,000	$8,000,000		$10,088,000
Suicide Prevention	$2,050,000			$2,050,000
FAS Prevention	$1,700,000			$1,700,000
Youth Risk Behavior		$4,000,000		$4,000,000
MN ENABL		$2,000,000		$2,000,000
EHD – Tribal Grants	$1,000,000			$1,000,000
EHD-RHITB	$500,000			$500,000
Subtotal	$55,192,000	$14,000,000	$23,165,000	$92,357,000
Reduction	$6,676,000	$6,000,000		$12,676,000
Local Public Health Grant	**$48,516,000**	**$8,000,000**	**$23,165,000**	**$79,681,000**

Key Measures

The department will continue to track federally or state required outcomes to monitor the overall impact on the health and well-being of Minnesotans and develop results oriented accountability measures.

Alternatives Considered

The department reviewed all expenditures when preparing reduction proposals for the FY 2004-05 budget. Alternatives included choosing specific grant funds to reduce. This approach combines grants with related purposes and constituencies into one rather than 13 grants. In the Local Public Health grant, the reductions will be spread proportionately across the Community Health Boards by formula, with funding decisions to be made at the local level based on community priorities. This recommendation reflects our effort to streamline administrative activities, reduce redundant and burdensome categorical grant requirements and increase the focus on program results.

Statutory Change: M.S 145.88; 145A.; 144.9507 Subd. 3; 145.928 Subd 9 and 10; 145A.17; 145.56; 145.9265; 145.9266;

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($1,966)	($1,966)	($1,966)	($1,966)
Revenues	0	0	0	0
Other Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact	($1,966)	($1,966)	($1,966)	($1,966)

Recommendation

The Governor recommends a reduction in General Fund appropriations of $1.966 million each fiscal year as a result of reducing Rural Hospital Capital Improvement Grants and Eliminating Health Disparity Planning Grants, and from eliminating two grants that support the long term care industry: Transition Planning Grants and Quality Demonstration Grants.

Background

The **Long Term Care Home Transition Planning Grant Program** provides support to nursing homes to analyze their specific circumstances and plan their response to a changing environment. Applications and grant awards have decreased from the first year of funding to the second. In addition, the average grant award has been $15,000 vs. $30,000 originally anticipated. This proposal will eliminate the Transition Planning Grant program.

The **Long Term Care Quality Demonstration Grant Program** was designed to support nursing home innovations in quality. In FY 2002, the department awarded 10 grants out of 45 applications. The proposals received by MDH have been similar to those received by a grant program at the Department of Human Services that funds *improvements* in nursing homes. Most proposals received by MDH have not been truly innovative or focused on *quality* improvement, but have been seeking funds to replicate known strategies or buy equipment. This proposal will eliminate the Quality Demonstration Grant program.

The **Eliminating Health Disparities Initiative (EHDI**) was created in 2001 to address the serious disparities in health status between Minnesota's American Indians and populations of color and the majority white population. The Initiative contains both planning grants and implementation grants. The purpose of the planning grants is to assist communities in the planning stages with assessment, coordination, and development of community strategies. This proposal will eliminate this component of the EHDI.

Rural Hospital Capital Improvement Grants support rural hospitals with 50 or fewer beds. Grant funds are used to update, remodel, or replace aging hospital facilities and equipment necessary to maintain the operations of small rural hospitals. This proposal will reduce the funding level for these grants.

Relationship to Base Budget

Base funding for the LTC Transition Planning Grant and the Quality Demonstration Grant is $500,000 for each program. This recommendation continues the Governor's FY 2003 supplemental budget recommendation to eliminate these two grant programs.

Base funding for the EHDI community grants is $3.6 million. The planning grant component of $400,000 will be eliminated.

Base funding for Rural Hospital Capital Improvement Grants is $2.12 million General Funds and $233,000 in Intergovernmental Transfer (IGT) revenue. These two funding streams will be combined into the General Fund and reduced by $566,000.

Key Measures

⇒ The extent to which nursing home grantees implement the plans developed with grant funds and modify their services to meet changing community needs will no longer be measured.

⇒ Reductions in health disparities will continue to be measured.

⇒ Urgent, unmet capital improvement needs among small rural hospitals will continue to be addressed, but at reduced levels.

Alternatives Considered

The department reviewed all expenditures when preparing expenditure reduction proposals for the FY 2004-05 budget. This recommendation reflects our effort to protect funding for public health priorities and activities that are core to the department's mission.

Statutory Change: Not Applicable

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Other Fund—Health Care Access				
Expenditures	($1,101)	($1,101)	($1,101)	($1,101)
Revenues	0	0	0	0
Net Fiscal Impact	($1,101)	($1,101)	($1,101)	($1,101)

Recommendation

The Governor recommends reducing Health Care Access Fund appropriations by $1.101 million each fiscal year as a result of grant and operations reductions in the Department of Health. 5.8 FTEs will be eliminated.

Background

The Health Care Access Fund supports the Office of Rural Health and Primary Care, Health Economics, and Data Analysis, to ensure access to health care for all Minnesotans. We will continue to focus on our core functions in these areas—ensuring access to health care for rural Minnesotans, workforce development programs, and ensuring quality data and quality reporting on costs, quality, access and utilization of health care in Minnesota. The following areas will be reduced.

The Office of Rural Health and Primary Care ($87,000)—One position that supports both the Rural Health Advisory Committee and rural health special studies will be eliminated; and contract funds that support physician recruitment will be reduced.

Health Policy and Systems Compliance Division ($293,000)—Division-wide oversight and support will be reduced.

Health Care Risk Adjustment ($108,000)—MDH has worked with DHS in recent years to develop risk adjustment models for setting capitated payment amounts for health insurance. Funding for this activity will be eliminated.

The Minnesota Health Data Institute ($113,000)—The Institute has dissolved and the funding which supported the organization will be eliminated.

The Rural Continuing Education Grant Program ($250,000)—This program was created by the Legislature in 1993 at a time when Minnesota (particularly rural Minnesota) was experiencing a shortage of nurse practitioners. The statewide supply of nurse practitioners has increased substantially in recent years. In some years, in fact, the supply of nurse practitioners seeking jobs in rural Minnesota has exceeded the number of openings available. Continuing to increase the number of nurse practitioners in rural Minnesota is a worthy goal. However, this reduction recognizes that more severe and immediate workforce shortages exist in other health-related fields.

Isolated and Rural Hospital Transition Grants ($150,000)—These two grant programs are similar enough to be combined into one Rural Hospital Grants program, at a reduced level, with considerations for both financial need and project merit. The Isolated Hospital Grant currently provides assistance to remote, financially troubled hospitals. The Rural Hospital Transition Grants support small rural hospitals to plan and adapt to change.

Health Professional Loan Repayments ($100,000)—The Rural Physician Loan Repayment, Midlevel Practitioner Loan Repayment, and Nurses Loan Repayment programs will be combined to streamline them and make them more market responsive.

Relationship to Base Budget

Overall, this recommendation reflects a 15% reduction in Health Care Access funds.

- Base funding for the Rural Continuing Education Grant is $250,000. This grant will be eliminated.

- Base funding for the Isolated Hospital Grant is $200,000 and the Rural Hospital Grant is $250,000. These two grants will be reduced by $150,000.
- Base funding for workforce development loan and grant programs is $1.454 million. $100,000 will be reduced from the following three programs: Rural Physician Loan Repayment ($675,000), Midlevel Practitioner Loan Repayment ($105,000), and Nurses Loan Repayment ($60,000).

Key Measures

- Viability of rural hospitals
- Health care workforce shortages in rural Minnesota
- Useful and timely data and information on the health care system

Alternatives Considered

The department reviewed all expenditures when preparing expenditure reduction proposals for the FY 2004-05 budget. This recommendation reflects our effort to protect funding for public health priorities and activities that are core to the department's mission.

Statutory Change: M.S. 62J.451-2; M.S. 144.1494; M.S. 144.1496-7; M.S. 144.1484

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund (100)				
Expenditures	0	0	0	0
Transfer-In	$4,000			
Special Revenue Fund (200)				
Expenditures - MERC	$8,250	$8,250	$8,250	$8,250
Expenditures - Tobacco	$1,700	$1,700	0	0
Revenues – MERC	$8,250	$8,250	$8,250	$8,250
Revenues – Tobacco	$3,400	0	0	0
Medical Education/Tobacco Endowment (561/562)				
Expenditures – Tobacco	($24,305)	($24,250)	($23,303)	($24,255)
Expenditures – Tobacco	($7,400)			
Expenditures – MERC	($8,927)	($8,623)	($8,425)	($8,634)
Revenues	0	0	0	0
Net Fiscal Impact	($15,032)	($14,673)	($15,228)	($16,389)

Recommendation

The Governor recommends dedicating 2.5-cents of the cigarette tax to replace endowment funding for medical education and research costs (MERC). These funds will be deposited in a special revenue account and the existing balance and activity will be transitioned to the special revenue account. These funds will be available for expenditure by the Department of Health.

Further, the Governor recommends eliminating the appropriation from the Tobacco Use Prevention Endowment, transferring $4 million to the general fund, and transferring the remaining balance to the special revenue fund. This amount is estimated to be $3.4 million and will be expended on intervention projects. Additional information on the elimination of the tobacco use prevention endowment and the medical education endowment can be found in the state and local finance budget book.

Background

The MERC fund was established to address the increasing financial difficulties of facilities providing graduate medical education in Minnesota. Eligible grantees are 'sponsoring institutions' that are financially or organizationally responsible for one or more accredited training programs operating in Minnesota. Funds are currently distributed to 18 sponsoring institutions, with 80% of the funds being distributed to the Academic Health Center and the Mayo Foundation. Medical Education Endowment appropriations (and corresponding federal match) represented 28% of MERC fund resources in FY2002-03. While appropriations were set at the maximum amount allowed in law (5% of the fair market value of the fund), market volatility makes the value of future appropriations very uncertain.

Tobacco Use Prevention and Local Public Health endowment expenditures target youth tobacco use and youth risk behaviors through statewide activities (including Target Market) and local intervention activities. In anticipation of reduced endowment appropriations resulting from significant stock market volatility, MDH began setting aside funds in fiscal years 2002 and 2003, and set program funding levels that could be maintained between declining endowment appropriations and funds held in reserve. Strategies put in place in the past three years have yielded significant reductions in the use of tobacco products by youth. To continue the successful efforts of a few selected communities, the Governor recommends funding a targeted, two-year Minnesota Youth Tobacco Prevention Program, which would focus on youth ages 12 to 14 and would fund state/local partnership intervention projects in selected areas.

Relationship to Base Budget

Medical Education Endowment appropriations for FY 2004-05 are forecasted to be $17.6 million. These appropriations will be replaced with a 2.5-cent dedication of the cigarette tax, yielding $16.5 million for the biennium. While cigarette tax revenue for MERC will be 6.3% less than forecasted endowment appropriations, overall funding for MERC in FY 2004-05 will increase.

Change Item: MED. EDUC. & TOBACCO ENDOWMENT CHANGES

Under current statute, base funding for tobacco prevention and youth risk behavior activities is from the Tobacco Use Prevention and Local Public Health endowment. Forecasted appropriations from this fund are $24.305 million in FY04 and $22.550 million in FY05. This funding will be eliminated beginning in fiscal year 2004. Of the remaining balance in the fund, $4 million will be transferred to the General Fund, and $3.4 million will be transferred to the Special Revenue Fund for a targeted, two-year tobacco prevention program.

Statutory Change: M.S. 62J.694, M.S. 144.395, M.S. 144.396.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	$1,150	$1,150	$1,150	$1,150
Revenues	0	0	0	0
Net Fiscal Impact	$1,150	$1,150	$1,150	$1,150

Recommendation
The Governor recommends a General Fund appropriation of $1.15 million each fiscal year to maintain the current funding level for the statewide Minnesota Poison Control System.

Background
The Minnesota Poison Control System operates statewide 24 hours a day, 365 days a year and provides immediate information and treatment advice about poisonings and toxic exposures to the general public. It also provides information to Minnesota health professionals who care for poisoned patients and provides a variety of public education activities around the state that inform the public about when and how to call the poison center, how to prevent poisonings, and how to provide first aid in a poisoning situation. The system responds to requests from the general public and health care professionals at no cost to the caller. The Minnesota Poison Control System receives approximately 44,000 poisoning exposure calls and 18,000 information calls each year, the majority of which involve children and youth. Minnesota uses the national poison control hotline number (1-800-222-1222), which routes phone calls to the center that takes calls for the caller's geographic area.

A national study in 1997 documented that every dollar spent on poison centers saves an estimated $6.50 in medical spending, mainly by eliminating the need for emergency department care for cases that can be managed safely at home. In Minnesota, the poison control system saves almost $9 million each year for health plans, purchasers, and risk-bearing providers.

Relationship to Base Budget
The Minnesota Poison Control System is funded in FY 2003 by the General Fund ($1.36 million), the host organization ($428,000), a federal grant ($230,000), and the state 9-1-1 fund ($50,000 that ends in FY 2003). The 2001 Legislature did not extend General Fund support for the system beyond the FY 2002-03 biennium. Total annual funding for the system currently is $2,068,000, which is below the national average (based on population and expected number of calls) of $2,574,000.

This recommendation maintains funding for the poison control system at FY 2003 levels, and replaces a portion of general funds with federal bioterrorism grant funds.

Key Measures
Health outcomes related to this proposal include:
- All Minnesotans will continue to have access to specialized and efficient poison control services.
- The unnecessary use of emergency treatment services for poison exposures will continue to be minimized.
- Savings to the health care system of almost $9 million per year.

Alternatives Considered
If state funding were no longer provided to the Minnesota Poison Control System, the host organization would not be able to continue operating a statewide system. Callers to the national poison control hotline number would reach a recording stating that there is no poison control center in their area and advising them to hang up and call 911. If Minnesota had no statewide poison control center, treatment costs for poison exposures would increase and there would be no centralized access to specialized expertise regarding poison control. Delayed and less expert treatment of poison exposures would likely result in preventable death and disability.

Statutory Change: Not Applicable

Change Item: ALCOHOL AND DRUG COUNSELOR REGULATION

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Other Fund – State Government Special Revenue				
Expenditures	0	0	0	0
Revenues	$226	$235	$235	$235
Net Fiscal Impact	$226	$235	$235	$235

Recommendation

The Governor recommends additional revenues in the State Government Special Revenue Fund of $226,000 in FY 2004, and $235,000 in FY 2005 from increasing the license fee for the Alcohol and Drug Counselor regulation program to cover an accumulated and structural deficit in the program's operation.

Background

In 1994 the department was charged with the responsibility of developing a licensure process for alcohol and drug counselors. The start-up phase lasted until 1998 when the program first began licensing counselors. During the start-up phase, expenditures were being incurred. The fee was originally established to recover these start-up costs. However, the number of licensees is far fewer than anticipated, and fees are not sufficient to neither recover the deficit nor recover annual program costs. Now that the program has been in existence for several years, the department has a better understanding of both the number of practitioners and the associated revenue and the expenses that must be incurred to operate the program. This proposal would increase the fee to recover annual operating costs and establish a temporary surcharge to recover the accumulated deficit.

Relationship to Base Budget

The fee increase for the Alcohol and Drug Counselor program will be an on-going fee increase and will support the existing activities of the program. Current fee revenues are estimated to be $270,000 in FY 2004. The licensure fee increase will add $54,000 in revenues, and the surcharge will add $172,000 in revenues. The surcharge will expire after six years.

Key Measures

The Alcohol and Drug Counselor program is able to process licenses for practitioners and respond to citizen complaints in a timely manner.

Alternatives Considered

Expenses have been reduced as much as possible. The surcharge could be spread over 10 years instead of six, reducing the annual amount assessed and collected.

Statutory Change: yes

Change Item: HEARING INSTRUMENT DISPENSER REGULATION

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Other Fund—State Government Special Revenue				
Expenditures	0	0	0	0
Revenues	($78)	$58	$58	$58
Net Fiscal Impact	($78)	$58	$58	$58

Recommendation

The Governor recommends a revenue reduction of $78,000 in FY 2004 from the suspension of certification application and renewal fees for one year for the Hearing Instrument Certification system. In addition, the Governor recommends a revenue increase of $58,000 in FY 2005 from a fee adjustment to fully recover the costs of regulating and so that all practitioners pay the same amount for each type of fee.

Background

Hearing Instrument Dispenser regulation began in 1988. Certification fees were adjusted and a surcharge fee was enacted in 1998 to recover accumulated deficits attributable to a contested case hearing, examination development costs and a high rate of consumer complaints about dispensing activities. Based on the higher number of complaints, investigations and enforcement actions against non-audiology dispensers, fee differential s were created for audiology and non-audiology dispensers. The surcharge expires automatically in FY 2003, and there will be a projected account surplus of $179,000.

In addition, current fees (without the surcharge) are not fully recovering the cost of regulating hearing instrument dispensers. Since complaints are now about the same for audiology and non-audiology dispensers, the fees will be set at a level that equalizes the fee structure between the two dispenser groups, and fully recovers costs. Therefore, a fee reduction for non-audiology dispensers and a fee increase for audiology dispensers is necessary. Both will have a fee holiday for FY 2004 to spend down the accumulated surplus.

Overall, both audiology dispensers and non-audiology dispensers will benefit from the fee holiday. The fee adjustment will involve a fee reduction for non-audiology dispensers and a small fee increase for audiology dispensers.

Relationship to Base Budget

The fee suspension for certification applications and renewals will be for one year. In the second year of the biennium, fee adjustments will be ongoing and expected to produce revenues to approximate the ongoing estimated costs of regulating hearing instrument dispensers.

Key Measures

The Hearing Instrument Dispenser Certification system is able to issue credentials, investigate consumer complaints and take enforcement actions in a timely manner.

Alternatives Considered

Taking no action would increase the account surplus and perpetuate a fee inequity between audiologist and non-audiologist dispensers that is no longer justified.

Statutory Change: M.S.153A.17.

Change Item: OCCUPATIONAL THERAPIST FEE HOLIDAY

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Other Fund-State Government Special Revenue Fund				
Expenditures	0	0	0	0
Revenues	($220)	($220)	0	0
Net Fiscal Impact	($220)	($220)	0	0

Recommendation
The Governor recommends reducing revenues in the State Government Special Revenue (SGSR) fund by $220,000 in each fiscal year as a result of suspending the licensure fee for the Occupational Therapy program for one biennium.

Background
The fees collected for the regulation of Occupational Therapists have been more than expenditures and a surplus has accumulated in the fund. Annual fee collection and annual expenditures are now in line with one another, but the surplus is large enough to support a fee holiday for the next biennium.

Relationship to Base Budget
The fee suspension for the Occupational Therapist regulation will be for one biennium, FYs 2004-05 only.

Fee revenues collected by the program are deposited to the fund; they are not dedicated to the department. The department receives a direct appropriation from the SGSR fund to support its activities. This fee holiday will not impact MHD appropriations.

Key Measures
The Occupational Therapy program is able to process licenses for practitioners and respond to citizen complaints in a timely manner.

Statutory Change: none, rider language only.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Other Fund—Future Resources				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact	0	0	0	0

Recommendation

The Governor has recommended the elimination of the dedicated funding for the Future Resources Fund. The Governor is not making specific recommendations on LCMR projects at this point, but intends to provide a statement of the administration's priorities for Environmental Trust Fund projects at a later time. This change item is shown in the MDH budget for informational purposes.

Background

The Legislative Commission on Minnesota Resources is recommending two proposals at the Department of Health.

Healthy Schools: Indoor Air Quality and Asthma Management: $198,000 from the Future Resources Fund to assist school districts with developing and implementing effective indoor air quality and asthma management plans.

Economic-based Analysis of Children's Environmental Health Risks: $100,000 from the future Resources Fund to assess economic strategies for children's environmental health risks.

Relationship to Base Budget

There is no base funding for these projects.

Statutory Change: Not Applicable

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures				
Revenues	0	0	0	0
Other Fund (SGSR)				
Expenditures	$3,045	$2,727	$2,727	$2,727
Revenues	2,870	2,870	2,870	2,870
Net Fiscal Impact	($175)	$143	$143	$143

Recommendation

The Governor recommends an increased appropriation of $3.045 million in FY 2004, and $2.727 million in FY 2005 from the State Government Special Revenue Fund to continue and enhance the Newborn Screening Program. This appropriation will be offset by a $40.00 increase to the newborn screening fee to cover both one time and ongoing program costs.

Background

Each year 70,000 infants born in Minnesota are screened shortly after birth to detect rare heritable and congenital (present at birth) medical conditions. The newborn screening system is designed to detect and treat these medical conditions as early as possible. By detecting these conditions soon after birth, treatment can begin that will prevent chronic illness, physical disability, mental retardation, developmental problems, or infant death.

Screening in Minnesota began in 1965 with a test for phenylketonuria or (PKU). PKU is an enzyme deficiency that results in mental retardation unless the baby is started on a specialized diet soon after birth. Recognition that the cost of testing was far less than the cost of caring for a mentally retarded or disabled person supported the adoption of four additional disorders for screening, including: congenital adrenal hyperplasia, congenital hypothyroidism, galactosemia, and hemoglobinopathies, such as sickle cell anemia and thalassemia.

These conditions are so rare that most physicians lack familiarity and expertise needed to diagnose and treat these disorders. In addition, treatment may require multiple services that are often provided by a patchwork of agencies, both public and private, and some resources may not be available locally for the management of such rare disorders. An important role of public health is to assist families in accessing appropriate treatment and other services that might benefit them before the onset of symptoms. This proposal will enhance the ability of providers and families to manage their child's health care needs.

The science of newborn screening is evolving at a rapid pace. In 1999 the Minnesota Legislature appropriated funding to purchase advanced equipment called tandem mass spectrometry (TMS). TMS makes it possible to expand the number of medical conditions screened and to screen for multiple conditions using a single test. A pilot test of this technology is currently underway.

During the first year of the pilot study, twenty-seven infants were diagnosed with one of the thirty disorders included in the expanded screen. Without newborn screening, these infants could have been subject to countless tests once symptoms developed; needed lengthy stays in neonatal intensive care units; and suffered serious delays in diagnosis and treatment. The clinical outcome for the disorders identified would have been mental retardation, disability, and death.

The Mayo Clinic's Biochemical Genetics Laboratory (BGL) Scientists have closely collaborated with MDH and have provided technical assistance instrumental to the success of the pilot. Building on this close collaboration, this proposal includes a public-private partnership with Mayo and MDH to enhance Minnesota's Newborn Screening Program. Mayo would screen for thirty medical disorders using TMS. Using alternative technology, MDH would adopt new screening tests for two added medical conditions and would continue to screen for four of the five currently screened disorders. MDH would maintain overall responsibility for the screening program: set and collect fees; receive and distribute specimens for analysis; notify physicians of presumptive positive results; and provide follow-up to assure infants are connected with specialty care.

This public-private partnership will build on the scientific expertise of both partners; enhance screening using advanced technology; reduce rate of false positive results and consequently minimize the medical, emotional, and financial costs to the families and the health care system; facilitate a rapid expansion of conditions screened when the benefits of newborn screening have been well documented; and improve the quality of provider and public education. This unique public-private partnership will place Minnesota at the forefront of national discussions of NBS standards.

Relationship to Base Budget

The Governor recommends a fee increase of $40.00 per newborn and an increased appropriation. This fee was last raised in 1998 from $13.00 to $21.00. The Newborn Screening Program Advisory Committee supports the proposed $40.00 fee increase.

Screening Component ($1.077 million): includes specimen processing, laboratory analysis, and notification of physicians and families of presumptively positive screening results.
Follow-up and Assuring Access to Care Component ($571,000): includes locating families, improving provider and family education; and helping physicians and families locate specialty services before the onset of symptoms.

⇒ *Mayo Component ($1.397 million):* annual contract with the Mayo Clinic to screen for the 30 disorders utilizing TMS.

Key Measures

This change item will provide the revenue needed for MDH to improve health outcomes for Minnesota newborns by increasing the number of treatable medical conditions identified and confirmed as positive.

Number of newborns identified with treatable disorders per year

Historical 1993-2000	Actual 2001	**Target 2002**	**Expanded Screening Target 2003**	**Without Expanded Screening Target 2003**	**Expanded Screening Target 2004**	**Without Expanded Screening Target 2004**
32-50 (range)	58	**~65 to ~75**	**~65 to ~75**	**~32 to ~50**	**~175 to ~210**	**~32 to ~50**

Source: Public Health Laboratory, Minnesota Department of Health

Alternatives Considered

Without the expanded newborn screening, these infants would be subjected to: countless tests once symptoms developed; lengthy stays in neonatal intensive care units; a serious delay in diagnosis and treatment; and permanent harm. The opportunity would be lost to save 175 babies born in Minnesota annually from suffering permanent disability or death.

Statutory Change: M.S. 144.125, M.S. 144.126, M.S. 144.128

Change Item: PLUMBING PLAN REVIEW

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Other Fund – SGSR				
Expenditures	$834	$884	$884	$884
Revenues	985	985	985	985
Net Fiscal Impact	$151	$101	$101	$101

Recommendation

The Governor recommends that the State Government Special Revenue Fund appropriations be increased by $834,000 in FY 2004 and $884,000 in FY 2005 to provide adequate resources for the department's plumbing plan review activity. In addition, the Governor recommends that the appropriation increases be offset by a $985,000 increase in fee revenues.

Background

Currently, all plumbing plans submitted to MDH are reviewed for compliance with Minnesota Rules Chapter 4715 (Minnesota Plumbing Code). Plan review helps identify potential problems in a plumbing system before it is installed. MDH conducts inspections of plumbing installations in public and commercial projects. In addition, MDH is responsible for inspecting *plumbing systems for all state facility projects and MDH-licensed facilities*. Only about 20% of the plumbing systems for public facilities submitted to MDH for review are inspected.

At present, there is no fee for plan review activities. Current activities have been subsidized by other funding sources, which will not be adequate in the next biennium to provide inspection services for all state facility projects and MDH-licensed facilities. This proposal will establish a new fee category for plan review, allowing plumbing program activities to continue at their present level. In addition, the current plan review program staff will be increased by one to provide faster plan review by MDH.

To learn more about this program, see the web site at http://www.health.state.mn.us/divs/eh/plumbing/.

Relationship to Base Budget

The current annual budget for these activities is approximately $1.5 million. The entire program, which is being expanded by one plan review staff, will cost $1.623 million for each year of the FY 2004-05 biennium. A plan review fee would provide an increase of $884,000 in funding for plan review and some inspection activities. Costs for plan review and inspection would be borne directly by plumbers, designers or owners of facilities proposing construction.

Key Measures

- Number of plumbing plan reviews conducted.
- Number of inspections conducted state wide.

Alternatives Considered

- Increasing the number of cities that have plan review agreements with MDH, to reduce the number of plans received by MDH.
- Providing inspection services through contract inspectors similar to those who do electrical inspections.

Statutory Change

This would affect M.S. 326, which would be amended to reflect the necessary changes.

Change Item: SWIMMING POOL REGULATION

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Other Fund - SGSR				
Expenditures	$70	$75	$75	$75
Revenues	87	87	87	87
Net Fiscal Impact	$17	$12	$12	$12

Recommendation

The Governor recommends that the State Government Special Revenue Fund appropriations be increased by $70,000 in FY 2004 and $75,000 in FY 2005 to provide adequate resources for the department's pool plan review and inspection activity. In addition, the Governor recommends that the appropriation increases be offset by an $87,000 increase in fee revenues.

Background

The purpose of this program is to protect public health by ensuring proper design, construction, maintenance, and operation of public swimming pools and spas, such as those at schools, hotels, and municipal facilities. Conditions that pose a health risk that can be averted by plan review include drowning, falls, infection, and transmission of disease. MDH provides public pool and spa plan review and construction inspections throughout Minnesota. Staff of this program have a variety of responsibilities, including the review of plans and specifications for construction of public swimming pools and spas, and the inspection of each prior to use.

The MDH pool program is an effective means to ensure health protection through comprehensive, consistent oversight for construction of public pools and spas. Staff also provides technical assistance to the public and state and local officials on issues related to pool safety and sanitation. Ensuring adequate funding allows program services to continue to be provided.

Plan review and inspection fees are currently required for public pool construction. However, the present fee level does not support the staffing required to carry out the required activities. This proposal will increase the current fee and establish a new fee for reviewing variance proposals, which require as much time to process as a plan review. Costs for plan review, inspection, and variance requests would be borne directly by owners, designers or by the facilities proposing construction.

To see more about this program, see the web site at http://www.health.state.mn.us/divs/eh/pools/index.html.

Relationship to Base Budget

The current annual budget for these activities is approximately $50,000. The proposed budget of $120,000 would provide adequate funding for the single staff person and associated clerical support. An increase in fees for plan review and the establishment of a variance request review fee would fund the proposed activities. Fees for plan review; variances and construction inspection are currently in rule and will be set in statute.

Key Measures

Number of inspections completed and relative changes in plan review service.

Alternatives Considered

An alternative to this recommendation would be to reduce the level of program services.

Statutory Change

This would affect M.S. 144.

Change Item: SGSR TRANSFER FOR HEALTH

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	0	0	0	0
Transfer-In	$3,000	0	0	0
Other Fund – State Government Special Revenue				
Expenditures	0	0	0	0
Transfer Out	($3,000)	0	0	0
Net Fiscal Impact	0	0	0	0

Recommendation
The Governor recommends a one-time transfer of $3 million of revenues collected in the State Government Special Revenue (SGSR) fund to the General Fund. This amount represents revenues collected over time by fee programs operating in the SGSR fund to offset earlier deficits incurred in the General Fund.

Background
Individual fee-based programs at MDH are managed to that each program stays in fiscal balance over time. However, in order to avoid changing all fees every ear, fees are set to over-recover costs for a period of time, break even, and then under-recover for a period of time.

Prior to fiscal year 1994, MDH fee-based programs operated out of the General Fund. Fee revenues collected at that time were deposited into the General Fund and corresponding appropriations to support these programs were made from the General Fund. In fiscal year 1994, the legislature moved these fee-based activities to the SGSR fund, and required these programs to support and sustain their operations.

In 1994 when the legislature moved the fee programs to the SGSR fund, several fee programs had been under-recovering their costs, resulting in a deficit. At this time fees in these programs were adjusted to fully recover current operating costs and the previous deficit. These funds have been deposited in the SGSR fund.

Relationship to Base Budget
MDH fee revenue is deposited as non-dedicated revenue to the SGSR fund. This means that the revenues are not dedicated to the department, but are resources of the fund. MDH receives direct appropriations out of the fund. This transfer to the General Fund will not negatively impact MDH program operations or those of any other agency operating out of this fund.

Key Measures
This transfer will not impact outcome measures of individual fee-based programs.
The transfer will reduce the operating capital of the SGSR fund.

Alternatives Considered
The Fund has a positive cash balance. This revenue could remain in the SGSR fund. However, without these resources in the fund, MDH will be responsible for maintaining these account so that the entire fund remains in balance.

Statutory Change: none, rider language only

Minnesota Department of **Human Services**

February 18, 2003

The Minnesota Legislature
State Capitol
St. Paul, Minnesota

Dear Legislators,

I am submitting the fiscal year 2004-05 budget for the Minnesota Department of Human Services. This budget consists of approximately $8.0 billion in direct appropriated funds for the biennium. Containing savings of nearly $1.1 billion, the budget represents a 12 percent change from current projected spending levels.

Our proposals reduce spending in ways that allow us to preserve core services to the most vulnerable people, advance important reforms, and provide a solid foundation to build upon in the future.

While much of the attention of this budget process has been on reducing spending so we can preserve core services, it is also important to note that we begin or continue promising reforms:

⇒ We are forwarding an exciting proposal that expands the community mental health system, eventually blending all state-operated adult mental health and nursing facility services into that system rather than state-run institutions.
⇒ Our proposal for people with disabilities continues to emphasize community-based services over institutional care.
⇒ We have launched the next generation of welfare reform, putting greater emphasis on work and personal responsibility.
⇒ We remain committed to long-term care reform for the elderly — a framework put in place by the Legislature two years ago that will better serve our seniors and their families.

Developing a budget to meet the most critical needs while significantly reducing spending requires a careful balancing act. We worked to identify those people who are “most vulnerable” and services that are “most critical” to their well-being. Anything falling outside this definition was reduced or eliminated in order to preserve these core services. For example:

⇒ We preserved publicly funded health care coverage for most families with children, the elderly, people with disabilities and legal immigrants. We reduced or eliminated coverage for people at higher eligibility levels, some adults without children, people who entered the country illegally and non-immigrants, such as tourists and students.
⇒ We preserved the long-term care safety net. We reduced payment rates to providers of these services and growth in programs for people with disabilities.
⇒ We continued key investments in children. We fully funded adoption assistance, which helps families adopt special needs children who are under state guardianship. We also expanded or improved some children’s mental health services because of the great need for a cost-effective delivery system. We consolidated 20 separate children’s grants and provided flexibility in service delivery with a focus on outcomes; however, we reduced the total amount of funding available for the services provided through these grants.

⇒ We preserved food, cash and emergency assistance for the most vulnerable: the elderly, people with disabilities and families with children. We placed caps on emergency assistance and reduced cash grants for some families.

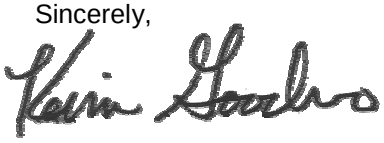
While I believe we did an excellent job of preserving core services, I also want to acknowledge that the services we are reducing benefit people. By definition we are a safety net agency providing people in need with useful supports, many of which I authored or supported in the Legislature. It is important to remember, however, that even with the reductions in our budget proposal, human services spending will still be greater in '04-'05 than in the previous biennium. We recognize that our proposals create challenges for our partners. Counties will have to make similar judgments about priorities at the local level.

When we reduce services to the people we serve we need to achieve administrative cost savings as well. We have proposed reducing Central Office General Fund operations spending and the number of full-time equivalent (FTE) positions in this area by 15 percent by the end of the biennium. We have constructed administrative reductions to recognize that it will take a considerable effort in fiscal year 2004 to implement the changes we have proposed on the program side.

The reforms, along with the care we took to preserve core services, will give us a solid foundation to build upon once this budget crisis is behind us. Minnesota has a strong tradition for caring for people in need. Together, we will continue to provide a critical safety net for the people of Minnesota.

I look forward to working with you in the coming weeks as these important issues unfold.

Sincerely,



Kevin Goodno
Commissioner

	FY 2004-05 Expenditures ($000s)		
	General Fund	**Other Funds**	**Total**
2003 Funding Level	6,685,835	10,277,731	16,963,566
Biennial Appropriations	804	0	804
February Forecast Adjustment	-27,777	-14,281	-42,058
Forecast Caseload/Enrollment Changes	423,379	140,598	563,977
Legislatively Mandated Base	133,771	-5,412	128,359
New Programs To Agency Base	0	3,400	3,400
November Forecast Adjustment	575,391	17,126	592,517
One-Time Appropriations	0	-53,080	-53,080
Program/Agency Sunset	0	-43,860	-43,860
Transfers Between Agencies	-564	0	-564
Adjusted Base Funding	7,790,839	10,322,222	18,113,061
Change Items			
Adjust PDP Appropriation To Forecast	-6,019	0	-6,019
Adolescent Mental Health Crisis Facility	-1,283	0	-1,283
Adoption And Relative Custody Assistance	2,177	0	2,177
Alternative Care Program Changes	-22,009	0	-22,009
Apply Hard Edits For Pharmacy Claims	-2,891	0	-2,891
Apply MA/GAMC/Minnesotacare Co-pays	-29,714	-3,983	-33,697
Broker MA Non-emergency Transportation	-1,769	0	-1,769
Child Support Grant Reduction And Fees	-1,098	0	-1,098
Children's & Community Services Grant	-37,500	0	-37,500
Children's Mental Health MA Benefit	1,948	0	1,948
Children's Mental Health Screening	2,733	0	2,733
Comply With Federal Managed Care Regs	1,166	0	1,166
Consolidate GAMC And Minnesotacare	-208,395	-115,668	-324,063
Consolidated MFIP Support Services Grant	0	40,000	40,000
County Share On Large ICF/MR	-16,605	0	-16,605
Delay HCBS Service Improvements	-3,956	0	-3,956
Delay MA Fee For Service - Acute Care	-25,118	0	-25,118
Discontinue MA/GAMC/PDP Weight Loss Prod	-637	0	-637
Eliminate Access And Visitation Grants	-200	0	-200
Eliminate Automatic NF COLA	-24,642	0	-24,642
Eliminate Consumer Supp Grant Exceptions	-2,478	0	-2,478
Eliminate ICF/MR Occupancy Special Rate	-2,384	0	-2,384
Eliminate MA Hospital Pmt Rebasing	-3,327	0	-3,327
Eliminate MA NF Scholarships Program	-1,843	0	-1,843
Eliminate MA/GAMC For Undocumented	-50,122	0	-50,122
Eliminate Mandate For DT&H Services	-1,593	0	-1,593
Eliminate Some Continuing Care Grants	-25,769	0	-25,769
Emergency Assistance Programs	-4,929	-11,001	-15,930
Increased PDP Rebates	-1,768	0	-1,768
Limit MA Asset Sheltering	-2,942	0	-2,942
Limit MA/Mncare Auto Newborn Coverage	-7,241	-91	-7,332
MA Pmt Of Cost-effective Premiums	-383	0	-383
Manage TBI Waiver Caseload Growth	-4,921	0	-4,921
MFAP Shortfall	159	0	159
MFIP Budgeting & SSI	6	-29,942	-29,936
MFIP Education And Training	0	-7,591	-7,591
MFIP Exit Level - 115%	0	-8,068	-8,068
MFIP For Legal Non-citizens	0	11,248	11,248
MFIP Time Limit Policy	-30	2,143	2,113
MFIP-welfare Reform	0	-11,488	-11,488
Mncare Insurance Barrier Exemption	0	436	436
Modify MA-EPD	-3,901	0	-3,901
Modify Minnesotacare	0	-19,318	-19,318
Nursing Home Surcharge And IGT	48,425	0	48,425
Phase Out MA Day Treatment	-2,463	0	-2,463
Reduce Continuing Care Provider Rates	-81,711	0	-81,711

Reduce Gamc Medical Education Pmt	-6,734	0	-6,734
Reduce General Fund Operations By 15%	-12,109	0	-12,109
Reduce MA Children 170% To 150%	-3,060	248	-2,812
Reduce MA First 90-day NF Payment	-5,141	0	-5,141
Reduce MA NF Rates/capacity	-33,867	0	-33,867
Reduce MA Payment For NF Hold Days	-864	0	-864
Reduce MA Payment For NF Medical Co-pay	-9,033	0	-9,033
Reduce MA Pregnant Women 275% To 200%	-749	232	-517
Reduce MA/GAMC Hospital Pmt 5%	-26,108	0	-26,108
Reduce MA/GAMC Managed Care Pmt	-17,517	0	-17,517
Reduce MA/GAMC/PDP Pharmacy Reimb	-29,629	0	-29,629
Reduce MR/RC Waiver Growth	-12,938	0	-12,938
Reduce State Fset Grants	-2,642	0	-2,642
Reduce Subsidy Of County PMAP	-3,883	0	-3,883
Refinance Group Residential Housing	-10,795	0	-10,795
Repeal MA Coverage Of New Autism Service	-4,220	0	-4,220
Repeal MA Income Deductions	-1,268	0	-1,268
Repeal One-month Rolling MA Eligibility	-15,077	0	-15,077
Repeal PDP Expansion 135% To 120%	-6,001	0	-6,001
Require Authorization For Pharmacy DAW	-1,351	0	-1,351
Restructure Adult MH Treatment	-617	0	-617
Rollback Mncare Children Exceptions	0	-3,844	-3,844
Shift County Payment	-14,792	0	-14,792
SOS Refinancing Strategy	2,614	0	2,614
TANF Refinancing	-22,199	22,199	0
Governor's Recommendations	7,029,832	10,187,734	17,217,566
Biennial Change, 2002-03 to 2004-05	723,206	988,373	1,711,579
Percent Change	11%	11%	11%

Brief Explanation Of Budget Decisions

Base Funding Levels

Base funding level for this agency starts with 2003 appropriation level and is adjusted for increased expenditures based on obligations in current law. Given the timing of the budget release, this document reflects the impact of the November 2001, February 2002, November 2002, and February 2003 forecast. These adjustments are reflected above as “Forecast Caseload/Enrollment Changes” (November 2001 and February 2002), “November Forecast Adjustment” (November 2002), and “February Forecast Adjustment” (February 2003).

Legislatively mandated base changes further adjust base figures by recognizing legislative tracking of costs for FY 2004-05. Key increases include: the effects of delaying county social service payments; refinancing information systems (i.e., PRISM/SSIS/MAXIS); expansions to prescription drug coverage for the elderly and persons with disabilities; and maintaining service levels in the Alternative Care program.

The $804,000 biennial appropriation increase represents an adjustment to the State Operated Services account for special equipment. The $564,000 transfer between agencies reflects money moved to the Department of Corrections for inmate mental health discharge planning and medications.

Finally, several downward adjustments to Federal TANF spending levels for FY 2004-05 were made to account for one-time program appropriations and program sunsets in the economic support area.

Recommendations

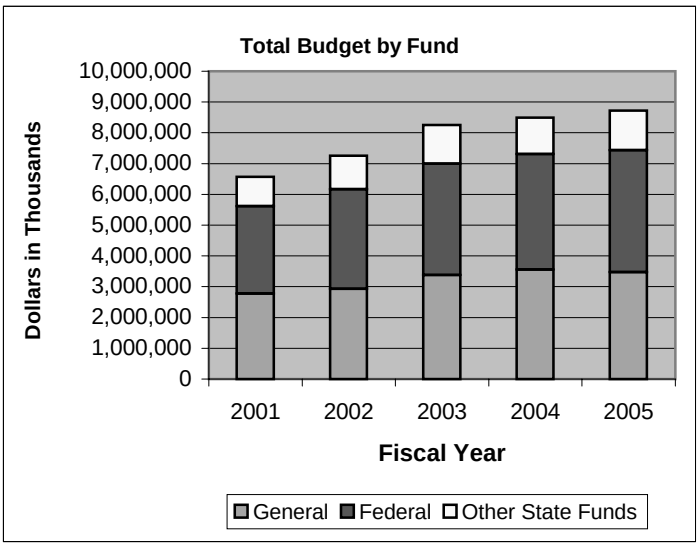
The Governor’s budget for the Department of Human Services contains savings of $1.07 billion and represents a change of 12 percent from projected funding levels for the 2004-2005 biennium. Savings are generated by a combination of expenditure reductions ($895 million) and additional revenues ($117 million).

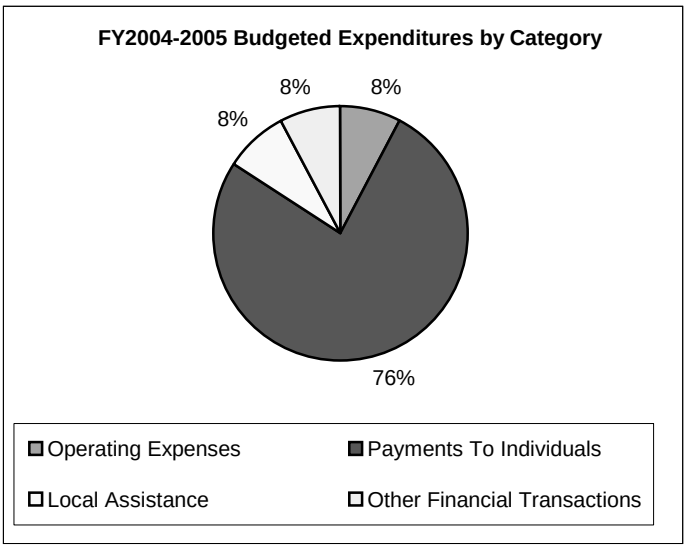
Expenditures:
Recommended reductions to the Department of Human Services' budget total $895 million for the FY2004-05 biennium, across all funds. Of this amount, $761 million in savings will come from the General Fund, and $134 million will come from other funds, namely the Health Care Access Fund.

After incorporating these reductions, the Department's General Fund budget will still grow by $725 million, or by 11%, for the upcoming biennium. Growth in this area of the budget, despite the significant reductions mentioned above, is due primarily to November 2002 and February 2003 forecasted caseload/spending adjustments, as well as other 2002 legislative session changes.

Revenues:
The Governor recommends increasing revenues to the General Fund by $177 million for the biennium. Several proposals would result in additional revenues, including: increasing state expenditures eligible for federal Medicaid funding; increasing medical provider surcharges and intergovernmental transfers used to match federal Medicaid funding; increasing state-operated services collections; and increasing fees that are charged by the Department for licensing activities.

	FY 2004-05 Revenues ($000s)		
	General Fund	**Other Funds**	**Total**
FY 2004-05 Current Law Revenues	595,864	539,743	1,135,607
Change Items			
Restructure Parental Fees	4,150		
Comply with Federal Managed Care Regs	428		
Reduce MA/GAMC Hospital Pmt 5%	2,563		
Repeal MA Coverage of New Autism Service	-79		
Broker MA Non-Emergency Transportation	872		
Maximize MA Estate Recovery	495		
Limit MA Asset Sheltering	75		
Nursing Home Surcharge and IGT	141,071		
Eliminate Some Continuing Care Grants	-1,532		
Restructure Adult MH Treatment	10,316		
Refinance Group Residential Housing	7,500		
Alternative Care Program Changes	52		
SOS Refinancing Strategy	12,119		
Increase License Fees	2,450		
S-CHIP for Undocumented Pregnant Women	4,000		
Reduce MA/GAMC Managed Care Pmt	80		
Reduce MA NF Rates/Capacity	-2,368		
Reduce General Fund Operations by 15%	-4,843		
FY 2004-05 Total Revenues	773,213	539,743	1,312,956
Biennial Change 2002-03 to 2004-05	161,301	-184,220	-22,919
Percent Change	26.3%	-25.4%	-1.7%





Dollars in Thousands						
	Actual	Actual	Preliminary	Governor's Rec		Biennium
Expenditures by Fund	**FY2001**	**FY2002**	**FY2003**	**FY2004**	**FY2005**	**2004-05**
Direct Appropriations						
General	2,601,324	2,906,509	3,323,608	3,495,179	3,405,970	6,901,149
State Government Special Revenue	512	482	534	534	534	1,068
Health Care Access	156,511	209,608	271,422	263,014	333,106	596,120
Federal Tanf	292,205	305,896	351,015	261,482	261,161	522,643
Lottery Cash Flow	1,514	2,164	1,495	1,306	1,306	2,612
Open Appropriations						
Special Revenue	467	418	666	340	340	680
Statutory Appropriations						
General	175,238	23,084	53,425	62,462	66,221	128,683
State Government Special Revenue	1,290	0	0	0	0	0
Health Care Access	23,054	27,700	23,292	28,358	31,853	60,211
Special Revenue	172,427	217,194	262,237	156,514	143,520	300,034
Federal	2,542,785	2,924,666	3,267,077	3,492,018	3,697,516	7,189,534
Miscellaneous Agency	534,423	566,345	604,169	645,645	689,102	1,334,747
Gift	109	32	88	150	61	211
Endowment	153	5	3	0	0	0
Revenue Based State Oper Serv	46,119	50,270	57,733	57,733	57,733	115,466
Mn Neurorehab Hospital Brd	2,724	7,439	15,744	15,744	15,744	31,488
Dhs Chemical Dependency Servs	13,948	15,207	16,460	16,460	16,460	32,920
Total	**6,564,803**	**7,257,019**	**8,248,968**	**8,496,939**	**8,720,627**	**17,217,566**
Expenditures by Category						
Operating Expenses	582,192	607,739	699,717	679,193	643,060	1,322,253
Capital Outlay & Real Property	1,179	163	249	249	249	498
Payments To Individuals	4,546,804	5,342,157	6,213,443	6,461,102	6,702,264	13,163,366
Local Assistance	897,616	738,663	732,252	709,424	684,713	1,394,137
Other Financial Transactions	537,012	568,297	603,307	644,870	688,240	1,333,110
Transfers	0	0	0	2,101	2,101	4,202
Total	**6,564,803**	**7,257,019**	**8,248,968**	**8,496,939**	**8,720,627**	**17,217,566**

Dollars in Thousands	Actual	Actual	Preliminary	Governor's Rec		Biennium
Expenditures by Program	**FY2001**	**FY2002**	**FY2003**	**FY2004**	**FY2005**	**2004-05**
Agency Management	41,609	45,735	58,333	61,249	46,872	108,121
Revenue & Pass Through	930,781	942,950	996,495	996,093	1,040,906	2,036,999
Childrens Services Grants	132,942	146,350	156,214	198,428	188,503	386,931
Childrens Services Management	11,084	11,549	14,912	14,901	14,649	29,550
Basic Health Care Grants	2,197,355	2,512,662	3,122,610	3,430,388	3,645,120	7,075,508
Health Care Management	52,216	55,883	80,798	79,439	66,828	146,267
State Operated Services	288,975	287,276	312,460	295,806	287,484	583,290
Continuing Care Grants	2,291,679	2,578,647	2,829,265	2,779,652	2,805,751	5,585,403
Continuing Care Management	31,962	38,810	45,919	45,198	44,074	89,272
Economic Support Grants	513,005	566,281	547,526	511,568	495,994	1,007,562
Economic Support Management	73,195	70,876	84,436	84,217	84,446	168,663
Total	**6,564,803**	**7,257,019**	**8,248,968**	**8,496,939**	**8,720,627**	**17,217,566**
Revenue by Type and Fund						
Non Dedicated						
General	202,104	285,835	326,077	382,718	390,495	773,213
Health Care Access	2,298	4,548	3,175	2,549	2,549	5,098
Special Revenue	3	2	1	1	1	2
Cambridge Deposit Fund	58,119	0	0	0	0	0
Federal Tanf	300,488	321,847	394,256	267,482	267,161	534,643
Miscellaneous Agency	0	134	0	0	0	0
Subtotal Non Dedicated	563,012	612,366	723,509	652,750	660,206	1,312,956
Dedicated						
General	174,363	24,910	24,389	28,771	28,205	56,976
State Government Special Revenue	1,049	0	0	0	0	0
Health Care Access	22,838	27,724	23,292	28,358	31,853	60,211
Special Revenue	95,376	126,608	148,722	143,205	135,671	278,876
Federal	2,543,601	2,931,512	3,272,402	3,492,629	3,698,290	7,190,919
Miscellaneous Agency	532,917	566,828	603,996	645,566	689,023	1,334,589
Gift	107	45	75	51	47	98
Endowment	11	3	3	2	2	4
Revenue Based State Oper Serv	48,902	52,067	60,188	60,188	60,188	120,376
Mn Neurorehab Hospital Brd	4,398	11,082	16,269	16,264	16,264	32,528
Dhs Chemical Dependency Servs	12,362	15,671	18,177	18,177	18,177	36,354
Subtotal Dedicated	3,435,924	3,756,450	4,167,513	4,433,211	4,677,720	9,110,931
Total Revenue	**3,998,936**	**4,368,816**	**4,891,022**	**5,085,961**	**5,337,926**	**10,423,887**
Full-Time Equivalents (FTE)	**6,099.3**	**6,171.3**	**6,076.3**	**6,074.1**	**6,012.1**	

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	0	($12,109)	($12,109)	($12,109)
Revenues	0	(4,843)	(4,843)	(4,843)
Net Fiscal Impact	0	($7,266)	($7,266)	($7,266)

Recommendation

The Governor recommends reducing General Fund operations and positions by 15% by June 30, 2005. The structural changes necessary to address these reductions will be implemented over the FY 2004-05 biennium. The department estimates that 107 positions will be eliminated by June 30, 2005.

Background

The Department of Human Service's FY 2003 General Fund operating budget totals $78.9 million. This figure includes amounts budgeted for central office administration, children's services management, health care management, continuing care management, and economic support management.

The Department is proposing to reduce operating expenditures and positions during FY 2004-05, as well as absorb any operating cost increases that result from the implementation of necessary program reductions.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	0	($14,792)	$14,792	0
Revenues	0	0	0	0
Net Fiscal Impact	0	($14,792)	$14,792	0

Recommendation

The governor recommends delaying payment to counties within calendar year 2005 for specific adult mental health and developmental disability grants. Calendar year 2005 county allocations for these grants are not affected by this proposal.

Background

Grants affected by this shift include: Rule 12 adult residential grants; adult mental health initiative/integrated fund grants; Rule 78 adult mental health grants; Semi-Independent Living Skills (SILS) grants; and Family Support Grants (FSG). Under the Governor's recommendation, total budgeted amounts for these grants in FY 2005 will be $40.9 million.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	0	0	0	0
Revenues	$1,225	$1,225	$1,225	$1,225
Net Fiscal Impact	($1,225)	($1,225)	($1,225)	($1,225)

Recommendation

The Governor recommends increasing revenues by establishing and increasing licensure fees for DHS licensed facilities in state statute.

Background

License fees are established in Minnesota Rules, parts 9545.2000 to 9545.2040. The rule was adopted in September 1986 with the last scheduled fee increase 7-1-91. Because the rule was adopted in 1986, it does not address all the current types of services licensed. Thus, interpretations are made to establish fees for some services.

M.S. 16A.1283 requires legislative approval of a fee increase:

> **M.S. 16A.1283 Legislative approval required.** (a) Notwithstanding any law to the contrary, an executive branch state agency may not impose a new fee or increase an existing fee unless the new fee or increase is approved by law. For purposes of this section, a fee is any charge for goods, services, regulation, or licensure, and, notwithstanding paragraph; (b) clause (3) includes charges for admission to or for use of public facilities owned by the state.

Because the license fee schedule and the amount of the license fee will change, the governor is requesting that the legislature approve these proposed changes.

Currently, approximately $775,000 is collected each calendar year from the 3,800 licensed programs. Revenues are captured in the second quarter of the fiscal year (October – December) for the approaching calendar year. The amount varies greatly by type of program and the number of clients served:

⇒ Family systems programs (family child care, family foster care, and adult foster care) are exempt from license fees.

⇒ Child care centers pay a base rate of $27.50 plus $3 times the licensed capacity.

⇒ Residential programs pay a base rate of $55 plus $8 times the licensed capacity.

⇒ Developmental Disability waiver services are issued a county specific license and pay a base rate of $55 plus $8 times the number of clients served on July 1.

⇒ Outpatient chemical dependency programs pay a base rate of $55 plus 80 cents times the number of persons served in the previous year.

⇒ Child placing agencies pay a base rate of $55 plus 80 cents times the number of adoption decrees and foster homes supervised in the previous year.

⇒ Mental health clinics pay a certification fee of $875 for the first year and $437.50 for subsequent years. All license fees are prorated for the months remaining in the year. A new program licensed in July would pay one-half the annual fee.

Under this proposal,

⇒ Fees would be established in statute.

⇒ Applicants would pay an application fee ($500) that would include the first year license fee (would not be prorated).

⇒ Except for child care centers, license fees for nonresidential programs with a specific licensed capacity and for residential programs will be based on the program's capacity, according to the same fee schedule, and will range from $400 to $2,500.

⇒ License fees for nonresidential programs without a licensed capacity will be a flat rate fee of $400.

⇒ Child care centers have a separate fee schedule that continues to recognize the historically lower licensure fee for these services, and will range from $300 to $2,000.

⇒ State programs would be exempt from license fees.

To generate $1.225 million in additional revenue, the average license fee would be increased by approximately 250%. Specific programs could see increases of as much as 400-500%. Even with the increase in license fees, license fees are a small component of a program's overall operating costs. As such, except for programs serving extremely small numbers, the fee impact would not have a significant impact on operating costs. Further, competition in many areas would limit the ability to pass through increased operating costs to consumers.

Some programs could move from a higher capacity to a lower capacity especially if they are near a fee break point (for example, a child care center serving 75 children would pay $750 whereas a child care center serving 74 children would pay $600). However, the loss in revenue would be many times more than the license fee increase. For example, in a child care center charging $3 per hour per child (infants are much higher), one additional child would generate $6,000 per year ($3 per hour x 8 hours per day x 5 days per week x 50 weeks per year). While it is possible to build in more fee levels to smooth out the costs between the different capacities, a majority of the programs have a capacity of less than 25 (64%) with approximately 80% of the programs serving less than 50 clients. As shown in the preceding example, the licensed capacity of the program is not dictated by the license fee, but by other factors.

Relationship to Base Budget

This proposal does not replace General Fund expenditures related to DHS licensing activities (current budget is approximately $3.6 million). However, it does generate increased revenue to the General Fund for other purposes.

Minnesota Statutes, sec. 16A.1285, subd. 2, states that, unless otherwise provided by law, specific charges must be set at a level that neither significantly over recovers nor under recovers costs, including overhead costs, involved in providing the services.

The General Fund budget for licensing activities is approximately $3.6 million. The legislature has exempted certain activities from any fee – specifically, background studies and family systems programs. The background study and family systems costs are approximately $1.6 million. Excluding those costs from the budget requires that license fees generate approximately $2 million to fully recover costs.

Statutory Change: M. S. 245A.10.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	0	0	0	0
Revenues	$2,075	$2,075	$2,075	$2,075
Net Fiscal Impact	($2,075)	($2,075)	($2,075)	($2,075)

Recommendation

The governor recommends a redesign of the parental fee schedule to a sliding fee payment structure comparable to other DHS premium-based healthcare programs.

Background

Currently, parental fees are assessed to parents of children on TEFRA , Home and Community-Based Services (HCBS) Waiver Options, and certain out of home placements.
The parental fee is determined by analyzing

- the family's adjusted gross income;
- family size, to determine parental income deduction;
- whether the child lives at home;
- whether the family carries private health care coverage; and
- whether child support payments are being made.

Under the current program families receive a parental income deduction which is equal to 150% of the federal poverty guideline for the applicable household size. In addition, the family receives a $200 per month reduction to the amount of the fee if the child resides in the home. Noncustodial parents receive a reduction in the amount of the fee equal to the amount of court-ordered child support that he or she pays for the child.

The parental income deduction and fee reductions are unique to the parental fee program. These deductions are not allowed in other premium-based programs administered by DHS such as MinnesotaCare and Medical Assistance for Employed Persons with Disabilities (MA-EPD).

The Parental Fee program was implemented at a time when the department had little experience with premium-based programs. However, with the creation of MA-EPD and MinnesotaCare, DHS is prepared to align the Parental Fee program with other premium-based health care programs.

Under the new Parental Fee payment structure, the $200 per month fee reduction would be replaced with a $200 per month income deduction if the child resides in the home. The child support fee reduction would also be replaced with an income deduction. The current parental income deduction would be eliminated (this deduction is currently equal to 150% of federal poverty guidelines). A payment schedule very similar to MA-EPD and MinnesotaCare will be implemented. Under the new payment schedule, the following steps would be used to calculate the fee:

⇒ Families with income below 100% of poverty will not pay a fee.
⇒ Families with income at or above 100% of poverty and below 175% of poverty will pay a $4 per month fee.
⇒ The sliding fee scale begins at 1% of income at 175% of poverty and increases to 7.5% of income for those with incomes at 375% of poverty.
⇒ For families with income above 375% of poverty and below 675% of poverty, the fee is 7.5% of adjusted gross income.
⇒ For families with income at or above 675% of poverty and below 975% of poverty, the fee is 10% of adjusted gross income.
⇒ For parents with income at or above 975% of poverty, the fee is 12.5% of adjusted gross income.

This proposal aligns the parental fee with premiums assessed to other health care program families, applies a principle of ability to pay in making decisions on what programs will be reduced and/or cut and generates additional revenue to the General Fund. The proposal also preserves a level of no fees for very low-income families and charges minimal fees for families with incomes below 175% of poverty.

For comparison: A family of four with monthly income of $3,018 or 200% of poverty would pay $54 per month under the new parental fee payment structure and $59 per month for a MinnesotaCare family covering one person. If the monthly income for this family of four was $4,149 or 275% of poverty, the parental fee would be $176 per month under the new fee structure and $121 per month under MinnesotaCare.

Relationship to Base Budget

The new parental fee payment structure is estimated to generate approximately $4.15 million to the General Fund over the biennium.

The automated system needs for this proposal are in place; however, some administrative implementation work is required. The department will notify current program participants by mail of the changes to the fee structure.

Statutory Change: M.S. 252.27.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($12,500)	($25,000)	0	0
Revenues	0	0	0	0
Net Fiscal Impact	($12,500)	($25,000)	0	0

Recommendation

The governor recommends consolidation of a variety of existing programs to support counties in ensuring the safety, permanency, and well-being of children and young adults. The consolidated grant will increase county flexibility and provide financial incentives for performance and accountability for outcomes. This proposal also includes a time-limited funding reduction.

Background

This proposal combines funds from the following state grants and eliminates the specific programs

- Community Social Services (CSSA) Grants;
- Family Preservation Grants;
- Rule 78 Children's Mental Health Grant;
- Mental Health Adolescent Services;
- CMH Collaborative Wraparound Grant;
- Juvenile MH Screening;
- CMH Homeless Children Grants;
- Crisis Nursery Grants;
- Homeless Children Grants;
- Children with Substance Abusing Mothers Grants;
- Red Lake Grants to Beltrami and Clearwater counties.;
- Fetal Alcohol Intervention, Education and Advocacy Demonstrations;
- Children whose Mothers were Incarcerated Grants;
- Social Services Supplemental Grants;
- Hennepin County Social Services Grants for Group Residential Housing Recipients;
- Minority Placement Grants; and
- Training of Criminal Justice.

This proposal combines the following federal grants into consolidated grant allocations to counties

- Title XX Social Services Grants and
- Title XX Concurrent Permanency Planning (TANF) Grants.

CSSA and Title XX Social Services Block Grants are flexible state and federal grants to counties for social services. This proposal redirects these and other categorical grants and aids for social services to children and families into a performance-based fund dedicated to child and adolescent outcomes of safety, permanency, and well-being. Focusing on performance standards enables the state to leverage more purchasing power from its grant programs. The Social Services Information System currently collects much of the outcome data. Counties can review their status through this system on a regular basis throughout the year.

No new service mandates will be imposed on counties as part of this proposal and specific mandate reductions will be made. The Community Social Service Act process requirements under Minnesota Statutes, section 256E will be repealed and a new Children and Community Services Act will be instituted. To provide counties greater flexibility, maintenance of effort requirements that exist under the current programs will be eliminated along with those program's requirements.

Funds will be distributed to each county board as follows:

⇒ For 7-1-03 through 12-31-03, funds will be allocated to each county equal to that county's allocation for the former children's services and community service grants for calendar year 2003 less payments made on or before 6-30-03 for these allocations.

⇒ For calendar year 2004, available funds will be allocated to each county in proportion to that county's proportion of the calendar year 2003 allocations for the former children's services and community service grants allocation to the statewide total of calendar year 2003 allocations for the former children's services and community service grants.

⇒ For calendar year 2005 and each calendar year thereafter, 95% of available funds will be allocated to each county in proportion to that county's proportion of the previous calendar year's children and community service grant to the statewide total for the same period. Five percent of available funds will be used as incentive payments for counties based on actual county performance on several specific outcome measures.

Relationship to Base Budget

The existing base budgets for the grants listed above will be transferred for the purpose of creating a single combined grant allocation to counties. To support the overall state budget, one time reductions will occur in FY 2004 and 2005.

Key Measures

- Specific measures on child safety, permanency and well-being

More information on key measures is available on the Web:
http://www.departmentresults.state.mn.us/hs/index.html.

Statutory Change: M.S. 245.4886; M.S. 245.496; M.S. 254A.17; M.S. 256E; M.S. 256F; M.S. 257.075; M.S. 257.81; M.S. 260.152; M.S. 626.562

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	$0	$2,177	$6,818	$9,968
Revenues	0	0	0	0
Net Fiscal Impact	$0	$2,177	$6,818	$9,968

Recommendation

The governor recommends funding the non-federal share of the projected shortfall in adoption assistance (AA) and relative custody assistance (RCA) grants.

Background

Funding this shortfall will provide permanency for over 960 children with special needs in FY 2004 and an additional 960 in FY 2005 through adoption and assistance to relatives. These are children with special needs that the juvenile court determines cannot return to their parental home and who are now wards of the state. This request also supports the annualized cost of children who entered the program from the previous biennium and makes changes to facilitate the support of American Indian children through these programs.

In the previous biennium, the legislature did not fund projected growth for adoption assistance (AA) and relative custody assistance (RCA) for FY 2004 and FY 2005. Current forecasts for the programs suggest a biennial deficit in the RCA program for existing children who entered during the current biennium. This proposal requests funds to fill the RCA base deficit as well as cover growth projections in the following biennium. Minnesota was able to receive federal approval for a federal match on child care expenses by adoptive families in the AA program. As a result this program requires less base level funding for children currently on the program but needs additional funding to cover new children projected to enter the program in FY 2005 and on. A one-time federal fund balance in Adoption Assistance of $2 million reduces the FY 2004-05 General Fund request.

Adoption assistance and relative custody assistance address the governor's commitment to protecting vulnerable children. Adoptive parents and legal custodians assume parenting responsibility for children who have experienced serious neglect and often emotional or physical abuse. Many have additional neurological or medical issues. Commitment to parenting these children quite often requires psychological, medical, educational, and social services. Many parents adopting such children simply cannot meet their obligation to be good parents if they do not have the necessary financial and other supports to address the special needs. These children would continue to be wards of the state and counties would continue to pay their foster care costs if not for the efforts of new families willing to make these children one of their own. Close to 600 children per year experience a termination of parental rights and are in need of adoption. Another 400 children per year experience a transfer of permanent legal and physical custody to a relative or person significant to the child. These children have suffered significant neglect or abuse and have needs that prospective adoptive parents or prospective legal custodians cannot meet without additional financial support.

Adoption Assistance: The AA program provides financial assistance to purchase necessary ongoing services and reimbursements for specialized services integral to addressing the child's special needs. Caseload growth is primarily a function of the number of children with special needs committed to state guardianship and the state's and counties' success in finding and supporting adoptive families. For 80% of these children, federal Title IV-E funding covers half of the assistance.

Relative Custody Assistance: RCA is funded entirely with state dollars. It provides the same level of monthly financial assistance to the relative or person significant to the child accepting permanent legal and physical custody as the child would be eligible for under the adoption assistance program, except that the monthly payment is adjusted based on the relative custodian's gross family income. The juvenile court must first determine that it is in the child's best interests to transfer permanent legal and physical custody rather than terminate parental rights. Thus, there is little or no difference in the needs of children experiencing a transfer of permanent legal and physical custody versus those experiencing a termination of parental rights.

There is a high degree of interactivity among foster care, adoption assistance, and relative custody assistance. Children reside in foster care and other residential treatment facilities during family reunification efforts. The primary permanency options for children who cannot return home are adoption or transfer of permanent legal and physical custody.

In addition, this initiative allows otherwise eligible children committed to the guardianship of the child's Tribal Social Service agency to be eligible for state funded adoption assistance and allows otherwise eligible children, adopted through "Customary Tribal Adoption" who are not eligible for federal Title IV-E Adoption Assistance, to receive state-only funded AA grants.

Funding this proposal will prevent reductions in ongoing assistance to children in need of and receiving assistance. The ability to find permanent homes will be strengthened, thereby avoiding the higher overall costs associated with the foster care system.

Additional information on adoption assistance and relative custody assistance can be found at:
http://www.dhs.state.mn.us/childint/social_serv_manual/ssmpdf/xiv1000.pdf
http://www.dhs.state.mn.us/childint/social_serv_manual/ssmpdf/xvi9000.pdf

Relationship to Base Budget

Child foster care expenditures currently total $82 million a year ($50 million of local county dollars, $15 million of federal dollars, $7 million of Community Social Services Act dollars, and $10 million in miscellaneous fees) and averages about $8,500 per child per year. Counties will see direct local savings of approximately $5,000 per child per year as a result of placing a child from foster care into a family receiving adoption assistance. For every 500 children placed in a year, counties would lower their local costs by approximately $2.5 million.

Base level funding: Adoption Assistance $20,460,000; RCA $4,746,000

Key Measures

- Children in out-of-home placements
- Adoptions of children under state guardianship

More information on key measures is available on the Web:
http://www.departmentalresults.state.mn.us/hs/index.html.

Statutory Change: M.S. 259.67

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($429)	($854)	($849)	($841)
Revenues	0	0	0	0
Net Fiscal Impact	($429)	($854)	($849)	($841)

Recommendation

The governor recommends that Medical Assistance (MA) coverage be expanded to include a short-term sub-acute care facility when used as part of a mental health crisis response system for adolescents.

Background

The Minnesota Children's Mental Health Task Force (2002) determined that one of the key issues confronting the children's mental health system is the well-publicized shortage of acute care hospital capacity for adolescents in emotional or psychiatric crisis. The Attorney General, the Department of Human Services, and other state and local metropolitan agencies have been collaborating to address the problem by improving community-based crisis response services. A crisis response system developed in the city of Baltimore is being used as a model in these efforts. One important resource employed in the Baltimore system and absent in Minnesota is a small short-term sub-acute care facility. The facility will serve adolescents in crisis who do not need hospital level care and will also serve as a short-term transitional resource for adolescents stabilized in the hospital and awaiting the development of the community supports necessary to allow their safe return to the community.

This proposal allows the Medical Assistance program to reimburse per diem costs of care for MA eligible children in the facility under the psychiatric services for individuals under 21 provisions in federal Medicaid law.

Relationship to Base Budget

Currently, over $150 million in state, federal and county funds are expended each year to provide mental health services for children with emotional disturbances. Medical Assistance fee-for-service payments for acute care psychiatric services in community hospitals during calendar year 2001 were over $7.5 million dollars. Because of the inherently high cost of hospital care, the proposed model is a cost-effective approach to meeting the needs of adolescents in emotional or psychiatric crises.

Statutory Change: MS 256B

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	$175	$1,773	$1,859	$1,947
Revenues	0	0	0	0
Net Fiscal Impact	$175	$1,773	$1,859	$1,947

Recommendation

The governor recommends improvements to the accessibility and effectiveness of community-based children's mental health services within the Medical Assistance (MA) program.

Background

This proposal draws on the findings and recommendations of the Children's Mental Health Task Force.

Minnesota's MA benefit set for community-based children's mental health rehabilitation services has been implemented piece by piece since the passage of the Children's Mental Health Act in 1989. As a result, the current benefit set is composed of a variety of categorical services constrained in ways that often limit consumer choice and the ability of service providers to fit the services delivered to the needs of the child and his or her family. The department proposes to accomplish this through the following steps:

⇒ Remove county contracting requirement from provider enrollment. This will allow more providers to offer services in a broader number of counties thereby improving access and increased choice of providers to Minnesota families.

⇒ Dismantle the current Family Community Support Services, Home-Based Mental Health Services, Day Treatment, and Therapeutic Support of Foster Care benefits into their component parts (primarily psychotherapy and skills training) and reconfigure the benefits through an individually-tailored assessment and authorization process. Children will then be able to access the services that best meet their needs where they need them.

⇒ Expand eligibility from children with severe emotional disturbance (SED) to children with emotional disturbance (ED) when warranted through the individualized authorization process. Children with emotional problems can receive services earlier, before problems become severe.

The Department proposes to remove the county contracting requirement effective 7-1-03 and to implement the remaining provisions a year later. The extra time is necessary in order to develop and train providers on the new individualized authorization process.

Relationship to Base Budget

Since original implementation, community-based children's mental health services within the MA benefit have been utilized at a rate well below that projected based on estimates of prevalence and service eligibility. Together, the changes proposed here are expected to increase utilization of community-based mental health rehabilitation services for MA eligible children by about 25%.

Key Measures

- Children in out-of-home placements
- Children who receive mental health services while on Minnesota Health Care Programs

More information on key measures is available on the Web:
http://www.departmentresults.state.mn.us/hs/index.html.

Statutory Change: M.S. 256B

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	$0	$2,733	$3,827	$5,467
Revenues	0	0	0	0
Net Fiscal Impact	$0	$2,733	$3,827	$5,467

Recommendation

The governor recommends implementation of a state-wide mental health screening for the identification of untreated emotional disorders of adolescents and children in the juvenile justice and child welfare systems.

Background

The Minnesota Children's Mental Health Task Force (2002) determined that one of the key issues confronting the children's mental health system is the need for earlier identification and treatment of emotional disorders. Based on the Surgeon General's Report of the Conference in Children's Mental Health (2001), the task force estimated that while one in 10 children suffers from an emotional disorder, only 20% of those children receive treatment. Further, the task force studied literature demonstrating that children's emotional problems can be treated effectively by evidence-based practices, with best outcomes associated with early and intensive intervention.

While emotional disorders affect children in all social strata, some groups of children are at particularly high risk, especially those in the child welfare and juvenile justice systems. The task force recommended that first steps be taken to screen these children as early as possible.

Relationship to Base Budget

Currently, over $150 million in state, federal and county funds are expended each year to provide mental health services for children with emotional disturbances. Similarly, Minnesota school districts are expending over $130 million each year in special education funds for children with emotional-behavioral disorders (E/BD). An estimated 70% of children in the juvenile justice system have emotional problems that contribute to their criminal behavior. The total public cost of childhood mental health problems is significant. Given evidence that emotional problems can be treated effectively, with best outcomes associated with early and intensive intervention, this proposal should benefit a broad range of publicly funded programs.

With the identification of emotional disorders in children comes an obligation to assist the children and their families in overcoming these disorders. This proposal includes funds for the additional mental health assessments and services for children identified through the screening. The department also intends to help counties maximize existing private third-party insurance resources for the services.

Key Measures

- Children in out-of-home placements
- Children who receive mental health services while on Minnesota Health Care Programs

More information on key measures is available on the Web:
http://www.departmentresults.state.mn.us/hs/index.html.

Statutory Change:

- M.S. 260B
- M.S. 260C
- M.S. 626

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	$11	($25,129)	$25,129	0
Revenues	0	0	0	0
Net Fiscal Impact	$11	($25,129)	$25,129	0

Recommendation

The governor recommends that the last FY 2005 Medical Assistance and General Assistance Medical Care payments to providers for basic fee-for-service health care be delayed until FY 2006.

Background

Provider payments are made every two weeks. If the last payment of the fiscal year is delayed until the next fiscal year, then the costs for that payment are moved from one fiscal year to the next.

Relationship to Base Budget

The savings shown in this proposal are the estimated value of one fee-for-service payment for all providers, excluding managed care, nursing home, Intermediate Care Facilities for Mental Retardation, and waiver service providers. Modifications to the Medicaid Management Information System (MMIS) would be required in FY 2004.

Statutory Change: Not applicable.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($13,716)	($12,392)	($11,758)	($12,948)
Revenues (DHS)	1,241	1,322	1,447	1,594
Revenues (MDH)	767	817	895	985
Net Fiscal Impact	($15,724)	($14,531)	($14,100)	($15,527)

Recommendation

The governor recommends decreasing Medical Assistance (MA) and General Assistance Medical Care (GAMC) payments 5% for inpatient and outpatient hospital services. The reduction excludes payments for inpatient mental health and Indian Health Services. General Fund revenues will also be increased through an associated intergovernmental transfer.

Background

A ratable reduction on payments has been used historically as a method of attaining budget savings. This proposal is limited to hospital services because they have had payment increases in recent years while most other service providers have not. For example, outpatient hospital services were increased 12% in 2000 due to the adoption of a prospective payment system. Inpatient hospital services were be increased 5.3% in 2003 due to rebasing the cost data forward two years. In addition, two hospitals were paid over $13 million in net gains from an intergovernmental transfer (IGT) in 2002. This IGT is expected to continue with net gains of $3 million per year.

This proposal also redirects the increased IGT net revenues generated by the ratable reduction to the General Fund. This is necessary to avoid an increase in payments to IGT hospitals, community clinics, and rural hospitals at the expense of other hospitals.

This proposal excludes inpatient hospital mental health services from the ratable reduction because of a current shortage of these services. Since mental health is 16% of inpatient payments, the 5% reduction is actually 4.3%. Facilities of the Indian Health Service are also excluded because those rates are based on a federal methodology and MA payments are 100% federally funded.

Relationship to Base Budget

With the past and anticipated increases in payments, hospitals will still see gains in payment levels. After the reduction, hospitals will still have payment levels that are somewhat higher than other provider groups.

The ratable reduction requires a change to the Medicaid Management Information System (MMIS). However, this will not prevent timely implementation.

Statutory Change: M.S. 256B.195; M.S. 256.929, subd. 3(a); M.S. 256B.32; M.S. 256B.75

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	0	($3,327)	($14,827)	($16,211)
Revenues	0	0	0	0
Net Fiscal Impact	0	($3,327)	($14,827)	($16,211)

Recommendation

The governor recommends that biennial rebasing of Medical Assistance (MA) inpatient hospital payment rates to more current cost data be discontinued.

Background

Current law requires the department to rebase each hospital's MA rates forward every two years based on the costs of each hospital. Essentially, this process incorporates hospital-specific inflation into the payment rates. Hospital rates were last rebased in 2003 which resulted in average rate increases of 5.7% under the MA program. No other provider has their own individual inflation automatically built into their rates.

This proposal eliminates the rebasing increase to hospital rates. To rebase rates could result in large increases for some hospitals at a time when other providers of medical services haven't had an increase in many years. In 2007, hospitals would then have rates based on costs that are moved forward four years. Rates would catch up to costs at that time.

In addition to individual cost-based rates, more than 30% of the hospitals are paid a disproportionate share add-on that ranges up to 54% of their base rate. Ninety-one hospitals are classified as small and rural for purposes of a payment add-on to their rates of either 15% or 20%.

A separate proposal would reduce hospital rates by 5%. It should be noted that this would result in less of a reduction in the 2003-2005 rates than the 2003 rebasing increased rates.

Relationship to Base Budget

After the elimination of rebasing, hospitals will not have decreased rates for two years, but will still be paid based on more current costs than other providers of medical services.

Statutory Change: M.S. 256.969, subd. 2b.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($4,294)	($2,440)	$0	$0
Revenues	0	0	0	0
Net Fiscal Impact	($4,294)	($2,440)	$0	$0

Recommendation

The governor recommends that medical education payments be eliminated from General Assistance Medical Care (GAMC) managed care payment rates.

Background

Managed care rates to health plans currently include payments for medical education. The amount, however, is transferred into the medical education trust fund for distribution. Payments to the trust fund from the managed care rates and intergovernmental transfers have increased over the past years from $26 million in FY 2002 to a projected $71 million in FY 2005.

Because the GAMC program would be consolidated with the MinnesotaCare program under the Governor's proposal, the reduction in GAMC contributions to the medical education fund would occur anyway, but just at a later time.

Relationship to Base Budget

After elimination of the medical education payments from the GAMC managed care rates and a 37% reduction in the MA managed care withhold, payments to the medical education trust fund will still exceed an estimated $55 million in FY 2004, not including the fee for service payments.

Statutory Change: M.S. 256B.69, subd. 5c.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($14,265)	($15,364)	($16,886)	($19,327)
Revenues	0	0	0	0
Net Fiscal Impact	($14,265)	($15,364)	($16,886)	($19,327)

Recommendation

The governor recommends that Medical Assistance (MA), General Assistance Medical Care (GAMC), and Prescription Drug Program (PDP) payment rates for pharmacy claims be reduced by using maximum allowable costs for more drugs and changing the average wholesale price discount applied.

Background

Federal and state statutes and regulations specify that the department is supposed to reimburse the actual acquisition cost (AAC) of a drug plus a "reasonable" dispensing fee. Where *AWP* represents average wholesale price, *AWP–14%* is a better estimate of AAC than *AWP–9%*. The Office of Inspector General (OIG) recently released a report indicating that the AAC ranges from *AWP–17.2%* to *AWP–72.1%*, depending on the type of drug. By changing to *AWP–14%* the department is complying with applicable federal and state requirements. The existing fee of $3.65, when added to the difference between AWP and AAC, constitutes a reasonable dispensing fee.

Prior to the 1999 session, the department had the authority to establish a maximum allowable cost (MAC) for any drug. DHS is now limited to establishing a MAC for only those drugs not already on the federal upper limit (FUL) list. Also, there must be two generic versions of a drug available before a MAC can be established. The use of MACs strongly encourages pharmacists to dispense generic drugs, which are usually far cheaper than the equivalent brand name products. This proposal will allow the department to establish MACs for more drugs than it does currently.

Therefore, the governor recommends changing the estimate of a drug's actual acquisition cost from *AWP-9%* to *AWP-14%*. The governor further recommends amending statute to allow for the establishment of maximum allowable costs for more drugs.

Relationship to Base Budget

This measure represents approximately 5.7% of the state share of fee-for-service expenditures for prescription drugs that are dispensed by a pharmacy. This proposal requires minimal administrative and system changes.

Statutory Change: M.S. 256B.0625, subd 13.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($402)	($949)	($1,073)	($1,230)
Revenues	0	0	0	0
Net Fiscal Impact	($402)	($949)	($1,073)	($1,203)

Recommendation
The govenor recommends increasing the use of drug authorizations for dispense-as-written (DAW) claims.

Background
Prescribers can currently indicate that a brand name drug should be dispensed by simply writing "DAW – brand medically necessary" on a prescription. It is usually considerably more expensive to pay for the brand name drug rather than the equally effective generically equivalent drug. DAW prescriptions are often written not because there is a medical necessity, but because the patient has demanded the brand name drug. By requiring prior authorization (PA) for DAW prescriptions, we can ensure that brand name drugs are dispensed only when use of the generic equivalent is truly not appropriate.

This proposal would allow DHS to require prior authorization when a prescriber indicates that a brand name drug is to be "dispensed as written". This would apply in those cases where an AB-rated generic equivalent is available.

Relationship to Base Budget
This measure represents less than 1% of fee-for-service expenditures for prescription drugs that are dispensed by a pharmacy.

System changes will have to be made so that DAW prescriptions will require PA. In some cases, it really will be appropriate for a brand name to be used, so DHS will have to pay Care Delivery Management, Inc., for additional PA requests. However, we expect that most prescribers will authorize use of a generic rather than going through the PA process.

Statutory Change: M.S. 256B.0625, subd.13.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($550)	($2,341)	($2,649)	($3,032)
Revenues	0	0	0	0
Net Fiscal Impact	($550)	($2,341)	($2,649)	($3,032)

Recommendation

The governor recommends an increase in the use of hard edits in the Department of Human Services (DHS) pharmacy point-of-sale billing system for Medical Assistance (MA), General Assistance Medical Care (GAMC), and Prescription Drug program (PDP).

Background

By making some pharmacy point-of-sale claims processing edits "hard", DHS prohibits system overrides by pharmacists in order to get a claim paid. DHS does not need new legislative authority to do this. However, the legislature will need to appropriate money for additional staffing.

Currently, pharmacists can easily override the reject edits that the DHS billing system generates. A preliminary data query revealed that from 1-1-02 through 3-3-02, there were 39,256 claims with a 660 or 877 edit, indicating that the drug was being refilled too soon. DHS paid approximately $3.5 million for those claims. This would be approximately $14 million annualized. It would take a detailed analysis to determine how many of those claims are actually inappropriate. However, if only 25% of those claims prove to be inappropriate, savings could be $3.5 million annually.

DHS can greatly reduce this problem by making the edits "hard" (i.e., not allowing pharmacists to override rejects). However, there are sometimes valid reasons for overriding a claim (e.g., a change in dosage). Most private pharmacy benefit managers handle these valid overrides by having the pharmacist contact a help desk. The help desk can override the edit so that the pharmacist can instantly retransmit the claim and have it paid.

Relationship to Base Budget

When fully implemented in FY 2005, this will represent approximately 1% of fee-for-service expenditures for prescription drugs that are dispensed by a pharmacy.

Administrative considerations: Help Desk hours might have to be extended to evenings and weekends. System changes will have to be made to allow Help Desk or claims processing staff to override rejected but appropriate claims.

Statutory Change: Not Applicable.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($493)	($1,275)	($1,565)	($1,892)
Revenues	0	0	0	0
Net Fiscal Impact	($493)	($1,275)	($1,565)	($1,892)

Recommendation
The governor recommends that collection of Prescription Drug Program (PDP) rebates from pharmaceutical manufacturers be increased.

Background
State law establishes that the rebates collected for the PDP "shall be equal to the basic rebate as defined for purposes of the federal rebate program in United State Code, title 42, section 1396r-8(c)(1). This basic rebate shall be applied to single-source and multiple-source drugs." This means that the rebates collected for brand name drugs are lower for the PDP than they are for Medical Assistance. The difference in rebate amounts makes administering the PDP rebate program slightly more difficult than it needs to be. Many other states collect rebates at the full Medicaid rate for their state-funded patient drug assistance programs.

Relationship to Base Budget
The additional rebates collected under this proposal amount to approximately 6.7% of the amount paid to pharmacies for PDP claims.

This change would take approximately six months to implement because manufacturers would have to sign amended rebate agreements. System changes would involve modifications in DRAMS, the rebate system used by the department to mange both Medicaid and PDP rebates.

Statutory Change: M.S. 256.01, subd. 2.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($5,652)	($11,865)	($12,915)	($13,544)
Revenues	40	40	0	0
Net Fiscal Impact	($5,692)	($11,905)	($12,915)	($13,544)

Recommendation

The governor recommends that Medical Assistance (MA) and General Assistance Medical Care (GAMC) managed care rates be reduced due to changes in those programs.

Background

This proposal reduces MA and GAMC payments to managed care organizations by approximately 1% beginning in October 2003 and an additional 1% beginning in January 2004. These amounts equate to the savings related to services provided by health plans that would result from program changes proposed elsewhere in the budget. These include making payment changes to providers that are consistent with the 5% reduction in hospital payments in the DHS proposal, reducing overall plan administrative costs allocated to public programs, and operational efficiencies gained due to the GAMC-MinnesotaCare consolidation.

New federal regulations require that the rates paid to Minnesota health plans for MA and MinnesotaCare be actuarially sound. Mandated rate changes must be based on operating changes that can be implemented by plans. Changes to rates must be reviewed and certified by an actuary and must be approved by the federal Center for Medicare and Medicaid Services (CMS) in order to maintain federal financial participation. Additional actuarial costs will be incurred to make these changes.

Relationship to Base Budget

DHS has already taken significant reductions in managed care over the last two years. June payments have been delayed one month each year since 2002. Rates were increased for the 2003 contract year by 4.6% on average. The 2003 contracts withhold 5% of payments for one year for performance incentives.

Statutory Change: M.S. 256B.69, subd 5h

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($1,783)	($2,100)	($2,100)	($2,100)
Revenues	0	0	0	0
Net Fiscal Impact	($1,783)	($2,100)	($2,100)	($2,100)

Recommendation

The governor recommends elimination of the state subsidy of the county share for Prepaid Medical Assistance Program (PMAP) administration for all counties where PMAP has been in place for more than twelve months.

Background

PMAP requires that each county provide certain functions that administratively support the program. These include education enrollment and advocacy for PMAP enrollees. Since the implementation of that program, the state has supported these county administrative functions by paying the county share of the Medical Assistance (MA) administrative funds. The counties then can draw down federal match for the MA administrative funds.

Beginning in FY 2004, this proposal would discontinue the state subsidy of the county share for PMAP administration for all counties where PMAP has been ongoing for more than 12 months. Under this proposal, the state would continue to provide funding only in areas where PMAP enrollment is being newly established. This proposal would fund counties for a period of 16 months (4 months prior to beginning of enrollment and the first 12 months of enrollment) at the conversion level of funding of $11.35 per enrollee based on average annual enrollment projections. This proposal would also support the enrollment into PMAP of American Indian recipients living on reservations by funding a tribal advocacy function up to a total of $120,000 per year ($160,000 for 16 months) to be shared across 9 reservation sites for a 16-month period in calendar years 2003-04. Tribes would be able to draw down federal match for MA administration.

Statutory Change: Not applicable.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	$6	($1,775)	($1,878)	($1,766)
Revenues	309	563	590	707
Net Fiscal Impact	($303)	($2,338)	($2,468)	($2,473)

Recommendation

The governor recommends the use of a broker/coordinator to manage non-emergency medical transportation (NEMT) for all Medical Assistance (MA) clients who reside within the seven-county metro area.

Background

From FY 1996 to FY 2001, metro transportation costs paid by MA increased from $12.9 million to $17.3 million in fee-for-service, even though the number of eligible recipients for special transportation decreased steadily during that time. The most expensive form of non-emergency medical transportation—special transportation services—accounted for 92% of all metro MA transportation expenditures in FY 2001. Fee-for-service transportation costs in the metro area are increasing while costs in the non-metro areas are decreasing, even though there are more public transportation options available in the metro area.

Non-emergency medical transportation currently consists of two different delivery systems. Counties administer the common carrier option for non-emergency medical transportation. Special Transportation Services are administered at the state level.

This proposal would have a broker/coordinator handle all aspects of service delivery, including telephone calls, verifying eligibility, screening for appropriate level of transportation, scheduling trips, recruiting providers, monitoring provider and client use, and maintaining outcome and performance data. Clients would have to call only one number to coordinate and secure rides simplifying a currently fragmented delivery system.

A broker system also improves the quality of service delivery. There are numerous concerns about the quality of current special transportation providers. These include such issues as not completed or inadequate background checks, insurance lapses, concerns about the types of vehicles being used, and drivers not completing required training. The broker would be in an excellent position to monitor driver and vehicle requirements, as well as monitor the service itself through the establishment and monitoring of pickup and delivery standards.

The use of a broker/coordinator for non-emergency transportation was a recommendation of a 1997 report on Medicaid transportation by the U.S. Office of Inspector General as well as a highly recommended option in Health Care Financing Administration sponsored reports. The Centers for Medicare and Medicaid Services also supports a broker approach. In the last 10 years, the number of states utilizing some form of a transportation broker/coordinator has increased from one to over 20.

In addition to improved quality and simplified client access, other states have experienced tangible cost savings by switching to transportation brokers.

Relationship to Base Budget

The transportation broker would be responsible for providing non-emergency transportation services for all fee-for-service and managed care enrollees in the seven county metro area. Full implementation of brokered transportation operations would occur by April 2004. This will allow a transition period for counties from the present system to the brokered one.

Statutory Change: M.S. 256B.0625, subd. 17.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($307)	($330)	($363)	($415)
Revenues	0	0	0	0
Net Fiscal Impact	($307)	($330)	($363)	($415)

Recommendation

The governor recommends reductions that Medical Assistance (MA) discontinue coverage of all weight loss products.

Background

Federal law allows state Medicaid programs to exclude from coverage drugs when used for "anorexia, weight loss, or weight gain." When the federal law was written, drugs used for weight loss were appetite suppressants (also known as anorectics or anorexiants). When state law was written, the word "anorectics" was used instead of the phrase contained in federal law. Since that time, a drug has been developed for weight loss that is not an appetite suppressant. Under current state law, we have to cover that drug. The long-term health benefits of the drug are questionable.

Relationship to Base Budget

The savings generated by this proposal represent less than 1% of the fee-for-service drug expenditures.

This proposal would require minimal system changes.

Statutory Change: M.S. 256B.0625, subd. 13.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($1,442)	($2,778)	($4,188)	($5,670)
Revenues	(30)	(49)	(67)	(85)
Net Fiscal Impact	($1,412)	($2,729)	($4,121)	($5,585)

Recommendation

The governor recommends the repeal of Medical Assistance (MA) coverage of the new autism program while continuing to cover treatment of children with autism spectrum disorder through currently covered services.

Background

The 2001 legislature enacted a MA program for children with autism. This new program was scheduled to begin 1-1-03. Children currently in the MA program with autism spectrum disorder are served through other MA coverage, including waivered services, children's mental health services, family-community supports, personal care attendant services, home-based mental health services, and/or behavior aide hours.

Relationship to Base Budget

Elimination of the new MA autism program will reduce current and future General Fund expenditures.

Statutory Change: M.S. 256B.0625, subd. 5a.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($12,535)	($17,179)	($16,630)	($18,408)
Revenues	0	0	0	0
Health Care Access Fund				
Expenditures	($1,452)	($2,531)	($2,870)	($3,199)
Revenues	0	0	0	0
Net Fiscal Impact	($13,987)	($19,710)	($19,500)	($21,607)

Recommendation

The governor recommends the application of copayments to Medical Assistance (MA), General Assistance Medical Care (GAMC), and MinnesotaCare. This proposal affects clients receiving services through fee-for-service or through contracted health plans.

Background

The proposal provides for copayments to be applied to the following services provided to adults age 21 and over, beginning 10-1-03:

- non-preventive office visits, $3;
- eyeglasses, $3;
- non-emergency visits to the emergency room, $6; and
- drugs, $1 co-payment for generic drugs, $3 co-payment for brand name drugs.

Copayments are not currently applied to Medical Assistance (MA) and General Assistance Medical Care (GAMC) enrollees. Adults in MinnesotaCare (except pregnant women) currently have a $3 co-pay on drugs and a $25 co-pay on eyeglasses. MinnesotaCare adults under 175% federal poverty guidelines have a 50% co-pay on restorative dental services. Some adults in MinnesotaCare have a 10% co-pay on inpatient hospital services.

Federal Medicaid law requires that co-pays not exceed $3 per service. Co-pays greater than $3 require the submission of a waiver to the Centers for Medicare and Medicaid Services (CMS). In recent years, CMS has approved state requests to charge $6 for non-emergency visits to the emergency room when the state certifies that enrollees have access to non-emergency services in other locations. Federal law prohibits the application of co-payments to children under 18; pregnant women for services that relate to pregnancy or to any other medical condition that may complicate the pregnancy; people residing more than 30 days in “medical institutions” which include hospitals, nursing homes, and ICFs/MR; or people receiving hospice care. In addition, co-pays cannot be charged for emergency services or family planning services.

The department would amend managed care contracts and rates, get actuarial certification for the amended capitation rates, and submit the amended contracts and rates for approval by the federal government. Health plans would have to amend their contracts with providers to require providers to collect the co-payments and would have to issue new certificates of coverage and member identification cards to members affected by the new co-payment requirements. Extensive MMIS systems changes will be needed to implement this proposal on the fee-for-service side.

Relationship to Base Budget

The addition of co-payments to non-emergency ER services, eyeglasses, non-preventive office visits, and drugs in the MA and GAMC programs will have the immediate and ongoing effect of lowering state expenditures.

Implementation would involve

- sending a notice to approximately 550,000 adult clients regarding the change;
- sending a Provider Update to all enrolled dental providers regarding the change;
- altering the MMIS system so that payment rates are adjusted to reflect co-pays;

- adjusting managed care rates and contracts to reflect the changes;
- seeking federal approval for amended rates and contracts; and
- coordinating with the health plans to ensure that the implementation occurs in a timely, smooth manner.

Federal compliance issues, such as the exclusion of co-payments for institutionalized people, have been factored into the costs of the proposal.

Statutory Change: M.S. 256B.03, subd. 4(e); M.S. 256L.03, subd. 5.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	$656	$510	$510	$510
Revenues	224	204	204	204
Net Fiscal Impact	$432	$306	$306	$306

Recommendation

The governor recommends an increase in the General Fund budget to address administrative changes necessary to comply with federal Medicaid managed care requirements.

Background

New federal Medicaid managed care regulations require that the state's Medical Assistance (MA) managed care programs (Prepaid MA Program, Minnesota Senior Health Options, and Minnesota Disability Health Options) make changes. Changes which require additional funding include

- additional clerical staff and funding for changes to appeal database needed to ensure tracking and timely decisions for state fair hearings;
- funding needed for actuarial contracts, to assure CMS that rates and payments are actuarially sound;
- changes to enrollment system to meet federal requirements, including re-enrollments, and collecting and transmitting to the health plan the race, ethnicity, and language spoken of each individual;
- additional professional staff needed to
  - ⇒ oversee managed care credentialing process;
  - ⇒ manage implementation and performance measurement of clinical practice guidelines;
  - ⇒ develop health care education and managed care performance materials for clients;
  - ⇒ develop mechanisms for conveying language, ethnicity, and other data (e.g., special needs information) to health plans; and
  - ⇒ monitor development and provision of culturally competent care; assess and monitor health care access standards, including ongoing monitoring of health plan networks and timely access to services; and
- increases for printing and mailing additional materials to enrollees and potential enrollees.

Relationship to Base Budget

This proposal is crucial to the Medical Assistance (MA) program in that compliance with these federal regulations will assure that DHS continues to earn federal financial participation (FFP) for all of its MA services.

Statutory Change: Not Applicable.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($7,449)	($7,628)	($4,443)	($4,805)
Revenues	0	0	0	0
Net Fiscal Impact	($7,449)	($7,628)	($4,443)	($4,805)

Recommendation

The governor recommends discontinuing one-month rolling eligibility for Medical Assistance (MA) recipients enrolled in the Prepaid MA Program (PMAP).

Background

Under current law, certain individuals who are late submitting income reports required to maintain eligibility are not terminated from managed care immediately. They have until the beginning of the next month to submit required paperwork. They remain enrolled in the health plan. This is known as "one-month rolling eligibility." This has resulted in increased continuity of care for many individuals and families as well as reducing administrative burden for health plans and counties. On average about 4,500 individuals per month fail to submit the required income reports. Approximately 75% of persons who do not initially submit their income reports in a timely manner do submit required materials and remain eligible for the programs in which they were enrolled. This proposal removes the one-month rolling eligibility period. Individuals who fail to submit required income reports would be disenrolled from managed care plans. Individuals who submit required information and who remain eligible will have eligibility restored and will be served under the fee-for-service program until the following month when they will re-enroll in managed care.

This proposal reflects the proposed consolidation of GAMC and MinnesotaCare.

Relationship to Base Budget

The savings shown in this proposal reflect the savings for the one-month rolling eligibility period for the 25% who do not remain eligible.

Statutory Change: M.S. 256B.69, subd. 2 (e)

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	0	0	($358)	($390)
Revenues	0	0	0	0
Health Care Access Fund				
Expenditures	0	0	($654)	($728)
Revenues	0	0	0	0
Net Fiscal Impact	0	0	($1,012)	($1,118)

Recommendation

The governor recommends the discontinuation of the approval of coverage before receipt of certain verifications for applicants for all health care programs and for MinnesotaCare enrollees whose annual renewals of eligibility are due.

Background

The Legislature implemented delayed verification for MinnesotaCare effective 1-1-99, as a way of reducing application processing time and avoiding coverage gaps. Under delayed verification, eligibility can be approved based on a completed application or renewal form showing that the household meets all eligibility requirements. Coverage then begins the month following the month in which the initial premium payment is received, conditioned upon the receipt of required verification within 30 days. Coverage ends if verification is not submitted or if the verification indicates ineligibility.

Delayed verification was extended the following year to Medical Assistance (MA) applicants whose completed applications showed income and liquid assets within 90% of the applicable limits and to General Assistance Medical Care (GAMC) applicants with reported income within 90% of the limit and liquid assets of no more than $700. Delayed verification is not used at the time of annual renewal for MA and GAMC.

Effective 7-1-05, or 4-1-05 if HealthMatch is operational, delayed verification would be eliminated in MA, GAMC and MinnesotaCare.

Although most people approved under delayed verification submit the verifications within the required time frames and remain eligible, a small proportion either fails to submit verification or is found ineligible based on the submitted information. Eliminating the delayed verification provisions would end short- term conditional coverage for all health care programs. Applicants to the health care programs would be required to submit verification before coverage is approved. MinnesotaCare enrollees would be required to submit timely verification to continue coverage at the 12-month renewal. This could result in lost or delayed coverage.

Relationship to Base Budget

Eliminating delayed verification would result in small program savings since it is a procedural requirement rather than an actual bar to eligibility. Some modifications to the MAXIS system would be required.

Key Measures

- Percent of Minnesotans who have health insurance

More information on key measures is available on the Web:
http://www.departmentresults.state.mn.us/hs/index.html.

Statutory Change: M.S. 256B.061, M.S. 256D.03, subd. 3, M.S. 256L.05, subd. 4.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($45,025)	($163,370)	($304,336)	($326,303)
Revenues	0	0	0	0
Health Care Access Fund				
Expenditures	(68,486)	(47,182)	41,585	34,661
Revenues	0	0	0	0
Net Fiscal Impact	($113,511)	($210,552)	($262,751)	($291,642)

Recommendation

The governor recommends that health care coverage for adults without children on General Assistance Medical Care (GAMC) and MinnesotaCare be consolidated and eligibility be reduced to those with incomes below 75% of the federal poverty guidelines (FPG), with a full-cost premium MinnesotaCare option for people with incomes between 75% and 175% FPG. The governor recommends that the Health Care Access Fund resources and liabilities be transferred to the General Fund at the close of FY 2005.

Background

GAMC currently serves the following citizens and legal non-citizens who meet all other eligibility criteria

- people automatically eligible for GAMC as recipients of General Assistance or Group Residential Housing;
- people ages 21-64 who do are not living with children under age 18, including some living in Institutions for Mental Diseases (IMDs);
- people who are ineligible for federally funded Medical Assistance (MA) solely because they are residing in an IMD;
- undocumented and non-immigrant people who are under age 18, meet the disability criteria of the Social Security Administration, or are age 65 and over; and
- people receiving services through a center for victims of torture who are otherwise ineligible for GAMC.

Emergency GAMC provides emergency care and services for the following groups who meet all other eligibility criteria

- undocumented and nonimmigrant adults ages 21-64 not otherwise eligible for GAMC and
- nonresidents of Minnesota suffering acute trauma from an accident in Minnesota.

Current law allows people on GAMC with incomes greater than 75% of FPG to spend down to achieve eligibility. Assets are limited to $1,000 per household.

MinnesotaCare currently enrolls citizen and lawfully residing non-citizen adults at incomes no greater than 175% of FPG who do not have children under age 21 living with them and do not have access to other insurance coverage. The asset limit is $15,000 for one person and $30,000 for a household of two or more. Under certain conditions, enrollees whose income exceeds 175% of FPG remain enrolled with the payment of a premium under the sliding fee scale until income reaches 275% of FPG, at which point they must pay a full-cost premium.

MinnesotaCare eligibility is currently established for a one-year period during which increases in household income do not impact eligibility or premium amount. MA and GAMC enrollees are currently subject to eligibility reviews at six-month intervals.

Effective10-1-03:

⇒ GAMC would end for all adults without children with gross incomes exceeding 75% of FPG.

⇒ Adults without children on MinnesotaCare with income over 75% FPG up to 175% FPG would be enrolled only with the payment of full-cost premiums.

⇒ GAMC would no longer provide retroactive coverage, currently allowed back to the first day of the month before the month of application; rather eligibility would begin with the date of application.
⇒ The MinnesotaCare asset limits ($15,000/$30,000) would be applied to GAMC.
⇒ GAMC would include a $10,000 cap on coverage for inpatient hospitalization benefits.
⇒ MA-eligible people residing in IMDs would be transferred to the state-funded MA program.
⇒ People receiving services in a center for victims of torture would be transferred to the state-funded MA program, which currently serves immigrants whose status precludes eligibility for federally-funded MA.
⇒ Coverage would be eligible for undocumented and non-immigrant people under age 18, age 65 and over or who meet the disability criteria of the Social Security Administration unless they are receiving services from a center for victims of torture.
⇒ Emergency General Assistance Medical Care (EGAMC) would be eliminated.

Effective 10-1-04:
The GAMC program would be eliminated. Adult enrollees without children who meet all other MinnesotaCare eligibility requirements would be transferred to MinnesotaCare, which would be modified as follows:
⇒ All adults without children would be ineligible for MinnesotaCare if they have access to any employer-subsidized health insurance, regardless of the employer's contribution level.
⇒ Eligibility reviews would occur every six months. The policy would be phased in over the course of one year starting with households that have annual reviews due for 10-1-04. Households would be scheduled for a review six months after their annual renewal. Failure to return the form would result in the entire household being closed.
⇒ Adults without children with incomes no greater than 75% FPG would not have premiums or a 4-month waiting period during which they must be uninsured.
County agencies will continue to administer MinnesotaCare at their option. Enrollees who live in counties that administer MinnesotaCare may choose to receive services from the county agency or MinnesotaCare Operations.

Relationship to Base Budget

This proposal would achieve savings by the consolidation of the two programs and by limiting coverage to the neediest segment of this population. This proposal affects only groups who are currently 100% state funded. It shifts costs for GAMC adults without children from the General Fund to the Health Care Access Fund beginning 10-1-04. The groups transferred to state-funded MA will continue to be funded through the General Fund. In FY 2006, revenues and expenditures of the HCAF would be found in the General Fund.

Six-month eligibility reviews will result in savings due to the termination of households in which income increases over standards and termination of households that fail to return the review forms. Phasing in of this component means that full savings will not be realized until the entire caseload has had six-month reviews, 18 months from the date this is implemented. There would generally be a significant increase in the staff time needed to complete reviews beginning six months after implementation because workers will be reviewing cases due for annual reviews as well as the first round of six-month reviews. Postage and printing costs to issue reviews will also increase. Due to the future availability of HealthMatch, the department is not requesting additional administrative funding for staff at this time. This change will affect both the MAXIS and MMIS systems and will require lead-time to implement. Managed care rates for these groups will need to be renegotiated.

Key Measures

♦ Percent of Minnesotans who have health insurance

More information on key measures is available on the Web:
http://www.departmentresults.state.mn.us/hs/index.html.

Statutory Change: M.S. 256B, M.S. 256D, M.S. 256G, and M.S. 256L.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
Health Care Access Fund				
Expenditures	($3,461)	($15,857)	($25,642)	($34,961)
Revenues	0	0	0	0
Net Fiscal Impact	($3,461)	($15,857)	($25,642)	($34,961)

Recommendation

The governor recommends an increase to premium contributions by parents and pregnant MinnesotaCare enrollees and further modification to MinnesotaCare policy to simplify the administration of the program and align it with Medical Assistance (MA) and General Assistance Medical Care (GAMC).

Background

To enroll in MinnesotaCare, children, parents and pregnant women must have incomes at or below 275% of the federal poverty guidelines (FPG). Premiums are paid on a sliding scale with full cost premiums beginning when family income reaches or exceeds 275% FPG.

If family income exceeds 275% FPG at the time of annual review, the income is compared to the cost of the premium amount for a policy with a $500 deductible available through the Minnesota Comprehensive Health Association (MCHA). If 10% of the gross annual income is less than what the household's MCHA premium would be, eligibility continues. If 10% of the gross annual income is equal to or greater than the MCHA premium, the household is notified that their eligibility will end in 18 months.

Currently, parents with children under age 21 can obtain MinnesotaCare coverage for their other children ages 21 through 24 who are living with them, are full-time students, and are financially dependent upon them. The children meeting these requirements are considered dependent siblings and are eligible if their families' income is equal to or less than 275% of poverty. Twenty-one to twenty-four year olds who do not meet the dependent sibling criteria may be eligible only as adults without children whose income must be equal to or less than 175% FPG. Children eligible as dependent siblings receive the same benefits as adults without children. There is no federal financial participation for dependent siblings.

MinnesotaCare eligibility is currently established for a one-year period during which increases in household income do not impact eligibility or premium amount. Medical Assistance and General Assistance Medical Care enrollees are currently subject to eligibility reviews at six-month intervals.

Effective 2-1-04:

⇒ Parents and pregnant women would be charged a full cost premium if income exceeds 200% FPG and eligibility would end for parents when family income exceeds 275% FPG.

⇒ The dependent sibling eligibility basis for MinnesotaCare would be eliminated. All applicants and enrollees over 21 would have to meet the income standard for adults without children, but their parents' income would not be counted toward that limit. The income standard for adults without children is assumed to be 75% FPG based on the proposal described in the budget page "Consolidate GAMC and MinnesotaCare." Some parents would lose parental status if the only child in the household had been eligible as a dependent sibling. These parents would also be treated as adults without children and would be subject to the 75% FPG standard.

⇒ The MCHA exemption would no longer apply to adults. It would continue to apply to children with family income over 275% FPG. If 10% of the child's family gross annual income were less than the MCHA premium amount, the children would remain eligible with a full-cost premium. If the amount were equal to or greater than the MCHA premium, the household would be notified that the child's eligibility would end in 12 months rather than 18.

⇒ All parents would be ineligible for MinnesotaCare if they had access to any employer-subsidized health insurance, regardless of the employer's contribution level.

Effective 10-1-04:

⇒ All MinnesotaCare households would become subject to review every six months to determine eligibility, premium amount, and benefit set. The policy would be phased in over the course of one year starting with households that have annual reviews due for 10-1-04. Households would be scheduled for a review six months after their annual renewal. Failure to return the form would result in the entire household being closed.

Relationship to Base Budget

Six-month eligibility reviews will increase revenue slightly by increasing MinnesotaCare premiums at an earlier date following an increase in family income. There would also be savings due to the termination of households earlier where income increases over standards and termination of households that fail to return the review forms. Phasing in of this component means that full savings will not be realized until the entire caseload has had six-month reviews, 18 months from the date this is implemented. There would generally be a significant increase in the staff time needed to complete reviews beginning six months after implementation because workers will be reviewing cases due for annual reviews as well as the first round of six month reviews. Postage and printing costs to issue reviews will also increase. Due to the future availability of HealthMatch, the department is not requesting additional administrative funding for staff at this time.

This proposal will require federal approval of an amendment to the MinnesotaCare waiver, which is anticipated to be received by the proposed effective dates.

Key Measures

- Percent of Minnesotans who have health insurance

More information on key measures is available on the Web:
http://www.departmentresults.state.mn.us/hs/index.html.

Statutory Change: M.S. 256L.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
Health Care Access Fund				
Expenditures	($1,440)	($2,404)	($2,584)	($2,778)
Revenues	0	0	0	0
Net Fiscal Impact	($1,440)	($2,404)	($2,584)	($2,778)

Recommendation
The governor recommends that the 7-1-03 expansion of minimum premiums and exemptions from insurance barriers to additional low-income children on MinnesotaCare be repealed.

Background
The 2002 legislature adopted a provision that would increase the income level at which children under 21 in MinnesotaCare pay a minimum $4 monthly premium and are exempt from most insurance barriers. The level is scheduled to increase from 150% of the federal poverty guidelines (FPG) to 175% FPG effective 7-1-03.

Effective 7-1-03, this proposal would retain the current income level of 150% FPG at which childrenunder 21 pay a $4 premium and are exempt from most insurance barriers.

Relationship to Base Budget
This proposal would achieve savings by not implementing the expansion in MinnesotaCare. This change will not require any system modifications as it has not yet been implemented.

Key Measures
- Percent of Minnesotans who have health insurance.

More information on key measures is available on the Web:
http://www.departmentresults.state.mn.us/hs/index.html.

Statutory Change: M.S. 256L.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
Health Care Access Fund				
Expenditures	$97	$339	$518	$562
Revenues	0	0	0	0
Net Fiscal Impact	$97	$339	$518	$562

Recommendation

The Governor recommends an increase in expenditures to treat private cost-effective insurance held by former MA recipients transitioning to MinnesotaCare as exempt from the four-month MinnesotaCare insurance barrier.

Background

Minnesota's MA program requires that private insurance held by a recipient be maintained if it is considered cost effective insurance. As required by federal law, the ongoing premiums are then paid for by MA as a covered service. The private insurance coverage pays for covered health services; MA pays the deductibles, co-insurance, co-pays, and for any services not covered by the private plan but covered by MA.

MinnesotaCare law has never considered MA to be insurance for purposes of the MinnesotaCare insurance barriers. However, in 1999, state law was amended to provide that if a former MA recipient had any other health insurance while on MA, all insurance barriers would apply to that person when the person applied for MinnesotaCare. The legislature intended to treat all MinnesotaCare applicants who had private insurance in the same manner to prevent private market erosion. The MinnesotaCare demonstration waiver protocol was amended to reflect this change.

This proposal would change MinnesotaCare law to exempt former MA enrollees who had private cost effective insurance while enrolled in MA who transition to MinnesotaCare, from the four-month insurance barrier.

Relationship to Base Budget

This proposal would result in some increased eligibility for MinnesotaCare. Minor changes to systems to coordinate with Benefit Recovery may also be required.

Alternatives Considered

Alternatively, a separate program could be created to pay the premiums of private cost-effective insurance for people in higher MinnesotaCare income brackets as part of a larger plan under development to encourage the maintenance of private health insurance.

Statutory Change: M. S. 256L

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($22,944)	($27,178)	($30,524)	($34,621)
Revenues	0	0	0	0
Net Fiscal Impact	($22,944)	($27,178)	($30,524)	($34,621)

Recommendation

The governor recommends the repeal of Medical Assistance (MA) and General Assistance Medical Care (GAMC) eligibility to eliminate eligibility for undocumented or nonimmigrant persons.

Background

Undocumented persons are those immigrants who reside in the United States without legal authorization. Nonimmigrants are persons who have legal authorization to enter the United States for a temporary purpose, such as tourists or students. Currently, undocumented and nonimmigrant persons may be eligible for GAMC if they are under age 18, meet the disability criteria of the Social Security Administration (SSA), or are age 65 and over. Others between the ages of 21 and 65 may be eligible for GAMC only for the coverage of emergency services. In addition, pregnant women may be eligible for MA without federal financial participation for care and services through the period of pregnancy, and 60 days postpartum except for labor and delivery. People who are undocumented or nonimmigrant who have a MA basis of eligibility (i.e. children under 21, parents of children under 18, people age 65 and over, people who are disabled per SSA criteria, and pregnant women) are eligible for emergency services through federally funded Emergency MA (EMA) as mandated by federal law. Emergency services includes the costs of labor and delivery.

Effective 7-1-03, this proposal would eliminate eligibility for all undocumented and nonimmigrant people for GAMC, including coverage of emergency services, and MA without federal financial participation. Such persons would be eligible for EMA, provided they have a basis of eligibility for MA.

Relationship to Base Budget

This proposal would achieve savings by eliminating medical coverage that is currently 100% state funded.

Key Measures

- Percent of Minnesotans who have health insurance

More information on key measures is available on the Web: http://www.mnplan.state.mn.us/mm/goal.html. http://www.departmentresults.state.mn.us/hs/index.html.

Statutory Change: M.S. 256B; M.S. 256D.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	0	0	0	0
Revenues	$4,000	0	0	0
Net Fiscal Impact	($4,000)	0	0	0

Recommendation

The governor recommends that federal State-Children's Health Insurance Program (S-CHIP) funding be claimed for prenatal services for undocumented women.

Background

Recent instructions from the federal government informed states that they could claim federal S-CHIP match for prenatal services for undocumented women. Minnesota will claim $4 million in additional S-CHIP funds to pay for services provided to undocumented pregnant women during FY 2003.

Relationship to Base Budget

This is a one-time claim for S-CHIP dollars for undocumented pregnant women. It will have no impact on future budgets.

Statutory Change: Not applicable.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($71)	($678)	($1,075)	($1,214)
Revenues	0	0	0	0
Health Care Access Fund				
Expenditures	21	211	341	384
Revenues	0	0	0	0
Net Fiscal Impact	($50)	($467)	($734)	($830)

Recommendation
The governor recommends limiting eligibility for pregnant women on Medical Assistance (MA) by reducing eligibility from 275% of the federal poverty guidelines (FPG) to 200% FPG.

Background
To become eligible for MA, countable income must be at or below established income limits. Currently, for pregnant women, the income standard is 275% FPG.

Effective 2-1-04, this proposal would lower the income standard for pregnant women applying for MA to 200% FPG. Current enrollees would retain eligibility through the end of their 60-day post-partum period. Some of the pregnant women who would now be ineligible for MA may be able to move to MinnesotaCare if their gross household income is at or below 275% FPG, they are uninsured, and they do not have access to employer subsidized insurance. These women would have to pay full cost for MinnesotaCare.

Relationship to Base Budget
There will be modest program savings as a result of this proposal.

Key Measures
- Percent of Minnesotans who have health insurance

More information on key measures is available on the Web:
http://www.departmentresults.state.mn.us/hs/index.html.

Statutory Change: M.S. 256B.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($906)	($2,154)	($2,501)	($2,864)
Revenues	0	0	0	0
Health Care Access Fund				
Expenditures	74	174	211	229
Revenues	0	0	0	0
Net Fiscal Impact	($832)	($1,980)	($2,290)	($2,635)

Recommendation

The governor recommends lowering the Medical Assistance (MA) income limit for children ages 2-18 to 150% of federal poverty guidelines (FPG) and reinstating the $90 work expense deduction.

Background

The 2001 legislature expanded MA eligibility for families and children, effective 7-1-02, by increasing income and asset limits for these groups. Effective 10-1-03, this proposal would modify the 2001 expansion by lowering the income level to 150% of federal poverty guidelines for children ages 2-18 and reinstate the $90 work expense deduction.

Relationship to Base Budget

This proposal would achieve savings by reducing coverage of children in MA. Some will move to MinnesotaCare due to loss of eligibility for MA. This change will affect the MAXIS system and will require 3 months' lead time to implement.

Key Measures

- Percent of Minnesotans who have health insurance.

More information on key measures is available on the Web:
http://www.departmentresults.state.mn.us/hs/index.html.

Statutory Change: M.S. 256B.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($407)	($861)	($943)	($1,033)
Revenues	0	0	0	0
Net Fiscal Impact	($407)	($861)	($943)	($1,033)

Recommendation
The governor recommends the elimination of certain income disregards and deductions used when calculating Medical Assistance (MA) eligibility for pregnant women, infants under two, and some children.

Background
To become eligible for MA, countable income must be at or below established income limits. In some circumstances, when calculating an applicant's countable income, certain income is either disregarded for a set time period or deducted from countable income. When the 2001 legislature increased the income limit for children to 170% of the federal poverty guidelines (FPG), it also replaced an existing earned income disregard method with a 21%, four-month time limited, earned income disregard for children ages two through five. This disregard was applied because it was believed to be required for federal compliance.

Currently, an extra earned income deduction based on family size is allowed when determining the MA eligibility of pregnant women and infants under two who do not meet their income limits (275% FPG for pregnant women and 280% FPG for infants). If this deduction reduces their income below their income limit, they are eligible. If not, they can only become eligible by the spend down method, meaning that their incurred medical expenses must equal the difference between their income and 100% FPG for their family size. This extra deduction was adopted at the time the income limit was increased for pregnant women and infants under two because it was believed to be required for federal compliance.

The department has since clarified with the federal agency, the Centers for Medicare and Medicaid (CMS), that the earned income disregards and extra earned income deductions are not required for federal compliance for these groups.

Effective 7-1-03, this proposal would eliminate the 21% earned income disregard for children ages two through five who use the 170% FPG standard and the extra earned income deduction for pregnant women and infants under two.

Relationship to Base Budget
This proposal will result in small savings because there will be some loss of eligibility for higher income enrollees.

Key Measures
- Percent of Minnesotans who have health insurance
- Children in Minnesota Health Care Programs who received preventive health care service, ages 0-20

More information on key measures is available on the Web:
http://www.departmentresults.state.mn.us/hs/index.html.

Statutory Change: M.S. 256B.056 and M.S. 256B.057.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($1,651)	($5,590)	($6,309)	($7,122)
Revenues	0	0	0	0
HCAF Fund				
Expenditures	(31)	(60)	(34)	(13)
Revenues	0	0	0	0
Net Fiscal Impact	($1,682)	($5,650)	($6,343)	($7,135)

Recommendation
The governor recommends that automatic eligibility for newborns on Medical Assistance (MA) and MinnesotaCare be reduced from two years to one.

Background
Currently, children whose mothers are on MA or MinnesotaCare at the time of their birth are automatically eligible for two years without regard to income.

Effective 7-1-03, this proposal would reduce the period of automatic coverage for newborns on MA or MinnesotaCare to one year. From age one-two, the child would remain eligible for MA if family income was at or below 280% of the federal poverty guidelines (FPG) and eligible for MinnesotaCare if family income was at or below 275% FPG.

Minnesota receives enhanced federal match through the State Children's Health Insurance Program (SCHIP) for infants enrolled in Medical Assistance who have income greater than 275 and at or below 280% of the FPG. This expanded income standard is required and must be maintained to continue Minnesota's overall SCHIP enhanced funding. Minnesota also receives enhanced federal match through SCHIP for MinnesotaCare parents with income above 100 and at or below 200% of the FPG, through a section 1115 waiver of Title XXI. That waiver expressly requires Minnesota to maintain the income standard for those infants for whom we receive enhanced SCHIP funding. Reducing the income level for infants below 280% of the FPG would nullify the waiver and result in the loss of all enhanced federal match through SCHIP.

Relationship to Base Budget
This proposal would achieve savings by reducing coverage of children ages one-two in MA and MinnesotaCare.

Key Measures
- Percent of Minnesotans who have health insurance

More information on key measures is available on the Web:
http://www.departmentresults.state.mn.us/hs/index.html.

Statutory Change: M.S. 256B

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($1,475)	($2,426)	($2,426)	($2,426)
Revenues	0	0	0	0
Net Fiscal Impact	($1,475)	($2,426)	($2,426)	($2,426)

Recommendation

The governor recommends that the Medical Assistance for Employed Persons with Disabilities (MA-EPD) option be modified and contributions from enrollees be increased.

Background

People with disabilities have identified the loss of Medical Assistance (MA) coverage as one of the major obstacles that they face as they seek to become employed. Private sector health insurance generally does not cover personal care services and other long-term supports needed by people with disabilities and Medicare does not cover long-term supports or prescription drugs.

In 1999, the Minnesota Legislature adopted MA-EPD - an optional Medicaid eligibility group - as a work incentive for people with disabilities who are employed. This group is allowed a higher income and asset limit than standard MA to encourage disabled individuals to move toward self-sufficiency through employment. Enrollees are required to pay a premium based on a calculation that was approved in the last legislative session.

Proposed changes to the program are designed to support MA-EPD as a work incentive that will lead to greater self-sufficiency. Currently, enrollees are required to pay a premium based on the individual's gross income, family size, and a sliding scale that begins with 1% of income at 100% of poverty and increases to 7.5% of income at or above 300% of poverty. People must enroll in Medicare (Part A and B) as a condition of eligibility for MA-EPD. Medicare premiums are reimbursed either through the Qualified Medicare Beneficiary (QMB) program, Service Limited Medicare Beneficiary program (SLMB), or, if the enrollee is not eligible for QMB or SLMB, Medicare premiums are paid using 100% state dollars. MA-EPD applicants and enrollees are allowed to enroll if they are receiving any type of earnings. Loss of earnings results in disenrollment the month following a report of job loss (except if employment is interrupted due to medical reasons).

Effective 1-1-04, this proposal would:

⇒ Require all enrollees to pay an additional obligation (beyond the premium) of 5% of unearned income. This amount would be billed with the premium.

⇒ Create an additional charge to the current premium structure to offset state expenditures in reimbursing Medicare Part B premium payments. The Medicare sliding scale payment offset charge would be targeted only to those enrollees with income that exceeds the SLMB income limit of 120% ($906 per month for individual, $1,214 per month for a family of two).

⇒ Require an individual to have earned income above the $65 disregard level in order to qualify for MA-EPD. This disregard is currently applied to earned income of disabled individuals in regular MA. All current MA-EPD enrollees who do not meet this new eligibility requirement will be given a grace period of up to the next six-month review date, but not less than four months to meet the requirement.

⇒ Require for MA-EPD eligibility that earned income have withholding of Medicare, Social Security, and applicable state and federal income taxes. This will require documentation of earned income tax withholding. This will disqualify employees of an employer who has been granted an exemption from payment of taxes by the Internal Revenue Service due to the non-work effort associated and will disqualify casually employed individuals. All current enrollees who do not meet this new eligibility requirement will be given a grace period of up to the next six-month review date, but not less than four months to meet the requirement

⇒ Allow an enrollee up to four months without earnings to obtain new employment following job loss unrelated to work performance. Individuals would be able to request a four-month extension from the first day of the month after the job loss. All other eligibility requirements must be met and the enrollee must pay all

calculated premium costs for continued eligibility. The addition of a "safety net" for MA-EPD enrollees who lose their job through no fault of their own is an important strategy to achieve the long-term goal of self-sufficiency for disabled individuals.

⇒ Create a minimum (base) premium for MA-EPD enrollees of $35 per month. The current premium structure would remain in place, and if through the current calculation the minimum premium was not met, the minimum premium of $35 per month would be charged. The establishment of a minimum premium payment reflects a similar approach to private health care coverage. A minimum premium payment assumes that all enrollees are responsible for a share of their health care costs, not unlike workers who have private health insurance. The minimum payment would become effective for all new enrollees at the time of enrollment. For current enrollees the minimum premium would become effective at the next six-month review date.

Relationship to Base Budget

These proposals offset MA program expenditures either by increasing the MA-EPD premium charges or increasing MA spenddowns, without sacrificing the incentive to work inherent in assuring health coverage to disabled individuals.

Key Measures

- Minnesotans between the ages of 21 and 64 with a disability who are working and Minnesotans enrolled in MA-EPD

More information on key measures is available on the Web:
http://www.departmentresults.state.mn.us/hs/index.html.

Statutory Change: M.S. 256B.057, subd. 9.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($1,924)	($4,095)	$1,028	$7,052
Revenues	0	0	0	0
Net Fiscal Impact	($1,924)	($4,095)	$1,028	$7,052

Recommendation

The governor recommends reductions in the General Fund budget in FY 2004-05 by adjusting the base funding for the Prescription Drug Program (PDP) to February 2003 estimates.

Background

Seniors and people with disabilities meeting the income guidelines for PDP are eligible to enroll in the program. However, PDP is a non-entitlement grant program, so enrollment must be limited to available funding. Statute directs the commissioner of human services to cease new enrollment when the commissioner determines that the program costs will exceed appropriated funds and rebate proceeds. To manage this situation, the department projects PDP costs in November and February of each year, in conjunction with the forecast for entitlement grant programs (e.g., Medical Assistance). The legislature may then consider the PDP projections as it establishes appropriation law.

The 2002 legislature established the FY 2004 and FY 2005 base funding for PDP as the February 2001 forecast for these years (adjusted for 2002 session actions). The February 2003 forecast provides the opportunity to adjust PDP base funding to the latest estimates.

Statutory Change: Not Applicable.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($1,936)	($4,065)	($5,633)	($7,599)
Revenues	0	0	0	0
Net Fiscal Impact	($1,936)	($4,065)	($5,633)	($7,599)

Recommendation

The governor recommends the repeal of the July 2003 planned expansion of the Prescription Drug Program (PDP) to the elderly with income of at least 120% of the federal poverty guidelines (FPG) but less than 135% FPG.

Background

Currently, elderly people, age 65 and over, with income up to 120% FPG and enrolled in the Qualified Medicare Beneficiary (QMB) or Service Limited Medicare Beneficiary (SLMB) Medicare Supplement Program, are eligible to enroll in the state-funded PDP.

Elderly with income above 100% FPG ($739/mo.) must spend their income down to 75% FPG ($554/mo.) to qualify for coverage under Medical Assistance (MA), which includes prescription drug coverage.

Effective 7-1-03, elderly people age 65 and over, with income no greater than 135% of FPG, enrolled in the Qualified Individual, Group 1 (QI-1) Medicare Supplement Program, are eligible to enroll in PDP. Originally, this group was to be added to PDP on 1-1-02. In 2002, the Governor's budget recommendations proposed the elimination of this expansion to help resolve the budget shortfall for the PDP. However, the 2002 Legislature instead amended statute to delay the expansion to 7-1-03.

This proposal would repeal the planned expansion of the PDP to the elderly with income of at least 120% of the FPG but less than 135% FPG.

Relationship to Base Budget

This proposal has is no fiscal impact to MMIS or MAXIS. There are no savings or costs to the DHS pharmacy program. There is a projected program savings.

Statutory Change: M.S. 256.955.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($133)	($250)	($300)	($300)
Revenues	0	0	0	0
Net Fiscal Impact	($133)	($250)	($300)	($300)

Recommendation

The governor recommends reductions in the General Fund budget in FY 2004 and FY 2005 by exempting clients with cost effective health insurance from enrollment in managed care.

Background

This proposal would provide payment for health insurance premiums for Medical Assistance (MA) clients if their private health plan is determined to be cost effective. These clients would be exempt from enrollment in managed care. Cost sharing amounts and medical care not covered by the private health plan benefit package will be covered under fee-for-service if it is provided in the MA benefit set.

Relationship to Base Budget

Administrative costs are needed for one full-time equivalent position to conduct an expanded review of private health insurance plans available to a person through employment to determine if it is more cost effective than payment of a monthly managed care capitation.

Statutory Change: M.S. 256B.69.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	$0	$0	$0	$0
Revenues	175	320	420	500
Net Fiscal Impact	($175)	($320)	($420)	($500)

Recommendation

The governor recommends that the Department of Human Services be provided increased authority to recover from the estates of deceased enrollees of Minnesota Health Care Programs.

Background

This proposal would provide for increased recovery from the assets of Medical Assistance (MA) recipients upon their death by including them in the definition of the estate. MA liens on life estate property, property held in joint tenancy, and other property would secure the asset for recovery after their death. Federal law allows states to use an expanded definition of "estate" to recover from assets that pass by operation of death of the person and other assets not included in the probate definition of an estate.

Relationship to Base Budget

Administrative costs are needed for filing liens on additional property and recovery of MA expenditures from assets of deceased recipients.

Statutory Change: M.S. 256B.15.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($980)	($1,962)	($3,924)	($3,925)
Revenues	25	50	100	100
Net Fiscal Impact	($1,005)	($2,012)	($4,024)	($4,025)

Recommendation
The governor recommends further limitations to asset sheltering techniques used to establish or maintain eligibility for Medical Assistance (MA) long term care (LTC) services.

Background
Currently, individuals may apply for and receive MA-LTC and home and community based Elderly Waiver (EW) services in certain circumstances when they have given away assets that could have been used to pay for their own cost of care.

The proposal would clarify that the rebuttable presumption that an uncompensated transfer was made to obtain or retain MA eligibility applies equally to transfers by the community spouse of a LTC spouse since the assets of a couple always have the potential for becoming available to one another during the marriage.

The proposal would also start the period of ineligibility for making improper transfers at a later date in order to discourage improper transfers. Effective for applications or renewals pending or submitted on or after 7-1-03, the period of ineligibility would begin one month after the month of the improper transfer. In addition, this proposal requests authority to submit a demonstration waiver proposal to the Centers for Medicare and Medicaid to delay the start of the period of ineligibility until the first month of eligibility for long term care services. This would alter the current policy of beginning a period of ineligibility for LTC or EW in the month of transfer which does not discourage substantial transfers of assets made several months or years in advance of the MA-LTC application date, nor does it discourage the currently common practice of giving away a substantial amount of income or assets each month prior to application for long-term care.

This proposal would also allow lawsuits by the state or county in more circumstances where third parties receive property that has been improperly transferred. This proposal would permit a legal action to be brought by the state or county against a person who received property that was improperly transferred at any time the transfer is not timely reported. Current law permits a legal action by the state or the county against a person who receives the improperly transferred property only if the transfer was not reported at the time of MA application. The change would reach unreported transfers made after MA eligibility is established.

Finally, this proposal seeks authority to submit a demonstration waiver proposal to CMS to increase the lookback period. This period is the window of time during which an applicant's asset transfers are scrutinized. Currently, if a transfer is made more than 36 months before a person applies for MA-LTC, or more than 60 months before application for transfers made into a trust, it is not considered and no penalty is imposed, regardless of the size of the transfer. Transfers made within the lookback period may result in ineligibility for MA-LTC. This proposal would make a person ineligible for transfers made within 72 months (6 years) of MA-LTC application. It would increase the number of cases subject to penalty and thus result in cost savings.

Relationship to Base Budget
These changes would reduce state expenditures by ensuring that individuals with assets cover more of the cost of their own care.

Statutory Change: M.S. 256B.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	$,1815	$799	$9,949	$6,592
Revenues	592	11,527	25,675	31,796
Net Fiscal Impact	$1,223	($10,728)	($15,726)	($25,204)

Recommendation

The governor recommends a refinancing of State Operated Services to manage the projected operating budget deficit and to redesign the mental health safety net and reduce reliance on large institutions.

Background

State Operated Services (SOS) is projecting a $41.6 million General Fund operating deficit for the FY 2004-2005 biennium. To manage this deficit, SOS will restructure Adult Mental Health and Nursing Home services into a community-based model that allows for the collection of payments through existing funding sources that are available to all vendors. By operating multiple smaller hospital units and community services, clients will be able to receive treatment near their homes and natural support systems, and SOS will be integrated into the community mental health care system.

Relationship to Base Budget

Approximately 85% of the SOS General Fund base funding is used to cover salary expense, of which 70% is related to direct care salaries. Cost-of-living adjustments are not included in the base level funding. Historically, cost-of-living adjustments are not sufficient to cover increases in insurance costs or bargaining unit agreements.

Key Measures

- Length of stay in publicly-funded mental health treatment beds
- Percentage of Minnesotans satisfied with the amount and quality of services they get from state and local government

More information on key measures is available on the Web:
http://www.mnplan.state.mn.us/mm/goal.html.
http://www.departmentresults.state.mn.us/hs/index.html.

Statutory Change: Not applicable.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($33,091)	($48,620)	($52,123)	($56,221)
Revenues	0	0	0	0
Net Fiscal Impact	($33,091)	($48,620)	($52,123)	($56,221)

Recommendation

The governor recommends a 4% rate reduction to FY 2003 funding levels of most Continuing Care programs. The rate reduction on personal care assistance (PCA), private duty nursing (PDN), and home health agency services will be 2%. Nursing facilities are not included in this proposal.

Background

Over 350,000 people who are elderly or disabled receive some type of assistance from Continuing Care (CC) providers. About two-thirds of these people receive assistance that is reimbursed with public funds, much of it includes a federal match through the Medicaid program.. These CC providers deliver safety net, chronic health care, long-term supportive care in people's homes, in their communities, and in residential settings. This proposal produces General Fund savings by reducing CC provider rates or allocation levels to county agencies by 4%.

During the 2001 legislative session, payment rates for CC providers were increased by 3%, as a cost of living adjustment (COLA) on 7-1-01 and again on 7-1-02. This resulted in a cumulative rate increase of 6.1%. The providers who received these COLAs included those that deliver

- home and community-based waivered services;
- home health agencies, personal care assistance, and private duty nursing services;
- alternative care services for elderly persons at risk of nursing home placement;
- semi-independent living skills services;
- adult and children's mental health grants;
- some community social services grants;
- deaf and hard of hearing grants; and
- group residential housing supplementary services rates.

Payment rates for intermediate care facilities for the mentally retarded (ICF's/MR) and day training and habilitation (DT&H) services were increased an additional 0.5% for a total of a 3.5% COLA each year of the FY 2002–03 biennium for a cumulative increase of 7.1%. The authorizing legislation required that at least two-thirds of the appropriated funds be used to increase direct care staff wages and benefits.

Some continuing care service providers impacted by other budget proposals, determined to be engaged in priority system change activities, or identified as vital state plan benefits have been excluded from this proposed provider rate reduction or received a lower percent of the ratable reduction.

Relationship to Base Budget

Grant funds used by Continuing Care providers comprise approximately 36% of the Department of Human Services budget. Not including nursing facilities, the annual reimbursement to Continuing Care providers is about $2.5 billion a year. About half of the total funding in this service area is made with federal funds through the Medicaid program. For every dollar of state General Fund reimbursement reduced, a corresponding reduction in federal financial participation occurs.

Continuing Care rate reductions will affect provider budgets for wages and benefits and may result in reductions to current employee compensation and work force levels, depending on providers' ability to adjust other expenses.

Some aspects of a Continuing Care rate reduction could be automated using the state Medicaid Management Information System (MMIS); others will require coordination with the county agencies. The county agencies will need to modify their provider contracts and the individual service agreements for each recipient to reflect the rate changes.

Key Measures

- Public spending and the number of people in community-based long-term care versus institutional care

More information on key measures is available on the Web: http://www.mnplan.state.mn.us/mm/goal.html

Statutory Change: M.S. 256B.5013

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($2,178)	($10,760)	($17,263)	($17,263)
Revenues	0	0	0	0
Net Fiscal Impact	($2,178)	($10,760)	($17,263)	($17,263)

Recommendation

The governor recommends reducing the growth in the home and community-based waiver for persons with mental retardation or a related condition (MR/RC waiver) by eliminating the new diversion caseload growth (300 per year) for both years of the FY 2004-05 biennium.

Background

The MR/RC waiver serves as an alternative to the Intermediate Care Facility for persons with Mental Retardation (ICF/MR) entitlement in the Medical Assistance (MA) state plan. The MR/RC waiver currently serves about 15,000 individuals. It is the largest home and community-based services waiver in Minnesota and has a significant impact on the MA forecast.

The caseload level within the MR/RC waiver is impacted by three mechanisms: 1) the use of conversion slots that are allocated to relocate a person when an institutional bed closes, 2) the reuse of slots that are vacated by waiver recipients; and 3) the addition of new caseload through the distribution of diversion slots. This proposal manages caseload growth at lower levels over the two-year budget period by not allocating additional diversions during the biennium.

Federal law establishes that ICF/MR services are an entitlement. Because there has been ongoing reduction in the state's use of ICFs/MR services, diversion allocations are used to meet the state's obligation to provide services to individuals newly identified as In need of services. Turnover within the system is used by either people converting from institutional services or people who are recently identified as in need of services (thus, they also enable the state to meet its entitlement obligations but are not counted as *new* caseload growth).

During the 1999 session, the legislature enacted a number of provisions to address concerns about people in waiting for the MR/RC waiver. One of the provisions required the forecast for the MR/RC waiver to be locked in across two biennia and any unspent portion of the appropriated budget in each fiscal year to serve new caseload above the forecasted caseload.

Due to underspending in the MR/RC waiver in 2001, enrollment was opened from March 15 through June 30, 2001. At that time, county agencies added persons with mental retardation or a related condition who had been waiting for the waiver and were in most need of services. During this three-and-one-half month period, over 5,500 people were added to the MR/RC waiver. This is the equivalent of 18 years of diversion growth and exceeded the requirements of the 1999 state law provisions to increase the number of waivered services slots to serve people on the waiting list.

Relationship to Base Budget

The MR/RC waiver is the largest home and community-based waiver administered by the state. The projected total annual spending in the program will reach $385 million during FY 2004. The MR/RC waiver has been instrumental in assisting the state to achieve public policy goals of reducing institutional service use and achieving budget savings. Over 7,000 institutional ICFs/MR beds have been closed over the past 20 years using the MR/RC waiver.

This proposal assures the state will continue to provide ICF/MR entitlement services to eligible recipients. County agencies will be able to refill vacated allocations or "slots" of persons leaving the waiver. Turnover in the MR/RC waiver program is about 450-500 people per year. Because the MR/RC waiver waiting list is expected to continue to grow, the proposal does not assume that the reduction in the growth of the diversion caseload will continue

beyond the FY 2004-05 biennium. At that point, turnover will not adequately accommodate need. This proposal does not require major system or waiver plan changes.

Key Measures

- Public spending and the number of people in community-based long-term care versus institutional care

More information on key measures is available on the Web:
http://www.departmentresults.state.mn.us/hs/index.html.

Statutory Change: Not applicable.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($1,385)	($3,536)	($4,855)	($5,771)
Revenues	0	0	0	0
Net Fiscal Impact	($1,385)	($3,536)	($4,855)	($5,771)

Recommendation

The governor recommends limiting new caseload growth in the home and community-based waiver for persons with a traumatic brain injury to 150 slots per year.

Background

The Traumatic Brain Injury (TBI) Waiver serves as an alternative to the nursing facility (NF) or the neurobehavioral hospital entitlement in the Medical Assistance (MA) state plan. Persons who are eligible for the TBI Waiver have significant cognitive impairments and/or severe behavioral challenges. In addition to being at risk of institutionalization in an NF or neurobehavioral hospital, many TBI waiver recipients also face the possibility of being placed in a regional treatment center. Currently, the TBI Waiver serves 737 individuals; 564 who require the level of care provided in a NF and 173 who require a neurobehavioral hospital level of care

Over the past fiscal year, the TBI Waiver caseload has begun to increase significantly over projections. In SFY 2003, it is estimated that the caseload will increase by 50%. This growth in caseload has been influenced by: 1) 2001 legislation that expanded eligibility for the TBI Waiver to persons with degenerative brain injuries, 2) a shift of the responsibility to determine eligibility for the waiver to the county level, and 3) a significant increase in transfers from other waiver programs, particularly the CADI program.

This proposal manages caseload growth over the two-year budget period by limiting the allocation of slots to assure that the caseload increases do not exceed 150 in each year of the biennium. The allocation of slots will treat expected discharges from and avoidance of placements in institutions as a priority, but curtails transfers from other home and community-based programs.

Relationship to Base Budget

The TBI Waiver is a relatively small home and community-based waiver; by the end of the current fiscal year the program will serve about 740 recipients at a total cost of slightly less than $40 million. The TBI Waiver has been an important program in assisting the state to achieve past goals of reducing institutional service use and achieving budget savings. Federal 372 reports that compare the annual per capita Medicaid costs in Minnesota for the TBI Waiver population and a corresponding institutional population show that the TBI Waiver recipients cost $145,000 less per recipient per year for individuals needing a neurobehavioral level of care. The waiver serves individuals needing a nursing facility level of care at a per capita cost that is $14,300 per year less than the comparable institutional population.

This proposal attempts to assure the state continues to provide services to recipients who are in true need of the TBI waiver and who cannot be served by other home and community-based programs. It eliminates unnecessary shifts of recipients from other Home and Community-Based Services Waiver programs. This proposal does not require major system or waiver plan changes. It will affect counties and the state by requiring closer monitoring of the eligibility of persons for the TBI waiver to assure the program focuses on those recipients who cannot be served in other programs.

Key Measures

- Public spending and the number of people in community-based long-term care versus institutional care

More information on key measures is available on the Web:
http://www.departmentresults.state.mn.us/hs/index.html.

Statutory Change: Not applicable.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($1,809)	($2,147)	($209)	0
Revenues	0	0	0	0
Net Fiscal Impact	($1,809)	($2,147)	($209)	0

Recommendation

The governor recommends delaying, until 7-1-05, Medical Assistance (MA) coverage of targeted case management services for home care recipients and the home and community-based services (HCBS) common waiver menu.

Background

Minnesota has a strong commitment to providing home and community-based support options for people with disabilities. Our state's experience over the past two decades has demonstrated that most individuals who are currently institutionalized can be served appropriately and cost-effectively in home and community-based settings. The 2001 legislature authorized DHS to establish an initiative to relocate and divert Minnesotans with disabilities under the age of 65 from nursing facilities.

DHS established the "OPTIONS Initiative" to introduce program and administrative changes that result in increased access to community services and supports for Minnesotans with disabilities and special health care needs. A review of the current state policies and practices determined that persons with disabilities often do not have the necessary information, planning assistance, or access to program accommodations to that support the relocation and diversion of people from institutional settings. Addressing these variables, along with increasing program flexibility, were determined to increase the likelihood of persons with disabilities residing in the community instead of institutions.

Case management services are not routinely available to people who only receive MA home care services. This is despite some of the recipient population having high medical needs and many professionals involved in their care. As a result, the support and care these recipients receive can be fragmented, piecemeal, and sometimes duplicative. This is despite some of the recipient population having high medical needs and many professionals involved in their care. The Home Care-Targeted Case Management (HC-TCM) benefit was created to assist persons navigate an often fragmented service delivery system and to assure persons receive the information, support, advocacy, and assistance needed to access community-based supports.

The state administers five HCBS waiver programs that have been found to be complex, fragmented categorical programs that consist of varying eligibility requirements, screening processes, care plan elements, provider qualifications, service menus, and rates. Each HCBS waiver is targeted to assist persons to live in the community that meet a specified institutional level of care. In an effort to simplify program administration at the state and local level and to improve program accessibility for consumers, the 2001 legislature endorsed the creation of a standardized and simplified menu of HCBS waiver services and rates.

Relationship to Base Budget

The state administers five HCBS waivers that have been instrumental in assisting the state to achieve past goals of reducing institutional service use. This proposal maintains the current HCBS waiver programs and delays some desired improvements. Delaying implementation of these desired changes until 7-1-05 decreases the General Fund budget $5.4 million during the FY 2004-05 biennium. Current efforts to introduce consumer directed benefits to all the HCBS waivers to some degree mitigate the negative effects of the delay in the implementation of the common service menu.

This proposal does not require major information system changes.

Key Measures

- Public spending and the number of people in community-based long-term care versus institutional care

More information on key measures is available on the Web:
http://www.departmentresults.state.mn.us/hs/index.html.

Statutory Change: Not applicable.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($1,192)	($1,192)	($1,192)	($1,192)
Revenues	0	0	0	0
Net Fiscal Impact	($1,192)	($1,192)	($1,192)	($1,192)

Recommendation

The governor recommends suspension of the commissioner's authority to adjust the rates of an Intermediate Care Facility for Persons with Mental Retardation (ICFs/MR) to cover the cost of a vacant bed until it is filled.

Background

ICFs/MR provide 24-hour care, habitation, training, and supervision to persons with mental retardation or related conditions. Most ICFs/MR are less medically oriented than nursing facilities and focus on teaching independent living skills. A majority of the ICF/MR providers are small, having fewer than 10 beds. As such, vacancies affest funding levels for these providers significantly.

The 2000 legislature approved a number of ICF/MR special rate provisions. One rate provision allowed the Department of Human Services to grant a rate adjustment for ICF/MR providers to help defray the costs associated with a client leaving a facility or passing away. The provision allowed the daily base rate of the vacant ICF/MR bed to be spread amongst the occupied beds for a maximum period of 90 days.

As ICF/MR program expenditures began to rise more than projected, the 2002 legislative session took actions to reduce the special rate provisions. One of the changes enacted was to lower the number of days a facility would be eligible for the vacancy adjustment from 90 days to 75 days. This proposal would eliminate vacancy rate adjustments altogether.

Relationship to Base Budget

There are 249 MA-certified ICFs/MR. Last fiscal year, ICFs/MR served an average of 2,508 recipients per month. The monthly average payment was $5,404 per resident. In FY 2002, 23 ICFs/MR were closed and 244 additional beds were decertified.

Key Measures

- Public spending and the number of people in community-based long-term care versus institutional care

More information on key measures is available on the Web:
http://www.departmentresults.state.mn.us/hs/index.html.

Statutory Change: Not applicable.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($820)	($773)	($724)	($698)
Revenues	0	0	0	0
Net Fiscal Impact	($820)	($773)	($724)	($698)

Recommendation

The governor recommends eliminating the statutory authority requiring persons with mental retardation or a related condition to attend Day Training and Habilitation (DT&H). Savings associated with this proposal are specific to changes anticipated for persons residing in Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR).

Background

This proposal is designed to reduce state spending, provide consumers and families with choice and control, and allow county agencies more flexibility in assisting consumers with needed supports. It includes provisions that

- eliminate the existing mandate for DT&H services;
- redefine services during the day to include a variety of choices such as supported work, support for adult education, community volunteer opportunities, day activities, adult day care, personal supports for community integration and inclusion activities, recreational supports, and traditional DT&H services; and
- allow for voluntary participation in county-wide or region-wide implementation of a model for services during the day which would also include more flexibility in reimbursement.

The DT&H service system that now provides services during the day to people with developmental disabilities has not been substantially changed since the early 1980s. In many communities, consumers are not being given a choice to buy support services that enable them to be fully integrated in their communities. These options may include such things as attending adult education classes, offering volunteer services as part of their own community activism, working in local businesses with some training and support being provided, or attending community activities with people of their own age and interests. The existing DT&H mandate and method of reimbursement does not provide sufficient flexibility to meet the new interests and expectations of consumers for alternative services during the day. This is especially true for ICFs/MR residents. In practice, DT&H is currently the only day service option unless a person is retired.

ICFs/MR provide 24-hour care, habitation, training, and supervision to persons with mental retardation or related conditions. The Centers for Medicare & Medicaid Services (CMS) recognize the ICFs/MR as responsible for providing 24-hour active treatment. Since the 1980s, the state has mandated DT & H services as the accepted day service for federally-mandated active treatment plans for ICF/MR residents. Twenty years ago, the only option to provide services was the DT & H. Over recent years a diversification in day services has begun to be offered to home and community-based services waiver recipients and persons utilizing consumer–directed support options. The elimination of mandated DT & H services would treat ICF-MR residents more like persons who receive home and community based waiver services.

Relationship to Base Budget

There are currently about 13,000 individual with developmental disabilities currently receiving DT&H services. Three funding streams are used to reimburse DT&H providers – the MR/RC waiver, MA payments for ICF/MR recipients, and county CSSA funds. Total investments in this service using county, state, and federal funding is approximately $120 million per year.

Approximately 2,200 persons who attend DT&H reside in ICFs/MR. The average monthly payment for DT&H services is $1,458 per resident; these costs include transportation-related expenses. This proposal enables ICF/MR residents currently receiving DT & H services to have other options. It assumes that given an option, 20% of the ICF/MR recipients now attending DT&H services would choose an alternative. The cost of the alternatives is projected to be 75% of the cost of the DT & H service option. The elimination of the DT&H mandate will also

provide county agencies the latitude to provide the most appropriate services during the day within the local funding that is available.

Statutory Change: M.S. 252.41, M.S. 252.44, M.S. 252.64, M.S. 256B.501, M.S. 256B.5015, M.S. 256B.0625, and M.S. 256E.081.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($5,064)	($11,541)	($10,788)	($10,052)
Revenues	0	0	0	0
Net Fiscal Impact	($5,064)	($11,541)	($10,788)	($10,052)

Recommendation

The governor recommends establishing a 10% county share on the total cost of long-term placements of individuals in Intermediate Care Facilities for Persons with Mental Retardation or Related Conditions (ICFs/MR) that have seven or more beds. This proposal does not affect the smaller and more homelike ICFs/MR of six beds or fewer.

Background

Minnesota has a strong commitment to providing home and community-based support options for people with disabilities and to moving individuals with disabilities from institutional to community settings. In 1982, Minnesota had 9,200 ICFs/MR beds in state regional centers and community facilities. In 1984, the legislature placed a moratorium on the development of additional ICFs/MR beds and began offering services through the home and community-based services waiver program. Since that time, over 7,000 ICFs/MR beds have been closed in the state. ICFs/MR utilization continues to decline by about 200 beds per year as residents relocate to home and community-based services.

Our state's experience over the past two decades has demonstrated that most of the individuals who are currently institutionalized can be served appropriately in home and community based settings at a cost that is reasonable to the state. Numerous state and national studies have documented the benefits of community-based services for persons with disabilities. Recent federal 372 reports that compare the annual per capita Medicaid costs in Minnesota for the MR/RC Waiver population and the corresponding institutional population show that on a per capita basis MR/RC Waiver recipients cost $21,545 less per year than the ICFs/MR recipients.

In 1999, the United States Supreme Court ruled in Olmsted vs L.C. that states have an obligation to insure that people with disabilities are not forced to remain institutionalized when a more integrated setting is appropriate and the affected individuals do not object to the community placement. The court further indicated that states should have comprehensive, effectively working plans for placing qualified persons in less restrictive settings. This ruling has prompted states, including Minnesota, to review their current policies and practices and to determine whether they most effectively support the relocation and diversion of people from institutional settings.

During the 2001 1st Special Session, the legislature took important steps to improve access to and utilization of existing home and community-based service options for individuals with disabilities who are in, or are at risk of going into, institutions. With open enrollment, the waiting lists for ICF/MR services have virtually disappeared. Closure of ICFs/MR increased with many of those persons moving into community settings.

Relationship to Base Budget

In FY 2003, approximately 2,275 individuals with mental retardation or a related condition resided in an ICFs/MR. Total expenditures for that period are projected to be slightly over $155 million per year. This proposal also affects day training and habilitation costs that pass through the ICF/MR rate and ICF/MR reimbursement at the Minnesota Extended Treatment Options (METO). The ICF/MR caseload continues to decline at a rate of about 7.5% each fiscal year. Establishing a significant county share will decrease state General Fund expenditures. This change item is proposed for implementation 1-1-04.

Key Measures

- Public spending and the number of people in community-based long-term care versus institutional care

More information on key measures is available on the Web:
http://www.departmentresults.state.mn.us/hs/index.html

Statutory Change: M.S, 256.19, subd. 1

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	$1,168	($1,785)	($1,999)	($1,999)
Revenues	4,512	5,804	3,475	2,176
Net Fiscal Impact	($3,344)	($7,589)	($5,474)	($4,175)

Recommendation

The governor recommends restructuring and refinancing the delivery of adult mental health residential services.

Proposal Overview: This proposal restructures public funding and rules for mental health (MH) residential services by

- working with counties and providers so treatment is provided in the most integrated, culturally competent, and appropriate setting;
- expanding the housing options available to people with mental illness;
- obtaining federal Medicaid (MA) funding for mental health and ancillary medical services when possible;
- increasing the county share for use of Institutions for Mental Diseases (IMDs)
- promoting the use of evidence-based approaches to improve service outcomes; and
- eliminating regulatory barriers that inhibit effective treatment for persons experiencing co-occurring disorders such as mental illness and chemical dependency.

Background

During the past four years, Minnesota has begun to make progress to expand the range of community-based mental health services and maximize federal reimbursement for adults with serious mental illness. However, adults with mental illness continue to experience access problems when they require intensive sub-acute residential treatment and crisis stabilization services. Communication and language access problems are compounded for those consumers who are deaf, deafblind, or hard of hearing. Additionally, consumers' inability to maintain and access permanent housing options leads to less than effective use of existing resources. It is estimated that 20-30% of the current inpatient capacity is used by people who could be served in less intensive settings if appropriate housing and support services were available.

The current service delivery system and reimbursement mechanisms are not adequate to provide the required staffing and treatment to serve an acutely ill population with specialized needs. The proposal seeks to support regional approaches that restructure adult residential treatment to create more intensive, specialized MH residential settings, flexible mental health community services to meet individual needs, and additional options to maintain and establish permanent housing.

There are currently 71 residential treatment facilities (licensed under Rule 36) that provide services and supports to people needing residential mental health treatment. Of these 71 facilities, 67 have 16 beds and four have 16 or more beds. The size of the facility has significance because federal law classifies the larger facilities as IMDs and makes the residents under the age of 65 ineligible for Medical Assistance (MA) as long as they reside in the facility. The ancillary medical services for these recipients are paid for with 100% state funds through General Assistance Medical Care (GAMC). The costs for care and treatment in these larger facilities are paid almost entirely by Group Residential Housing (GRH), which is also 100% state funds. In the smaller facilities, residents can access MA for services outside the facility if they meet the MA eligibility criteria, while Supplemental Security Income and GRH fund room and board, and General Fund MH grants pay for care and treatment.

This proposal includes a 20% county share for the non-federal share of GRH payments to IMDs and an increase in the county share for RTCs from 10% to 20%, effective 1-1-04. This provision is necessary to incent counties to expand their use of MA reimbursed services and housing options for this population.

Relationship to Base Budget

Current state appropriations include about $6 million in GRH for nursing home/IMDs and about $19 million in MH grants for community-based residential treatment facilities. This proposal will increase flexibility to use these funds in the manner that will be most effective for the clients and most cost effective for the state and the counties.

The proposed restructuring of adult mental health residential treatment will require at least 12 months after legislative approval before the programmatic and fiscal benefits are realized. Specific activities needing to occur will include amending the state MA plan to allow MA reimbursement of adult MH residential treatment, enrolling providers for MA reimbursement, working with counties and providers to promote changes that are consistent with state policy directions and evidence-based practices, and reviewing and approving county-negotiated per diems for adult MH residential facilities.

Key Measures

- Public spending and the number of people in community-based long-term care versus institutional care

More information on key measures is available on the Web:
http://www.departmentresults.state.mn.us/hs/index.html.

Statutory Change: M.S. 246.54, M.S. 256B.0623, and M.S. 256I

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($904)	($1,559)	($3,144)	($3,773)
Revenues	0	0	0	0
Net Fiscal Impact	($904)	($1,559)	($3,144)	($3,773)

Recommendation

The governor recommends phasing out Medical Assistance (MA) coverage for adult mental health day treatment by 7-1-05 and allowing more cost-effective individualized mental health services to be delivered through adult mental health rehabilitative services (ARMHS) and/or partial hospitalization services.

Proposal Overview: This proposal phases out MA reimbursement for adult mental health day treatment services by

- lowering the prior authorization thresholds during FY 2004-05 to ensure that the amount of service provided is in fact medically necessary;
- allowing clients to switch to more individualized services such as ARMHS and partial hospitalization; and
- eliminating MA coverage for adult day treatment effective 7/1/05.

Background

Mental health day treatment has been an MA covered service in Minnesota for over 20 years. It is typically provided in group settings as a structured program of 3 hours per day, 5 days per week. This is an older model of service, which is gradually being replaced by a more individualized service model that began to be covered under MA in 2002 as adult mental health rehabilitative services (ARMHS). Currently adult mental health day treatment is allowed up to 390 hours per year without prior authorization. Under this proposal, requests for day treatment will be reviewed more closely and efforts will be implemented to assist local agencies to support people to receive service alternatives more focussed on individualized rehabilitation.

For some people day treatment has been used as a support following their hospitalization for an acute mental health condition. This proposal assures continued recipient access for this type of support through funding of partial hospitalization services. From a policy perspective, partial hospitalization can provide a more intensive, though shorter term, rehabilitative service as people transition back into their communities.

Relationship to Base Budget

During FY 2002, 4,000 adults received adult mental health day treatment reimbursed by MA at a total cost of $10.8 million. This included 331 people who received more than 390 hours of service per person per year.

The annual costs of the alternative services resulting from the implementation of this proposal are projected to be half of the current cost of adult MH day treatment.

Statutory Change: M.S. 256B.0625, subd. 23

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($1,166)	($1,312)	($1,328)	($1,346)
Revenues	0	0	0	0
Net Fiscal Impact	($1,166)	($1,312)	($1,328)	($1,346)

Recommendation

The governor recommends elimination of the Consumer Support Grant (CSG) program exceptions.

Background

The Consumer Support Grant program was a 1995 legislative initiative that enables consumers to directly receive funding for home care services they were eligible to receive through the traditional Medical Assistance (MA) state plan. It allows recipients of MA home care to directly receive a grant in the amount of the state share of the cost of their services. The CSG program allows consumers to be more in control of buying the services and supports they need without many of the administrative requirements associated with receiving Medical Assistance funded services. The program is administered by county agencies; however their participation is not mandatory. Existing law requires that the commissioner initiate efforts to make the alternative available on a statewide basis either through the counties or private entities as of 7-1-02.

Prior to 2001, county agencies determined the maximum allowable grant levels for consumer support grant recipients. This resulted in discrepancies in the maximum allowable amount of the grants from county to county, even when the assessed needs of the consumers were comparable. The 2001 legislature made statutory clarifications that provided a standard method by which consumer support grant amounts were to be calculated. These improvements provided for comparable benefits for consumer support grant recipients regardless of the county of residence and assured that state spending on the CSG grants was not greater than the amount the state would spend in the traditional MA program. The grant amounts for about 200 CSG recipients exceeded the amount that was allowed under the new methodology. Exceptions in the 2001 law allowed these recipients to be "grandfathered" in at the higher levels and required the commissioner to authorize up to 200 exceptions if any of these recipients exited the program. This proposal discontinues the "grandfathering" of exception grant levels, so that all CSG recipients are treated equitably.

Administration Issues and Implementation

Removing exceptions from the consumer support grants will simplify the grant program for counties and consumers. About 200 consumers will have their grant levels reduced by this proposal.

Relationship to Base Budget

This proposal saves $1.2 million in General Fund expenditures during FY 2004 and about $1.3 million in General Fund expenditures thereafter. Enactment of this proposal assures the maximum CSG state grant levels do not exceed the state funding that would otherwise be spent in the Medical Assistance home care programs.

Statutory Change: M.S. 256.476

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($12,892)	($12,877)	($12,877)	($12,877)
Revenues	(766)	(766)	(766)	(766)
Net Fiscal Impact	($12,126)	($12,111)	($12,111)	($12,111)

Recommendation

The governor recommends elimination of some Continuing Care (CC) non-entitlement grant programs.

Background

This initiative proposes to eliminate the following state aging grants:

⇒ Block Nurse Administration. A grant to the statewide Technical Assistance Center to provide oversight and management of local living at home/block nurse projects.

⇒ SAIL Grants. Grants to counties, area agencies and non-profit organizations to integrate, coordinate, and enhance informal, quasi-formal, and formal services for services for seniors.

⇒ Epilepsy Grants. A grant made to a non-profit organization for independent living skills training to adults with intractable epilepsy.

⇒ Senior Nutrition Support, Home Delivered Meals, and Senior Nutrition Program Grants**:** In FY 03, Minnesotans receive congregate dining services and home delivered meals paid for with $7.5 million in federal funding, $2.8 million in USDA reimbursements, $10 million in client donations, and state grants. This proposal eliminates the state grants. Federal funding, USDA reimbursements (allocated based on number of meals served) and client donations will continue to support the activity.

⇒ Foster Grandparents Program. These grants are awarded to non-profit organizations. The funding allows low-income seniors to provide services to special needs children. $1.9 million in federal funding remains available for this program.

⇒ RSVP. These are grants for counties and non-profit organizations to provide volunteer opportunities for seniors in a variety of community service areas. $1.3 million in federal funding remains available for this program.

⇒ Senior Companion Program Grants. Grants to non-profit organizations that supplement federal funding to allow low-income seniors to provide services to other seniors. $875,000 in federal funding remains available to support this activity.

⇒ Home Share. These are grants made to non-profit organizations to assist homeowners to stay in their homes longer by pairing them with home seekers willing to share the rent or provide services in exchange for sharing the home.

⇒ Health Insurance Counseling. These are grants to Area Agencies on Aging and non-profit organizations to provide information and counseling about Medicare bills and payments and supplemental insurance options. $365,000 in federal funding remains available for this program.

⇒ Home Care Ombudsman Grant. Grant to a non-profit organization to provide ombudsman services regarding in home health care services.

⇒ Regional Planning Grants. Grants to counties and Area Agencies on Aging to conduct gaps analysis for long-term care reform.

As part of this proposal, funding for the following aging grants will be pooled into a single, consolidated fund: Community Service Grants, Community Service Development Grants, Caregiver Support, and Living at Home Block Nurse. About $6.3 million will be available for this grant fund in FY 2004 and $7 million in FY 2005. All grantees will participate in a competitive request for proposals (RFP) process to be awarded future funding. Grantees whose funding was eliminated and persons with new proposals are also eligible to participate in future RFPs.

The initiative also proposes to eliminate the following chemical health grants:

⇒ Women's Ancillary Support Programs award competitive grants to counties, American Indian tribes, and community agencies to support women with children and pregnant women who are seeking chemical dependency treatment. Vendors provide services to increase rates of treatment completion such as prenatal care, fetal alcohol prevention counseling, child care, housing assistance, transportation, and parenting education. Federal funds received through the state's Substance Abuse Prevention and Treatment grants also partially support this activity. These grants served approximately 1,050 people in FY 2002.

⇒ CCDTF Tier II placements. State general funds are transferred to the Consolidated CD Treatment Fund to reimburse providers for the provision of chemical dependency treatment services to persons whose income is above the Medical Assistance (MA) standards but below 215% of Federal Poverty Guidelines. Approximately 3,500 Tier II recipients were served in FY 2002. About 40% of CCDTF Tier II placements are court ordered – these individuals will need to receive CD treatment funded by local resources.

⇒ Juvenile assessment and detox transportation grants. These grant funds reimburse counties for a portion of the cost they incur for providing these services. Approximately 40% of the county Juvenile Assessment costs and 35% of the detox transportation costs are reimbursed each year.

Grant funding reduced in the area of disability services include the Region 10 Quality Assurance Project and the Public Guardianship Initiative. The Region 10 Quality Assurance Project is a regional effort in southeastern Minnesota to implement an alternative system of evaluating and licensing services. The Public Guardianship Initiative was authorized by the legislature in 2001 to decrease the number of individuals under state public guardianship. Funds are allocated to counties to support local efforts to pursue private alternatives to public guardianship. These programs, while beneficial, are not viewed as vital as other state investments that provide direct services to the most vulnerable people or that can receive a federal match.

Relationship to Base Budget

The CD non-entitlement grants proposed for elimination comprise about 6.5% of the state and federal funds allocated for chemical health services. Aging grants proposed for elimination comprise about 20% of the state and federal grant funds allocated for aging services.

Key Measures

- Public spending and the number of people in community-based long-term care versus institutional care
- Consumers directing their own publicly funded home and community-based services

More information on key measures is available on the Web:
http://www.departmentresults.state.mn.us/hs/index.html.

Statutory Change: Repeals Minnesota Statutes 256.973; 256B.0928; 256.9752; 256.9753; 256.976; 256.977; 256.9772; 256B.0917; 2001 Laws of MN, 1st special session, Chapter 9, Article 13, Sec 24; 256B.095; and 254A. Amends 256B.437, subd. 2; 256.9754; and Laws 1988, chapter 689.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	$4	($10,799)	($12,959)	($14,255)
Revenues	2,500	5,000	5,000	5,000
Net Fiscal Impact	($2,496)	($15,799)	($17,959)	($19,255)

Recommendation

The governor recommends eliminating the Group Residential Housing (GRH) program supplemental room and board rate, transferring eligible costs to home and community-based services waiver programs, and establishing a federally-recognized room and board rate as the base GRH rate. This proposal also obtains reimbursement from the U.S. Department of Agriculture, Food and Nutrition Services (FNS), for GRH board payments on behalf of GRH recipients who are eligible for food stamps.

This proposal modifies the GRH program to capture federal financial participation for service and food costs, establishes a base room and board rate that is linked to the federal poverty guideline (FPG), and simplifies the program's administration on both the state and local levels. Specific components include

- eliminating the supplemental room and board element of GRH payments;
- establishing that the GRH rate for a community living setting is to be consistent with federal income standards used in related programs;
- amending the Medicaid home and community-based services (HCBS) waivers to permit expenses in the community above the basic room and board level standard to be paid for by the waiver; and
- establishing an agreement with FNS to invoice for reimbursement to GRH for the food portion of the GRH rate paid on behalf of persons eligible for food stamps.

This proposal provides time to seek approval for the waiver changes from the federal government and for county staff to renegotiate service agreements based on the waiver program for clients in adult foster care settings. Expected savings from the transfer of GRH services to waivers would occur in FY 2005. As a result, the changes to the GRH base rate would then become available in FY 2006. Savings as a result of FNS reimbursement would occur upon approval by the Department of Agriculture.

Background

GRH payments are made to providers for room and board and other related housing services for individuals whose illness or disability prevents them from living independently. A setting must be licensed as an adult foster home, a board and lodging establishment, a supervised living facility, a boarding care home, or, in some cases, registered as a housing with services establishment to receive a GRH payment. GRH-funded settings serve a variety of dependent persons, including persons with mental retardation, mental illness, chemical dependency, physical disabilities, advanced age, or brain injuries.

The GRH program currently consists of three different rates.

⇒ Rate 1 (the base rate) is used to supplement a person's income from social security resources or General Assistance in order to live in a licensed or registered setting. It does not have a direct relationship to the costs of room and board in the community nor is it currently tied to the costs incurred by the provider of room and board who is receiving the GRH base rate.

⇒ Rate 2 is a supplemental service rate, which is provided in situations where a person is ineligible for other service funds. Rate 2 can pay for basic support services, such as oversight and supervision, medication reminders, and appointment arrangement.

⇒ Rate 3 (a supplemental GRH room and board rate) is available only to corporate adult foster care settings. It covers additional costs of serving the disabled and elderly in small settings. These provisions were established to assist the state in its efforts to downsize or close institutional settings and to assure the level of care and quality of life afforded by these smaller settings. Other types of settings have not been able to access additional GRH funds for their clients.

Waiver. This proposal assumes that supplemental room and board costs above the GRH base rate are associated with essential services needed by the HCBS waiver recipient to live in the community. As such, the department has determined that these costs are appropriate for HCBS waiver reimbursement. Because GRH rates are funded through the state General Fund and waiver payments, which cover service costs, include 50% federal financial participation, transferring eligible costs to HCBS waiver programs will result in additional federal financial participation and a net savings to the state General Fund.

The simplified base rate to be used for community living in the GRH program is not significantly less than the current FPG, which is a well-understood standard use in federal housing programs and the state Medical Assistance program. By providing the same level of support for housing costs for all GRH housing and service settings, the proposal seeks to eliminate inconsistencies between them.

Food Stamps. In 1995-96, the department investigated the possibility of obtaining direct federal reimbursement for the cost of food for eligible GRH recipients. The Department of Agriculture did not approve the proposal. Several amendments to the 2002 federal Farm Bill significantly improve the possibility for approval of a renewed proposal.

Food Stamp criteria state that Supplemental Security Income (SSI) recipients are eligible, as are General Assistance (GA) recipients and both SSI and GA are a basis of eligibility for GRH. The GRH room and board payment is based on the MSA Equivalent Rate, which is composed of SSI, Minnesota Supplemental Aid, and the food stamp allotment for an individual in the community. Currently through GRH, state money is used to pay for food that would otherwise be paid for by food stamps. By certifying food stamp eligibility of eligible GRH recipients to the FNS, a proposal will be made to the Department of Agriculture to allow the state to invoice for reimbursement to GRH for the costs of food support provided in the room and board rate. Data available through the DHS MAXIS payment system will ensure that the request for reimbursement is based on accurate determinations of the period of eligibility and the amount of support the GRH recipient is eligible to receive.

Relationship to Base Budget

By FY 2005, the two components of this proposal will provide savings and additional revenue equal to 15% of the GRH budget. GRH expenditures for supplemental room and board costs in adult foster care settings are projected to be $18 million for FY 2004. Currently these payments are projected to increase by more than 10% each year. They represent the only growth in GRH besides the annual increase in the number of eligible people served. Past efforts to reduce the growth of GRH supplemental room and board rates established a system of county averages that increased the complexity of administration for this program. This proposal will eliminate the need to impose these averages.

Key Measures

- Public spending and the number of people in community-based long-term care versus institutional care

More information on key measures is available on the Web:
http://www.departmentresults.state.mn.us/hs/index.html.

Statutory Change: M.S. 256I.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($10,216)	($11,793)	($13,443)	($13,149)
Revenues	0	52	151	251
Net Fiscal Impact	($10,216)	($11,845)	($13,594)	($13,400)

Recommendation

The governor recommends changing Alternative Care (AC) eligibility, restructuring the premium payment criteria, and delaying changes in rates that were planned as part of a common service menu. This proposal also provides funding to meet projected increases in caseload in the next biennium.

Background

This proposal

- eliminates AC eligibility for some persons who are eligible for the Elderly Waiver (EW);
- increases revenues through premium collections and thereby decrease projected AC expenditures to help address the projected budget shortfall;
- implements estate recovery in the AC program (and liens against real property) similar to the current practice for Medical Assistance recovery;
- delays implementation of a common service menu between AC, home care, and other home and community-based waivers until 7-1-05;
- funds projected AC case load growth in the 2004-05 biennium; and
- makes technical changes to the AC statute and to several cross-referenced statutes.

Changes to Eligibility. To receive community-based services, persons with incomes below 120% of federal poverty guidelines (FPG) and assets of $3,000 or less will be required to receive their long-term care services through EW and pay a waiver obligation (personal contribution toward the cost of their long-term care). This change will eliminate the option for some people to choose the program from which they receive services (AC or EW). Because EW is a program in which the federal government pays a share of the cost, it is more affordable for the state to use EW to pay for services for this group of people.

Changes to Premiums. For people who remain eligible for AC, criteria for premium payments will be simplified and restructured to increase personal contributions.

⇒ Currently, AC recipients whose income is greater than 150% of FPG or whose assets are greater than $10,000 are assessed a monthly premium based on the costs of their services. This group will continue to pay a 25% premium toward their cost of care.

⇒ Persons with incomes below 150% of FPG and whose assets are $10,000 or less will be required to pay a 10% premium.

The method for calculating premiums will be simplified. Premiums will be a flat 10% or 25% of the total cost of services. The total cost of services upon which premiums are based will no longer exclude case management. However, policy changes will be implemented giving recipients greater choice in how they receive case management services.

These changes will increase the number of people who must pay premiums. Some people will want to evaluate their own financial situations to decide whether it is more affordable to stay on AC or to spend their assets to qualify for EW.

Persons using the new "consumer-directed" option would not make premium payments, but instead receive a service package that is implemented at a discount.

Estate Recovery. Currently, counties seek recovery of the cost of care from the estates of persons who received MA services. This proposal would implement the same recovery from estates of those who received AC-funded

services. This proposal will create fairness among available public programs, encouraging clients to choose a program based primarily on their medical and community-based needs instead of estate considerations.

Some persons who are making decisions about estate planning may choose to become MA eligible at the onset of need, instead of retaining some of their resources to qualify for the AC program. Those persons who choose to move directly to the MA program will incur MA basic benefit costs vs. participating in supplementary programs and retaining some financial responsibility for their own primary care needs. Others who primarily consider estate planning when making decisions about health and community care may choose not to participate in either MA/EW or AC and to go without services.

Delay of the Common Service Menu. Changes were to be implemented in the AC program effective 1-1-03 that would create a common service menu and rate structure between AC, MA Home Care, and home and community-based waivers. This proposal delays implementation of the common service menu until 7-1-05.

Full Funding for Case Load Growth. This proposal includes full funding to meet the anticipated demand for AC services during FY 2004-05.

Effect of Changes on People in Licensed and Congregate Service Settings. Settings, such as assisted living, are a rapidly growing service option. They are also generally the most expensive type of service. There is a concern that future use of assisted living and other congregate settings may grow faster than use of in-home services as people who could be served in their own homes opt to move to congregate service settings. This proposal will slow the growth in use of licensed and congregate settings, such as assisted living, through the proposed changes in the premium schedule.

Relationship to Base Budget

Changes to the AC program result in net expenditure savings of 14% by FY 2005. During FY 2004, there is a phase-in period that coincides with an individual's regular annual reassessment.

The proposed changes will marginally extend the existing duties of state and county personnel. Additionally, minor changes to MMIS, MAXIS, and the revenue tracking systems will be needed.

Key Measures

- Public spending and the number of people in community-based long-term care versus institutional care.
- Consumers directing their own publicly funded home and community-based services

More information on key measures is available on the Web:
http://www.departmentresults.state.mn.us/hs/index.html.

Statutory Change: M.S. 256B.0913; M.S. 256B.0915; M.S. 524.3-805; M.S. 256B.15; M.S. 514.990-514.994.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($8,055)	($16,587)	($17,280)	($17,417)
Revenues	0	0	0	0
Net Fiscal Impact	($8,055)	($16,587)	($17,280)	($17,417)

Recommendation

The governor recommends elimination of the automatic Medical Assistance (MA) rate adjustments for operating costs for nursing facilities (NF) under contract through the Alternative Payment System (APS) for FY 2004-05.

Background

The APS program was enacted in 1995. It permits nursing facilities to contract with the state for payment rather than using the rate setting process under Rule 50. Participation is voluntary. Currently, about 75% of all nursing facilities participate in APS.

A basic concept in APS is that contracted facilities no longer report costs. Instead they receive automatic inflation adjustments. However, as early as 1998, all facilities were provided the opportunity to receive additional or larger increases by an application to Department of Human Services (DHS) in which they committed to using the additional funds for costs related to the compensation of their workers. Since 1999 these larger rate adjustments have been in place of the automatic rate adjustments.

In 1999 and again in 2001, legislation was passed limiting the automatic inflation adjustment in APS to the property component of the rate.

The purpose of this proposal is to address the projected budget deficit. For the FY 2004–05 biennium, the budget does not include cost-of-living adjustments (COLAs) for nursing facilities reimbursed under Rule 50 or for any other continuing care providers. APS nursing facilities are the only continuing care providers that, by statute, receive automatic COLA increases. This proposal aligns treatment of APS providers' adjustments with that of other continuing care providers in regard to COLA adjustments.

Cost of living is increasing and real cost pressures will affect all continuing care providers, including APS facilities. To respond to these cost pressures, providers may reduce staffing levels, which may in turn reduce access and quality of care for residents.

Relationship to Base Budget

Within the overall scope of the nursing facility budget (state share of MA was $443 million in FY 2002), this proposal has an impact of about 1.7% in FY 2004 and about 3.6% in later years.

Statutory Change: M.S. 256B.434.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($15,729)	($18,138)	($17,806)	($17,188)
Revenues	(789)	(1,579)	(1,973)	(1,973)
Net Fiscal Impact	($14,940)	($16,559)	($15,833)	($15,215)

Recommendation

The governor recommends giving nursing facilities (NFs) a choice of either reducing the rates in effect on 6-30-03 by 4% or removing some of their licensed beds from service.

Background

The rate reduction associated with this proposal would be 4% of a facilitiy's total payment rate effective 7-1-03.

As an alternative to the rate reduction, NFs would be permitted to delicense beds, retaining 85% of the number that were occupied on 1-1-03. In order to meet the savings achieved by a 4% rate reduction, nursing facilities would need to delicense their vacant beds as of 1-1-03, plus 15% of their remaining beds. Nursing facilities would be required to phase in the bed delicensure and criteria would be developed for granting a limited number of extensions.

The purpose of this proposal is to address the projected budget deficit. The rate or capacity reduction may result in financial problems for certain nursing facilities and access or quality of care issues for residents.

It is projected that, rather than accept a rate or occupancy reduction, several NFs may choose to close. This proposal includes Alternative Care and Elderly Waiver costs associated with the diversion of residents from NFs that close, as well as receivership costs.

Relationship to Base Budget

The financial impact of this proposal to nursing facilities represents 4% of the state share of the nursing facility budget.

Statutory Change: M.S. 256B.431

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($894)	($949)	($945)	($951)
Revenues	0	0	0	0
Net Fiscal Impact	($894)	($949)	($945)	($951)

Recommendation
The governor recommends elimination of the per diem to nursing facilities (NFs) for the Scholarship Program.

Background
In 2001, the legislature authorized a rate adjustment of $0.25 per resident day to fund a Scholarship Program. These funds are to be used by NFs to enable their employees to pursue a degree or credential to advance their careers in long-term care. All employees are eligible under the program except the administrator, department supervisors, and registered nurses. The areas of study that qualified for the program include anything expected to lead to career advancement within the long-term care industry, medical care interpreter services, social work, and job-related training in English as a second language.

Under current law, the adjustment described above is to be included in rates until 6-30-03. Beginning 7-1-03, the per diem amount is to be the allowable expenses a NF incurred during the previous reporting year divided by resident days. Under this proposal, the 7-1-03 rate for scholarships will be eliminated.

Relationship to Base Budget
This is a relatively small portion of NF expenditures (state share of the reduction is approximately 0.2% of expenditures).

Statutory Change: M.S. 256B.431, subd. 36.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($417)	($447)	($446)	($449)
Revenues	0	0	0	0
Net Fiscal Impact	($417)	($447)	($446)	($449)

Recommendation

The governor recommends reducing the amount paid for nursing facility hold days from 79% of the usual rate to 60% of the usual rate.

Background

When a resident of a nursing facility (NF) is in need of hospitalization, the NF may charge the resident a fee to hold their bed. This is allowed when the NF's current occupancy is at least 93% of capacity. Medical Assistance (MA) will pay 79% of a resident's usual per diem for the first 18 days of hospitalization to hold that resident's bed. MA also pays up to 36 therapeutic leave days per year to hold the bed of an MA resident when they visit family or friends. If occupancy is below 93%, no bed hold payment will be made. Under this proposal, MA will reduce the amount paid for these leave days from 79% to 60% of the resident's usual rate.

Relationship to Base Budget

This is a relatively small portion of NF expenditures (state share of the reduction is less than 0.1%). There are systems costs identified with this change of approximately $4,000 (state share). These costs are incorporated in the savings shown above.

Statutory Change: M.S. Ch. 256B, sec. 431, subd. 2r.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($4,371)	($4,662)	($4,639)	($4,668)
Revenues	0	0	0	0
Net Fiscal Impact	($4,371)	($4,662)	($4,639)	($4,668)

Recommendation

The governor recommends reducing the Medicare coinsurance amount paid to nursing facilities by the state for Medical Assistance-qualified residents covered under a Medicare stay.

Background

Presently, the amount paid to nursing facilities (NFs) for Medicare coinsurance for days 21 to 100 of a Medicare stay for MA-qualified residents is an amount set each year by the federal Centers for Medicaid and Medicare Services (CMS). Under this proposal, the amount that will be paid to NFs will be the difference between the Medicare payment and the Medicaid rate (but never less than zero) rather than the Medicare coinsurance amount set by CMS. While this may present a cash-flow problem for nursing facilities, they will be able to claim the amount they were not paid in their Medicare settle-up as a bad debt and will be reimbursed this amount at a later date by Medicare. There are other states that have used this method. Currently, the federal government allows states to limit the amount they pay for MA residents covered under a Medicare stay to the Medicaid (state plan) rate.

Relationship to Base Budget

The financial impact of this proposal represents about 1% of the nursing facility budget.

This initiative will require systems work by DHS and training for nursing facilities as billing changes will be necessary.

Statutory Change: M.S. 256B.431, subd. 39.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($2,476)	($2,665)	($2,658)	($2,679)
Revenues	0	0	0	0
Net Fiscal Impact	($2,476)	($2,665)	($2,658)	($2,679)

Recommendation

The governor recommends reducing the number of days in which a rate enhancement may be paid for newly admitted nursing facility (NF) residents from 90 days to 30.

Background

When an NF admits a resident, the facility may charge a rate 20% higher than the usual rate for the first 30 paid days of their stay and 10% higher for the following 60 paid days. The difference between "paid days" and "days" means that unpaid leave days that occur within this window do not count as part of the 90 days. MA pays these amounts, as do private-pay residents. The rationale behind this provision, enacted in 2001, is that NFs incur more costs in the 90 days following admission because of care planning, assessments, and getting to know the person.

This proposal eliminates the 10% premium payments for the 60-day period and does not allow any premium payments at all when a resident transfers from one NF to another.

Relationship to Base Budget

This is a relatively small portion of NF expenditures (state share of the reduction is approximately 0.5%). There are systems costs identified with this change of approximately $6,000 (state share). These costs are incorporated in the savings shown above.

Statutory Change: M.S. 256B.431, subd 32.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	$24,275	$24,150	$24,161	$24,178
Revenues	70,749	70,322	70,322	70,322
Net Fiscal Impact	($46,474)	($46,172)	($46,161)	($46,144)

Recommendation

The governor recommends increasing the nursing home surcharge and intergovernmental transfer (IGT) revenues.

Background

This is a proposal to increase both the surcharge and the IGT. The surcharge is currently less than the amount that would be permissible under federal Centers for Medicare and Medicaid Services (CMS, formerly HCFA) tests. A larger IGT is possible due to refinements in the method of calculating the Medicare upper payment limit test for Medical Assistance (MA or Medicaid) payment rates.

Nursing Facility Surcharge: The nursing home provider surcharge was first enacted in 1991 at $500 per bed annually. The surcharge has been increased incrementally over the years. In 2002 the surcharge was increased from $625 to $990 per licensed nursing home bed per year. In this proposal, the surcharge is increased by $1,710 to $2,700 per licensed nursing home bed per year. In addition, the rates paid to nursing facilities would increase by $5.21 per resident day.

The fiscal impact noted above assumes an effective date of 5-31-03. The rate adjustment would be effective 6-1-03., which means that nursing facilities would receive the MA payments and would start to pay the higher surcharge in July 2003. Therefore, there should not be a cash flow problem for the facilities.

The surcharge provides revenues to the general fund that can be used to match federal Medicaid funding from MA:

⇒ The nursing home pays the surcharge, in monthly installments, to the state.

⇒ These revenues are deposited in the General Fund.

⇒ At the same time, the MA rate is increased by an amount that, when annualized and applied to private pay residents, is roughly similar to the annual amount of the surcharge. The MA portion of the rate adjustment includes a 50% federal match.

⇒ Because the MA rate is higher, the rate charged to privately paying people is also higher.

Although CMS has tightened the laws regulating surcharges several times in the past decade, they have not eliminated this avenue for states to collect these revenues from providers. CMS regulates taxes and surcharges on nursing facilities; however this proposal falls within these standards.

To comply with federal law:

⇒ There cannot be a direct relationship between the surcharge applied to nursing homes and any increase in the MA payment rate for nursing homes. There also may not be any mechanism to pay back private-paying consumers.

⇒ A surcharge must be broad based. Minnesota's approved surcharge is assessed across all licensed nursing home beds.

⇒ States cannot pay more in MA rates to MA-certified nursing homes than what it estimates it would have paid using Medicare payment methodology for the same services to the same individuals. The state receives federal financial participation (FFP) for legitimate MA expenditures up to what Medicare would theoretically pay. The Department of Human Services completes an "upper limit calculation" annually to determine the difference between the MA rate and this "Medicare upper payment limit" (UPL).

⇒ The surcharge should not be in an amount that exceeds specific standards established under federal rules.

It is within this framework of laws and calculations that Minnesota currently collects surcharge revenues from nursing homes, and that additional revenues may be collected.

Several factors need to be considered to achieve the full benefits from this proposal in FY 2004:

⇒ Because this proposal involves a rate increase for nursing facilities, public notice is required, under federal law, to be given in such a manner as to allow input into the decision process. This is accomplished by publishing a notice of proposed change in nursing facility rate in the *State Register* at the start of session and then a notice of final rate change before it is implemented. A reasonable amount of time should be provided between these two notices, and the second notice must be published before the rate increase goes into effect.

⇒ A amendment to the state Medicaid Plan must be submitted to the federal government during or before the quarter during which a rate adjustment takes effect.

County Nursing Home IGTs: IGTs are only collected from counties that operate nursing homes. Like the surcharge, the money collected is deposited in the General Fund. Payments that are made from the General Fund through the MA program earn federal matching funds. Although some of the requirements that govern the surcharge do not apply to IGTs, the Medicare UPL does apply.

For analysis purposes, non-state government-owned nursing homes must be grouped separately when conducting the Medicare UPL test. The IGT, as structured under current state law, is the lesser of a specified amount or the amount available within the most recent UPL tests. Any changes in Medicare rates will affect the IGT either favorably or unfavorably. Additionally, any increase in the surcharge will affect the UPL calculations for government-owned nursing homes for purposes of the IGT. Both revenue enhancement mechanisms must be kept in balance so as not to exceed the Medicare UPL test, and current law provides sufficient authority to accomplish this. However, any substantial increase in Medicare rates or any legitimate improvement in the method of conducting the UPL test will provide an opportunity to increase either the surcharge, the IGT, or both.

Other states have over-utilized IGTs, exceeding the UPL calculation for that group. CMS is scrutinizing Minnesota's IGT and UPL calculations to ensure that Minnesota complies with all requirements. This proposal includes funding for an expert consultant to assist Minnesota in strengthening its UPL calculation methodology.

Relationship to Base Budget

Within the overall scope of the nursing facility budget (state share of MA was $443 million in FY 2002), this proposal has a substantial impact, about 10.4%. The proposal increases the surcharge from $990 per bed to $2,700 per bed; an increase of 173%.

Statutory Change: M.S. 256B.19, 256B.431, and 256.9657.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
TANF Fund				
Expenditures	($2,857)	($8,631)	($9,732)	($9,453)
Revenues	0	0	0	0
Net Fiscal Impact	($2,857)	($8,631)	($9,732)	($9,453)

Recommendation

The governor recommends reforms to strengthen the Minnesota Family Investment Program (MFIP) with a work-first focus and program improvements that reinforce personal responsibility.

Background

Proposals include:

Work-first Focus

- **Work-first**. When families first apply for assistance, they will meet with a job counselor and develop an intensive employment plan for four months before going onto MFIP. This is based on a successful pilot in Dakota County.
- **Work plans for all.** All participants will have an employment plan to build skills and stay connected to job opportunities. Currently, 12% of MFIP participants are exempt from having an employment plan (such as disabled parents, caregivers or those with a disabled child, or caregivers over 60).
- **Education.** MFIP participants who choose to attend school will be required to work 25 hours a week while receiving cash assistance. This requirement is similar to situations faced by working families pursuing an education.
- **Emphasis on employment.** Unsubsidized employment will be the first goal for all MFIP parents.

Program Improvements

- **Case close for noncompliance** (100% sanctions). Those who do not meet MFIP requirements within six months will lose cash assistance. This ensures that people make serious efforts to become self-sufficient and supports MFIP families who are doing their best to get back to work.
- **Family cap.** An MFIP family's grant will not increase if a parent has another child while the family is on assistance.

Key Measures

⇒ MFIP Self-Support Index (percent of adults working 30+ hours or off MFIP cash assistance three years later)
- By race/ethnicity
- MFIP work participation rate

Statutory Change: M.S. 256J.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
TANF Fund				
Expenditures	$15,000	$25,000	$25,000	$25,000
Revenues	0	0	0	0
Net Fiscal Impact	$15,000	$25,000	$25,000	$25,000

Recommendation

The governor recommends increased funding and the consolidation of Minnesota Family Investment Program (MFIP) self-sufficiency programs, including development of a continuum of services, to meet the needs of families in their transition to work, and improve program performance.

Background

TANF investments in various intervention programs will decline by $85.3 million from the 2002-03 biennium to the 2004-05 biennium. These investments have been a critical piece in helping Minnesota Family Investment Program (MFIP) participants and other low-income families become more self-sufficient. In FY 2003, 39 separate intervention programs spread among six different state agencies used TANF funds. Nineteen sunset at the end of SFY 2003 and one at the end of 2004.

The scheduled sunset of some of the employment-related TANF programs creates an opportunity to redesign the service structure to better meet the needs of families in a "steady-state" program and to provide the flexible funding counties and tribes will need to successfully implement the governor's welfare reform initiatives. In exchange for this flexibility, counties would be held accountable for results by reporting on performance measures.

This proposal would consolidate funding for the following programs: county administration, current employment-related grants, Diversionary Assistance, Emergency Assistance, and Minor Parent Support Services. This consolidation is effective July 2003. Funding would be allocated to counties and tribes to administer self-sufficiency programs. Counties and tribes would be required to file a plan describing how they intend to allocate funds within the purposes specified by statute.

Of the consolidated funding, $3 million would be set aside to address specific self-sufficiency challenges as determined by the commissioner. The remainder would be allocated to counties and tribes, phased in over time based on historical spending and caseload. Five percent (5%) of the allocation formula will be based on performance.

Relationship to Base Budget

This proposal redirects TANF and General Fund appropriations for eleven programs and services to a single, consolidated fund. In FY 2004, General Fund appropriations totaling $8,630,000 and TANF appropriations totaling $101,060,000 will be redirected to the consolidated fund. In FY 2005, the redirected amounts are $8,642,000 in General Fund appropriations and $107,686,000 in TANF funds. Total funding available for the consolidated program is $109,690,000 in FY 2004 and $116,328,000 in FY 2005.

Key Measures

⇒ MFIP Self-Support Index
♦ race/ethnicity
⇒ MFIP Work Participation Rate

More information on key measures is available on the Web:
http://www.departmentresults.state.mn.us/hs/index.html

Statutory Change: M.S. 256J.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
TANF Fund				
Expenditures	($2,586)	($5,005)	($5,281)	($5,435)
Revenues	0	0	0	0
Net Fiscal Impact	($2,586)	($5,005)	($5,281)	($5,435)

Recommendation

The governor recommends limiting Minnesota Family Investment Program (MFIP) participants to post-secondary education and training of 12 months, without exception.

Background

Prior to July 2001, MFIP participants who enrolled in post-secondary education programs as part of their employment plan were limited to programs that were 12 months in duration. Programs that lasted up to 24 months could only be approved on an exception basis. The 2001 legislature passed a provision that allowed MFIP participants to enroll in post-secondary education programs lasting up to 24 months.

Nationally, research findings and outcomes vary on the impact of education and training as a path to higher paid employment or whether a combination of education and work requirements results in higher income. This proposal should not have significant impact on outcomes for MFIP families – yet will create needed savings. Minnesota has received TANF high performance bonuses for its successful efforts at promoting job retention and wage advancement.

Individuals who have completed 12 months of post-secondary education generally have the skills and abilities needed to become gainfully employed in the labor force. This change would require a transition period during which current employment plans would be honored.

Relationship to Base Budget

Based on national research and department data, the average monthly MFIP caseload, excluding child-only cases, is about 1.7% higher (approximately 500 cases) due to the implementation of 24-month education plans in place of direct job search.

Key Measures

- MFIP (welfare-to-work) Self-Support Index

More information on key measures is available on the Web:
http://www.departmentresults.state.mn.us/hs/index.html

Statutory Change: M.S. 256J.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	$6	0	0	0
Revenues	0	0	0	0
TANF Fund				
Expenditures	($15,376)	($14,566)	($14,304)	($13,964)
Revenues	0	0	0	0
Net Fiscal Impact	($15,370)	($14,566)	($14,304)	($13,964)

Recommendation

The governor recommends reducing the Minnesota Family Investment Program (MFIP) cash grant up to $175 for each Supplemental Security Income (SSI) recipient in an MFIP household, unless the caregiver in the household is a relative caretaker.

Background

Some MFIP households include members who receive SSI. These members do not receive MFIP cash assistance. Under current policy, MFIP does not consider the income of an SSI recipient in determining the MFIP benefit amount. However, Retirement, Survivors, and Disability Insurance (RSDI) income is counted when calculating the MFIP grant. Receipt of SSI and RSDI is based on an individual's disability status and, therefore, should be treated more consistently for purposes of determining the MFIP benefit level.

This is a proposal to reduce the MFIP cash grant up to $175 for each SSI recipient in an MFIP household, effective 7-1-03. The proposal does not add SSI recipients to the MFIP assistance unit, but rather reduces the MFIP benefit up to $175 for each SSI recipient. The estimated savings assume that, when calculating the grant amount for MFIP cases, the grant standard would be reduced by $175 for each SSI recipient in the household, unless the caregiver in the household is a relative caretaker.

Relationship to Base Budget

Based on department data, in an average month about 17% of MFIP cases have an SSI recipient in the household.

Statutory Change: M.S. 256J.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
Federal TANF				
Expenditures	($3,519)	($4,549)	($4,810)	($4,812)
Revenues	0	0	0	0
Net Fiscal Impact	($3,519)	($4,549)	($4,810)	($4,812)

Recommendation

The governor recommends reducing the Minnesota Family Investment Program (MFIP) exit level from 120% of federal poverty guidelines (FPG) to 115% of FPG.

Background

In 2001, the legislature enacted a policy that indexes the earned income disregard so that a working MFIP family would exit MFIP at 120% of FPG. To reward work, MFIP disregards part of families' earned income when calculating the MFIP grant amount. In FY 2003, the earned income disregard is scheduled to increase from 38% to 39% to maintain the exit level at 120% of FPG.

This proposal would reduce the exit level from 120% of FPG to 115% of FPG and make annual adjustments in the earned income disregard to maintain the 115% of FPG exit level. Working families on MFIP will see their benefits decrease slightly when the disregard is decreased.

The effective date of this change would be 10-1-03, so that the earned income disregard is adjusted after the MFIP transitional standard is changed to reflect the food stamp cost of living adjustment. It is only after we know the new transitional standard that we know where to set the earned income disregard to meet the 115% of FPG exit level.

This proposal has a fiscal interaction with the SSI and MFIP Budgeting proposal. Savings associated with this proposal may change, should the SSI and MFIP Budgeting proposal be modified.

Relationship to Base Budget

During FY 2002, an average of 52.6% two-parent families and 29.1% one-parent families were employed.

Key Measures

⇒ MFIP Self-Support Index (percent of adults working 30+ hours or off MFIP cash assistance three years later)
- ♦ By race/ethnicity

Statutory Change: M.S. 256J.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	0	($30)	($36)	($41)
Revenues	0	0	0	0
TANF Fund				
Expenditures	0	2,143	2,623	3,113
Revenues	0	0	0	0
Net Fiscal Impact	0	$2,113	$2,587	$3,072

Recommendation

The governor recommends improving the Minnesota Family Investment Program (MFIP) 60-month time limit extension policy.

Background

The proposal

- repeals the sunset of the employed participant extension category;
- clarifies/refines extension policy related to two-parent families; and
- clarifies/refines extension sanction policies.

Extensions to the MFIP 60-month time limit were established by the 2001 legislature. In late 2001, an emergency rule was promulgated to clarify ambiguous language. In addition, two categories of extension were added in 2002. In July 2002, the first major group of participants reached the time limit. A number of policy issues have been identified in the process of implementing the extension policy for this first group of participants. This proposal addresses those issues.

Relationship to Base Budget

Based on department data, in an average month about 67% of the cases with at least 60 eligible months (approximately 2,400 cases in FY 2003) qualify for a hardship extension. Of these, about 14% qualify for a working extension.

Based on department data, the refinement of the extension policy related to two-parent families is expected to impact less than 10 cases in an average month.

Key Measures

- MFIP (welfare-to-work) Self-Support Index

More information on key measures is available on the Web:
http://www.departmentresults.state.mn.us/hs/index.html.

Statutory Change: M.S. 256J.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
TANF Fund				
Expenditures	$5,107	$6,141	$7,251	$7,888
Revenues	0	0	0	0
Net Fiscal Impact	$5,107	$6,141	$7,251	$7,888

Recommendation

The governor recommends repealing the 6-30-03 sunset of Minnesota Family Investment Program (MFIP) cash and food assistance to legal non-citizen families.

Background

State funding was first authorized in 1997 following the enactment of Federal Welfare Reform, which eliminated federal funding for *some* legal non-citizens. It was funded with a sunset date because there was uncertainty about whether the restriction in federal funding would continue. This uncertainty exists because Congress has not yet reauthorized TANF and related programs.

Although modifications were made to federal food stamp policy, some legal non-citizens are still not eligible for the federal food stamp program that is used to fund the food portion of MFIP. If state MFIP funding ends for the legal immigrants who are not eligible for federal TANF, those families, who currently receive MFIP cash and a food portion, will no longer have a source of income or food.

If MFIP state funding for legal non-citizen families does not continue, there would be a fiscal impact to the Minnesota Food Assistance Program (MFAP) since some former MFIP participants could be eligible for MFAP.

Relationship to Base Budget

TANF funds identified in this proposal will be used for TANF-eligible persons while state funds currently in the MFIP base budget will be used to fund the eligible non-citizens for whom federal funding is not available.

Most state funds in the MFIP program are allocated to meet the TANF maintenance of effort (MOE) requirement. Currently there are more than enough state funds to meet this requirement.

Non-MOE expenses are estimated to be $1.9 million in FY 2004 and $2.1 million in FY 2005.

Key Measures

- MFIP (welfare-to-work) Self-Support Index

More information on key measures is available on the Web:
http://www.departmentresults.state.mn.us/hs/index.html

Statutory Change: Laws 2001, First Special Session, chapter 9, article 10, section 62.52.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	$27	$132	$246	$367
Revenues	0	0	0	0
Net Fiscal Impact	$27	$132	$246	$367

Recommendation

The governor recommends increased funding to cover the projected demand for food support to legal non-citizens who do not qualify for federal food benefits because of their citizenship status.

Background

The Minnesota Food Assistance Program (MFAP) was established in 1998. MFAP provides state-funded food assistance for legal non-citizens who do not qualify for federal food benefits because of their citizenship status. The program uses all of the policies, procedures, benefit rates, and eligibility criteria as the federal food support program.

In 2002 the President signed into law provisions of the Farm Bill that restore federal food benefits to most MFAP recipients. Disabled legal non-citizens had their eligibility for federal food benefits restored on 10-1-02. Legal non-citizens in the U.S. for five or more years will have their eligibility restored on 4-1-03. Legal non-citizen children under age 18 will have benefits restored on 10-1-03. Even with the Farm Bill there will be approximately 287 average monthly cases in FY 2004 and 338 in FY 2005 will depend on MFAP for their food assistance. To cover the projected MFAP shortfall and provide service to the estimated number of eligible cases for the FY 2004-05 biennium, the associated cost is $159,544.

Relationship to Base Budget

Base funding for MFAP in FY 2004 is $417,000. MFAP operates on a fixed appropriation, so the budget for the program is not adjusted when the number of eligible participants increases.

If Minnesota Family Investment Program (MFIP) state funding for legal non-citizen families does not continue, there would be a fiscal impact to the MFAP since some former MFIP participants would be eligible for MFAP.

Statutory Change: M.S. 256D.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($1,321)	($1,321)	($1,321)	($1,321)
Revenues	0	0	0	0
Net Fiscal Impact	($1,321)	($1,321)	($1,321)	($1,321)

Recommendation
The governor recommends reduced state grant funding for Food Support Employment and Training (FSET).

Background
FSET provides employment and training services to help people prepare for work and become employed. Minnesota is required by federal law to operate an FSET program. Services to clients are funded with a 100% federal grant and state funds with federal matching funds. Reimbursement of necessary client expenses is required and must be paid with state funds.

This proposal will reduce the state financial participation in the FSET program. Able-bodied adults without dependents are eligible for three months of Food Support benefits and can "earn" additional months by participating in FSET or by working more than 80 hours/month. This proposal will reduce the number of Food Support recipients served by FSET by about 72% to approximately 2,000.

Relationship to Base Budget
State base funding for FSET is $1,347,000 per year. This proposal will reduce the state appropriation by $1,321,,000 per year and use $950,000 in annual FSET federal funds to serve as many able-bodied adults without dependents as is possible. A $1,321,000 reduction in the General Fund results in a corresponding loss of up to $1,321,000 in federal matching funds.

Statutory Change: M.S. 256D.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($2,338)	($2,591)	($2,812)	($3,192)
Revenues	0	0	0	0
TANF Fund				
Expenditures	(4,946)	(6,055)	(7,721)	(9,414)
Revenues	0	0	0	0
Net Fiscal Impact	($7,284)	($8,646)	($10,533)	($12,606)

Recommendation

The governor recommends limiting funding for Emergency Assistance (EA), Emergency General Assistance (EGA), and Emergency Minnesota Supplemental Aid (EMSA) at 100% of FY 2002 expenditures levels and restricts EGA and EMSA eligibility to once every 12 months.

Background

Most expenditures under these emergency programs are for shelter costs, such as housing, damage deposits, and utility shut-offs.

EA provides short-term assistance to families for such items as housing or utilities. To receive EA, the unit must include a child under the age of 21 who is living in the home or who has recently lived with the family or a pregnant woman. The assistance must be able to resolve the problem and is issued for one 30-day period in a consecutive 12-month period. In FY 2002, during an average month, 6,100 people received help from EA. This proposal will cap funding for EA at 100% of the FY 2002 expenditure level.

Savings associated with capping EA funding at the FY 2002 expenditure level are $4.9 million for FY 2004 and $6 million for FY 2005, for a total of $11 million for the biennium.

Annually, EGA provides benefits to about 13,500 adults and families (FY 2002) who are not eligible for EA or the Minnesota Family Investment Program (MFIP). There are no absolute income limits; eligibility is based on the existence of an emergency that threatens health or safety and that cannot be resolved with available income and resources.

Savings associated with capping EGA funding at the FY 2002 expenditure level are $2.2 million for FY 2004 and for FY 2005, for a total of $4.4 million for the biennium.

EMSA provides emergency benefits to over 3,130 aged, blind, or disabled adults (FY 2002) who are not eligible for EA or EGA. MSA recipients who have an emergency that threatens health or safety and that cannot be resolved with available income and resources are eligible for EMSA.

Savings associated with limiting use of EMSA to once every 12 months are $169,000 for FY 2004 and $354,000 for FY 2005, for a total of $523,000 for the biennium.

Relationship to Base Budget

The total forecast spending for Emergency Assistance for FY 2004-05 is $53.4 million.
The total forecast spending for Emergency General Assistance for FY 2004-05 is $20.2 million.
The total Emergency Minnesota Supplemental Aid forecast spending for FY 2004-05 is $2.7 million.

Counties may continue to use the MAXIS computer system to determine eligibility for emergency programs. MAXIS programming changes would be needed to add the once every 12 months limitation for EGA and EMSA and to track funding allocations by county.

Statutory Change: M.S. 256D and M.S. 256J

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($12,927)	($9,272)	0	0
Revenues	0	0	$10,274	$10,827
TANF Fund				
Expenditures	$12,927	$9,272	$10,274	$10,827
Revenues	0	0	0	0
Net Fiscal Impact	0	0	0	0

Recommendation

The governor recommends the refinancing of General Fund spending with TANF funds that have been made available through TANF program cuts to the Minnesota Family Investment Program (MFIP).

Background

This proposal decreases the General Fund budgets of MFIP in FY 2004 and of the Children and Community Services Grant in FY 2005 to assist in balancing the state's General Fund budget. This proposal includes corresponding increase in the Temporary Assistance to Needy Families (TANF) spending in FY 2004 and FY 2005 in the MFIP program and Children and Community Services Grant program, respectively.

The refinancing of the MFIP cash assistance program in FY 2004 is made possible by the presence of state spending in excess of the minimum necessary to meet federal maintenance of effort (MOE) requirements. The refinancing of the Children and Community Services Grant in FY 2005 will be accomplished through a transfer of TANF to the social services block grant (SSBG) to substitute for General Fund spending. This type of refinancing was last done in the 1999 session of the legislature when such a transfer provided savings from the Community Social Services Act (CSSA) block grant to counties. Under another governor's recommendation, the CSSA funds will be combined with other funds to create the Children and Community Services Grant program.

The proposal for the FY 2006-07 biennium is to authorize additional refinancing in FY 2006 and FY 2007 and provide that the commissioner designate which programs will provide the General Fund savings as part of the FY 2006-07 budget, subject to approval by the legislature.

There are two reasons for not designating the out-year refinancing targets in the FY 2004-05 budget.

⇒ First, significant changes are being proposed in the governor's budget or may be proposed by the legislature that will affect programs that are potential refinancing targets.

⇒ Second, amendments to the TANF program being discussed by Congress as part of TANF reauthorization would increase the state's capacity to refinance by increasing the TANF available for SSBG transfer or making it easier to spend TANF funds on child care, as well as open up other refinance options.

Program recipients, providers, and counties will not be affected by this change in financing.

Relationship to Base Budget

This proposal would create an ongoing General Fund savings relative to the base budget and ongoing TANF commitments.

Statutory Change: Not Applicable.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($100)	($100)	($100)	($100)
Revenues	0	0	0	0
Net Fiscal Impact	($100)	($100)	($100)	($100)

Recommendation
The governor recommends the elimination of Access and Visitation grants.

Background
The primary recipient of Access and Visitation funds has been Cooperation for the Children, a custody and visitation mediation program operating in Ramsey and Stearns counties. An evaluation was recently completed from the pilot phase of these programs showing positive results, but low numbers of families served. An average of 170 mediations have been completed each year since the program began.

The state grant that is being eliminated has been coupled with an annual federal grant. Minnesota could continue to qualify for a federal grant if an alternative method of meeting the federal matching requirements is identified. The current legislative authority for use of this annual federal grant is limited to funding parent education and the Cooperation for the Children pilot programs in Ramsey and Stearns counties. Federal guidelines indicate that the grant money may be used for numerous activities, including mediation, counseling, parent education, development of parenting plans, family formation activities, and supervised visitation. A legislative change is necessary to allow the states to use the federal funds flexibly for other purposes and to benefit other counties in future applications for the federal grant.

Relationship to Base Budget
This state grant is currently $100,000 per year. This proposal would eliminate the state grant and Minnesota would also lose $100,000 in federal funds..

Statutory Change: Laws of Minnesota 1997, Ch. 245, Art. 2, Sec. 11.

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($462)	($636)	($884)	($884)
Revenues	0	0	0	0
Net Fiscal Impact	($462)	($636)	($884)	($884)

Recommendation

The governor recommends refinancing state-funded child support incentive grants to counties with revenue from a new 1% child support services user fee charged to parents beginning in FY 2005. This proposal includes a one-time 15% reduction in grant funding to counties in FY 2004.

Background

This proposal would reduce state incentive grants to counties and establish a 1% cost recovery fee to offset the reduction. The offset from the cost recovery fee would help avoid federal sanctions, maintain the health of the incentive fund, and ensure that counties continue to meet program objectives. It also links the fees users pay to the services they receive.

The fee would be paid or charged to the parent who applies for child support services. Revenues raised by this fee would be paid into a special revenue fund dedicated to the child support program. Revenues would support the county incentive fund and also pay for the costs of implementing the fee required to support the fund.

If the parent who is owed child support (obligee) applies for services, the fee would be deducted from child support collections prior to disbursing them to the obligee. If the parent owing the child support (obligor) is the applicant, the fee would be charged in addition to the child support order amount. Current public assistance (PA) cases and recent PA cases (most recent receipt of public assistance benefits 24 months prior) would be exempt from this fee. Minnesota law would be clarified to allow parents to opt-out of the IV-D child support system.

Currently, applicants for child support services pay a one-time application fee of $25. The state share of this fee is retained by the county providing the services. The state would need to split revenues from this new cost recovery fee with the federal agency 66%/34%. This proposal will not result in any administrative savings for the department; however, there will be added administrative costs to implement and maintain the fee. Implementation of the fee would be effective on 7-1-04 allowing for system development programming and implementation.

The state grant funds complement the federal performance incentives for the state. In Minnesota's state supervised-county administered structure, county performance on program objectives determines the amount of federal incentives the state earns and whether or not the state avoids federal sanctions.

A state that fails to achieve performance standards established in federal regulations may be penalized through a reduction in its Temporary Assistance for Needy Families (TANF) block grant. On the first violation, the block grant could be reduced by between 1% and 2%. For the second and third violation, a 3% and 5% percent reduction could be made (see 45 CFR 305.61). Minnesota's TANF block grant is approximately $267 million. A 1% reduction in the grant would amount to a loss of $2.67 million for the State of Minnesota. A 2% reduction in the grant would amount to a loss of $5.34 million.

County performance incentives facilitate core program activities that provide support to families, paternity establishment, medical support order establishment, and collections. It is important to maintain program performance incentives for counties, especially in light of the multi-million dollar federal penalties against the state's TANF grant should the state fail to reach the federal performance target on paternity establishment.

The net savings to the general fund when fully implemented in FY 2006 will be $884,000. Counties would continue to receive $3,789,000 in incentive payments each year from a reduced General Fund appropriation and forecasted revenues generated by the cost recovery fee, except in FY 2004 during development and implementation of the fee.

Relationship to Base Budget
The state General Fund base for child support incentive grants to counties is $3,789,000 in FY 2004.

Statutory Change: M.S. 518.551

State of Minnesota
Department of Finance

400 Centennial Building
658 Cedar Street
St. Paul, Minnesota 55155
Voice: (651) 296-5900
Fax: (651) 296-8685
TTY: 1-800-627-3529

February 18, 2003

The Minnesota Legislature
State Capitol
St. Paul, Minnesota

Dear Legislators,

I hereby respectfully submit for your consideration the FY 2004-05 Governor's budget proposals for the non-cabinet agencies in the Health and Human Services omnibus bill. These agencies collectively administer $163.2 million for the FY 2004-05 biennium. The Governor encourages the agencies to work diligently to be effective stewards of taxpayer resources and focus operations and spending on their highest service priorities.

The funding recommended for these agencies for FY 2004-05 represents a $1 million (0.6%) increase from the FY 2002-03 biennium. The funding for these agencies will be used to provide health and supportive housing services for Minnesota Veterans, license and regulate health professionals, promote high standards for treatment of mental illness, promote the protection of children, and coordinate training and administration for eight independent EMS organizations.

The magnitude of the projected budget shortfall and the desire to protect core government functions necessitates reducing or eliminating some functions. The Governor intends that agencies individually redesign their operations to minimize the disruption to public services as much as possible. It will also be important for them to collaborate with other agencies to consolidate operations, eliminate duplication, co-locate facilities, or otherwise cooperate to share services in order to reduce costs.

Agencies have focused reduction plans around administrative areas of the budget. In most cases this protects the core function of the agency, albeit at a reduced level. In some cases, reduced staff will have direct effects on citizens as they try to access government services.

The pages that follow provide more detailed information on individual agency spending history and budget plans for the next biennium.

I know that my staff, the agencies, and the Governor's Office all stand ready to provide you with additional information and assistance as necessary as you go about the difficult task of crafting a sound budget for the upcoming biennium.

Sincerely,

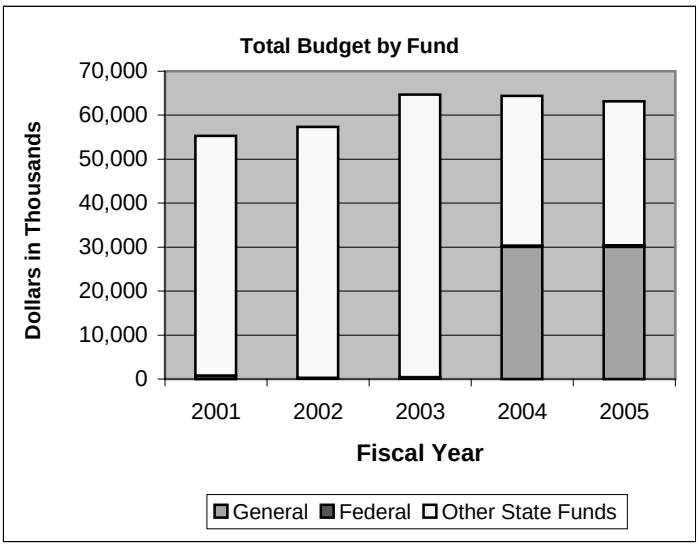
Dan McElroy
Commissioner

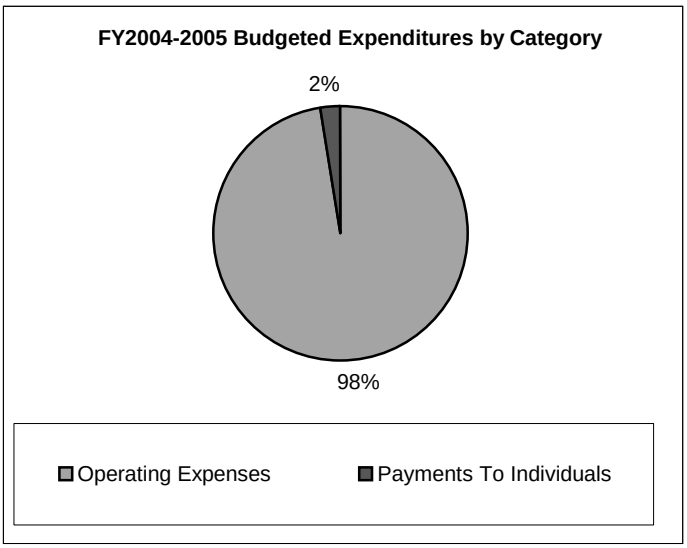
	FY 2004-05 Expenditures ($000s)		
	General Fund	**Other Funds**	**Total**
2003 Funding Level	61,860	67,546	129,406
One-Time Appropriations	-1,800	0	-1,800
Adjusted Base Funding	60,060	67,546	127,606
Governor's Recommendations	60,060	67,546	127,606
Biennial Change, 2002-03 to 2004-05	60,060	-54,480	5,580
Percent Change	n.m	-45%	5%

Brief Explanation Of Budget Decisions:

General Fund appropriations to the Veterans Homes Board are unchanged for the upcoming biennium. The appropriation adjustment removes one-time supplemental funding provided by the Legislature for FY 2003 from FY 2004-2005 funding levels.

Biennial change and percent change figures reflect that each fiscal year, the Veterans Homes Board's entire General Fund appropriation is transferred to the Special Revenue Fund and combined with receipts from the Veterans Administration and resident payments. This combined fund is used for the operation of the five veterans homes.





Dollars in Thousands						
	Actual	Actual	Preliminary	Governor's Rec		Biennium
Expenditures by Fund	**FY2001**	**FY2002**	**FY2003**	**FY2004**	**FY2005**	**2004-05**
Direct Appropriations						
General	680	0	0	30,030	30,030	60,060
Statutory Appropriations						
Special Revenue	52,443	55,084	61,909	31,906	30,649	62,555
Federal	80	245	340	275	308	583
Miscellaneous Agency	1,394	1,415	1,604	1,604	1,604	3,208
Gift	678	621	808	600	600	1,200
Total	**55,275**	**57,365**	**64,661**	**64,415**	**63,191**	**127,606**
Expenditures by Category						
Operating Expenses	53,456	55,603	62,803	62,857	61,633	124,490
Capital Outlay & Real Property	489	427	316	16	16	32
Payments To Individuals	1,327	1,332	1,538	1,538	1,538	3,076
Local Assistance	3	3	4	4	4	8
Total	**55,275**	**57,365**	**64,661**	**64,415**	**63,191**	**127,606**
Expenditures by Program						
Veterans Homes	55,275	57,365	64,661	64,415	63,191	127,606
Total	**55,275**	**57,365**	**64,661**	**64,415**	**63,191**	**127,606**

VETERANS HOME BOARD

Fiscal Report

Dollars in Thousands	Actual	Actual	Preliminary	Governor's Rec		Biennium
Revenue by Type and Fund	**FY2001**	**FY2002**	**FY2003**	**FY2004**	**FY2005**	**2004-05**
Non Dedicated						
General	12	230	0	0	0	0
Subtotal Non Dedicated	12	230	0	0	0	0
Dedicated						
Special Revenue	25,941	27,326	27,962	29,777	30,648	60,425
Federal	80	274	311	275	308	583
Miscellaneous Agency	1,381	1,458	1,610	1,610	1,610	3,220
Gift	589	575	616	616	616	1,232
Subtotal Dedicated	27,991	29,633	30,499	32,278	33,182	65,460
Total Revenue	**28,003**	**29,863**	**30,499**	**32,278**	**33,182**	**65,460**
Full-Time Equivalents (FTE)	**908.5**	**863.2**	**855.8**	**855.8**	**855.8**	

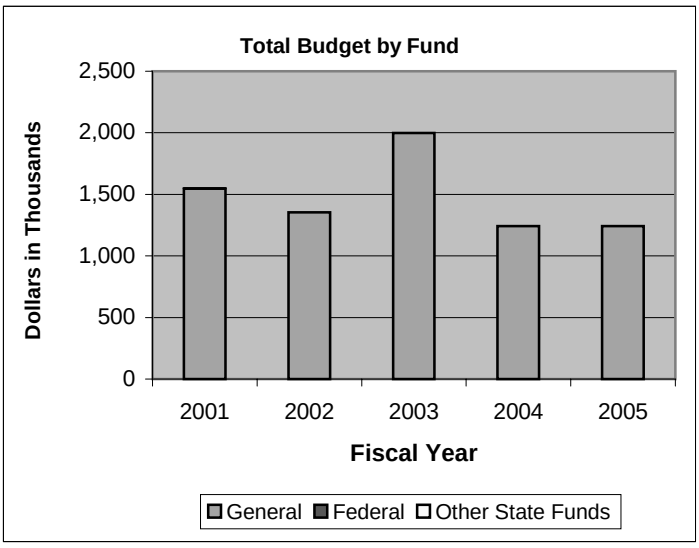
	FY 2004-05 Expenditures ($000s)		
	General Fund	**Other Funds**	**Total**
2003 Funding Level	2,924	0	2,924
Adjusted Base Funding	2,924	0	2,924
Change Items			
Reduction Plan	-439	0	-439
Governor's Recommendations	2,485	0	2,485
Biennial Change, 2002-03 to 2004-05	-866	0	-866
Percent Change	-26%	n.m.	-26%

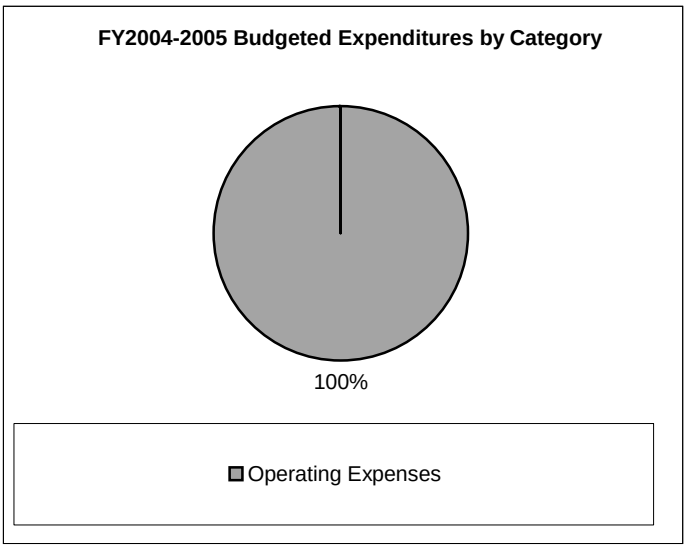
Brief Explanation Of Budget Decisions:

The Ombudsman for Mental Health and Mental Retardation (OMHMR) reviews serious injuries and deaths at licensed facilities, advocates for clients, and makes recommendations on issues surrounding mental health. OMHMR will continue to maintain high priority services with reduced administrative resources and personnel during the coming biennium. As a tool, OMHMR should collaborate with other state agencies on ways to achieve these reductions through consolidation or sharing of support services.

OMBUD FOR MENTAL HEALTH & M R

Fiscal Report





Dollars in Thousands	Actual	Actual	Preliminary	Governor's Rec		Biennium
Expenditures by Fund	**FY2001**	**FY2002**	**FY2003**	**FY2004**	**FY2005**	**2004-05**
Direct Appropriations						
General	1,547	1,353	1,998	1,243	1,242	2,485
Statutory Appropriations						
Special Revenue	1	0	0	0	0	0
Total	**1,548**	**1,353**	**1,998**	**1,243**	**1,242**	**2,485**
Expenditures by Category						
Operating Expenses	1,548	1,353	1,998	1,243	1,242	2,485
Total	**1,548**	**1,353**	**1,998**	**1,243**	**1,242**	**2,485**
Expenditures by Program						
Ombudsman For Mh & Mr	1,548	1,353	1,544	1,243	1,242	2,485
Crime Victims Oversight	0	0	454	0	0	0
Total	**1,548**	**1,353**	**1,998**	**1,243**	**1,242**	**2,485**
Revenue by Type and Fund						
Dedicated						
General	70	0	0	0	0	0
Subtotal Dedicated	70	0	0	0	0	0
Total Revenue	**70**	**0**	**0**	**0**	**0**	**0**
Full-Time Equivalents (FTE)	**19.1**	**17.6**	**22.6**	**15.1**	**15.1**	

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($219)	($220)	($219)	($220)
Revenues	0	0	0	0
Other Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact	($219)	($220)	($219)	($220)

Recommendation
The Governor recommends a reduction of $219,000 in FY 2004 and $220,000 in FY 2005 from the budget of the Ombudsman for Mental Health and Mental Retardation.

Background
The recommended reduction will be taken from the following areas of the agency operating budget.

- Salaries
- P/T services
- Travel
- Supplies and Equipment

The staff reduction will result in decreased services to the clients. Complaints would be prioritized and investigated in the order of severity. Some minor complaints may not be investigated at all.

Relationship to Base Budget
The recommended reduction represents 15% of the agency budget. Since there is no base funding for the Office of Crime Victims, the entire reduction will be taken from activities traditionally associated with the Ombudsman for Mental Health and Mental Retardation.

Alternatives Considered
None.

Statutory Change: Not Applicable.

OMBUDSPERSON FOR FAMILIES

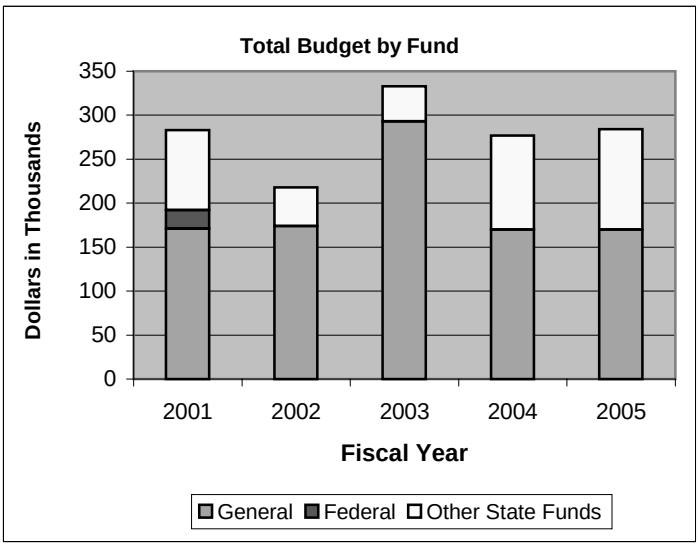
	FY 2004-05 Expenditures ($000s)		
	General Fund	**Other Funds**	**Total**
2003 Funding Level	490	221	711
Adjusted Base Funding	490	221	711
Change Items			
Reduction Plan	-150	0	-150
Governor's Recommendations	340	221	561
Biennial Change, 2002-03 to 2004-05	-127	137	10
Percent Change	-27%	163%	2%

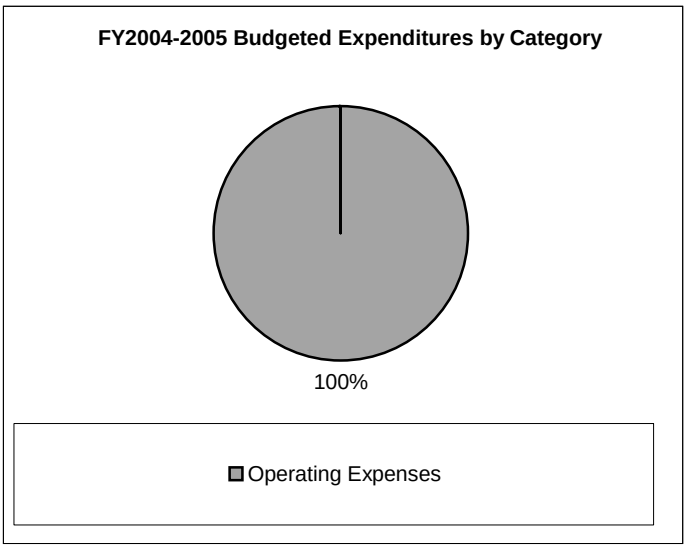
Brief Explanation Of Budget Decisions:

The Ombudsperson for Families is an organization that provides advocacy and protection for children and their families. This process can include working with the courts and policy makers. The ombudsperson will continue to maintain high priority services with reduced administrative resources during the coming biennium.

OMBUDSPERSON FOR FAMILIES

Fiscal Report





Dollars in Thousands	Actual	Actual	Preliminary	Governor's Rec		Biennium
Expenditures by Fund	**FY2001**	**FY2002**	**FY2003**	**FY2004**	**FY2005**	**2004-05**
Direct Appropriations						
General	171	174	293	170	170	340
Statutory Appropriations						
Special Revenue	91	44	40	107	114	221
Federal	21	0	0	0	0	0
Total	**283**	**218**	**333**	**277**	**284**	**561**
Expenditures by Category						
Operating Expenses	283	218	333	277	284	561
Total	**283**	**218**	**333**	**277**	**284**	**561**
Expenditures by Program						
Ombudspersons For Families	283	218	333	277	284	561
Total	**283**	**218**	**333**	**277**	**284**	**561**
Revenue by Type and Fund						
Dedicated						
Federal	19	0	0	0	0	0
Subtotal Dedicated	19	0	0	0	0	0
Total Revenue	**19**	**0**	**0**	**0**	**0**	**0**
Full-Time Equivalents (FTE)	**4.2**	**3.0**	**4.0**	**4.0**	**4.0**	

OMBUDSPERSON FOR FAMILIES

Change Item: REDUCTION PLAN

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($75)	($75)	($75)	($75)
Revenues	0	0	0	0
Other Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact	($75)	($75)	($75)	($75)

Recommendation

The Governor recommends a reduction of $75,000 in FY 2004 and FY 2005 from the budget of the Ombudsperson for Families.

Background

The recommended reduction will be taken from salaries. There will be no reduction in FTE because the office will use special revenue fund carry-forward to mitigate the General Fund reduction.

Relationship to Base Budget

The recommended reduction represents 30.6% of the agency budget.

Alternatives Considered

None.

Statutory Change: Not Applicable.

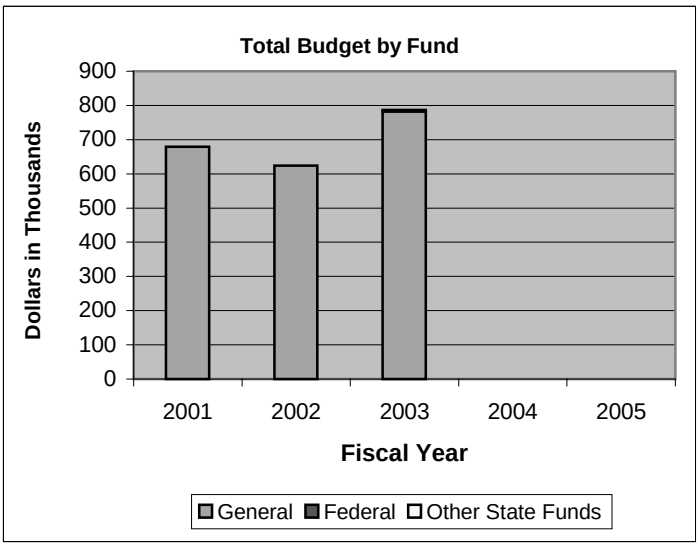
	FY 2004-05 Expenditures ($000s)		
	General Fund	Other Funds	Total
2003 Funding Level	1,428	0	1,428
Program/Agency Sunset	-1,428	0	-1,428
Adjusted Base Funding	0	0	0
Governor's Recommendations	0	0	0
Biennial Change, 2002-03 to 2004-05	-1,406	-5	-1,411
Percent Change	-100%	-100%	-100%

Brief Explanation Of Budget Decisions:

The Disability Council will sunset on June 30, 2003. No on-going funding has been allocated for this function during the next biennium. Funding for the Developmental Disabilities Council within the Department of Administration can be found in the State Government volume of the budget.

DISABILITY COUNCIL

Fiscal Report



Dollars in Thousands	Actual	Actual	Preliminary	Governor's Rec		Biennium
Expenditures by Fund	**FY2001**	**FY2002**	**FY2003**	**FY2004**	**FY2005**	**2004-05**
Direct Appropriations						
General	679	624	782	0	0	0
Statutory Appropriations						
Gift	0	0	5	0	0	0
Total	**679**	**624**	**787**	**0**	**0**	**0**
Expenditures by Category						
Operating Expenses	679	624	787	0	0	0
Total	**679**	**624**	**787**	**0**	**0**	**0**
Expenditures by Program						
Cncl On Disability	679	624	787	0	0	0
Total	**679**	**624**	**787**	**0**	**0**	**0**
Full-Time Equivalents (FTE)	**9.1**	**9.2**	**9.2**	**0.0**	**0.0**	

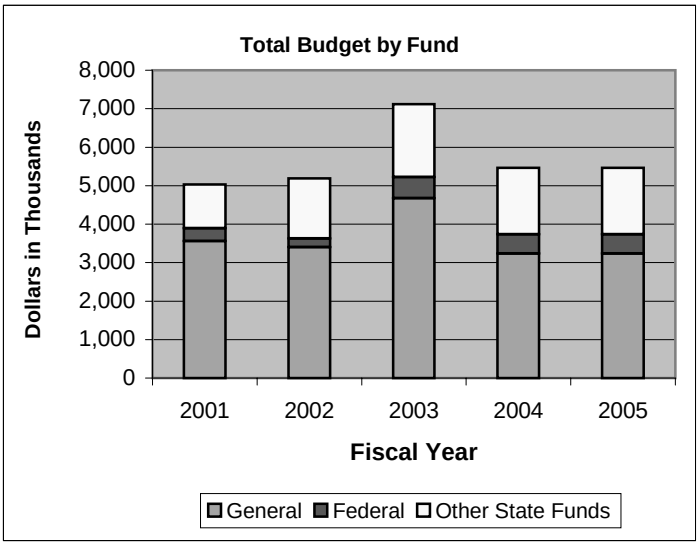
	FY 2004-05 Expenditures ($000s)		
	General Fund	**Other Funds**	**Total**
2003 Funding Level	7,610	3,366	10,976
Agency Technical Reallocations	0	1,092	1,092
Adjusted Base Funding	7,610	4,458	12,068
Change Items			
Budget Reduction	-1,142	0	-1,142
Governor's Recommendations	6,468	4,458	10,926
Biennial Change, 2002-03 to 2004-05	-1,605	221	-1,384
Percent Change	-20%	5%	-11%

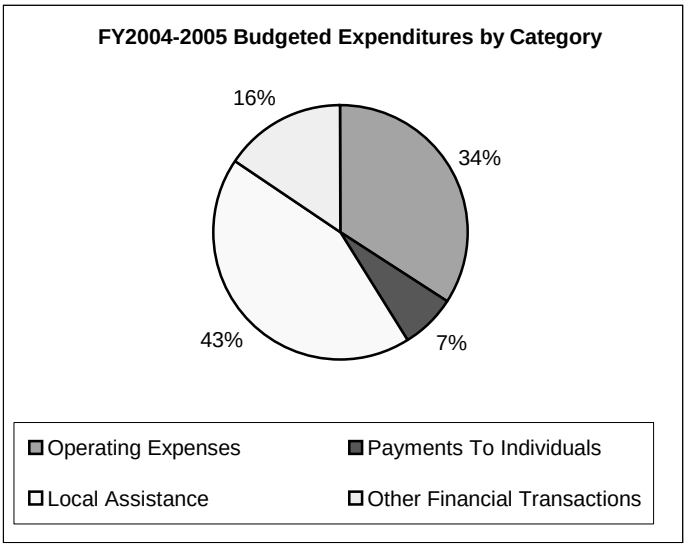
Brief Explanation Of Budget Decisions:

The Emergency Medical Services & Regulatory Board (EMSRB) is an organization that provides licensure and regulation services to ambulance services and EMS personnel. EMSRB will continue to approve training programs and work with the 8 regional EMS boards to maintain high priority services despite a decrease in administrative and grant funds for the coming biennium.

EMERGENCY MEDICAL SVCS REG BD

Fiscal Report





Dollars in Thousands	Actual	Actual	Preliminary	Governor's Rec		Biennium
Expenditures by Fund	**FY2001**	**FY2002**	**FY2003**	**FY2004**	**FY2005**	**2004-05**
Direct Appropriations						
General	2,618	2,470	3,638	2,387	2,387	4,774
State Government Special Revenue	0	432	629	546	546	1,092
Open Appropriations						
General	945	932	1,033	847	847	1,694
State Government Special Revenue	0	17	8	8	8	16
Statutory Appropriations						
Special Revenue	1,142	1,116	1,248	1,172	1,172	2,344
Federal	330	224	550	501	501	1,002
Gift	0	0	13	2	2	4
Total	**5,035**	**5,191**	**7,119**	**5,463**	**5,463**	**10,926**
Expenditures by Category						
Operating Expenses	1,494	1,781	2,371	1,867	1,867	3,734
Payments To Individuals	343	292	478	385	385	770
Local Assistance	2,253	2,186	3,237	2,364	2,364	4,728
Other Financial Transactions	945	932	1,033	847	847	1,694
Total	**5,035**	**5,191**	**7,119**	**5,463**	**5,463**	**10,926**
Expenditures by Program						
Emergency Medical Services Bd	5,035	5,191	7,119	5,463	5,463	10,926
Total	**5,035**	**5,191**	**7,119**	**5,463**	**5,463**	**10,926**

EMERGENCY MEDICAL SVCS REG BD

Fiscal Report

Dollars in Thousands	Actual	Actual	Preliminary	Governor's Rec		Biennium
Revenue by Type and Fund	**FY2001**	**FY2002**	**FY2003**	**FY2004**	**FY2005**	**2004-05**
Non Dedicated						
General	0	77	237	237	237	474
State Government Special Revenue	0	4	10	10	10	20
Cambridge Deposit Fund	55	0	0	0	0	0
Subtotal Non Dedicated	55	81	247	247	247	494
Dedicated						
General	23	12	30	30	30	60
Special Revenue	0	0	2	2	2	4
Federal	322	223	544	501	501	1,002
Gift	0	1	2	2	2	4
Subtotal Dedicated	345	236	578	535	535	1,070
Total Revenue	**400**	**317**	**825**	**782**	**782**	**1,564**
Full-Time Equivalents (FTE)	**13.6**	**19.5**	**19.3**	**19.3**	**19.3**	

EMERGENCY MEDICAL SVCS REG BD

Change Item: BUDGET REDUCTION

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	($571)	($571)	($571)	($571)
Revenues	0	0	0	0
Other Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact	($571)	($571)	($571)	($571)

Recommendation

The Governor recommends a reduction of $571,000 in FY 2004 and FY 2005 from the budget of the Emergency Medical Services and Regulatory Board.

Background

The reduction will be taken from a number of areas in the agency budget. Reductions include cuts to volunteer training reimbursement, longevity awards, comprehensive advanced life support grants, and agency operations. Agency operations will be reduced in travel, equipment, printing and compensation.

Relationship to Base Budget

The recommended reduction represents 15% of the agency budget.

Alternatives Considered

None.

Statutory Change: 144E.42. Change language to indicate 90% of the General Fund appropriation is transferred to the trust fund.

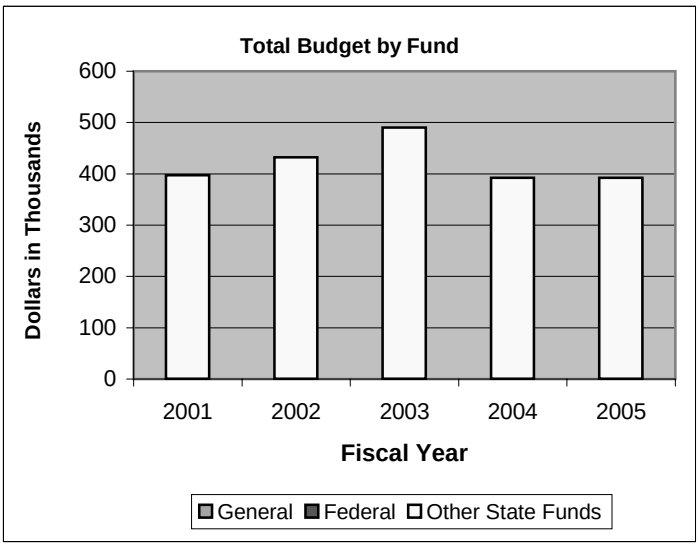
	FY 2004-05 Expenditures ($000s)		
	General Fund	**Other Funds**	**Total**
2003 Funding Level	0	784	784
Adjusted Base Funding	0	784	784
Governor's Recommendations	0	784	784
Biennial Change, 2002-03 to 2004-05	0	-138	-138
Percent Change	n.m	-15%	-15%

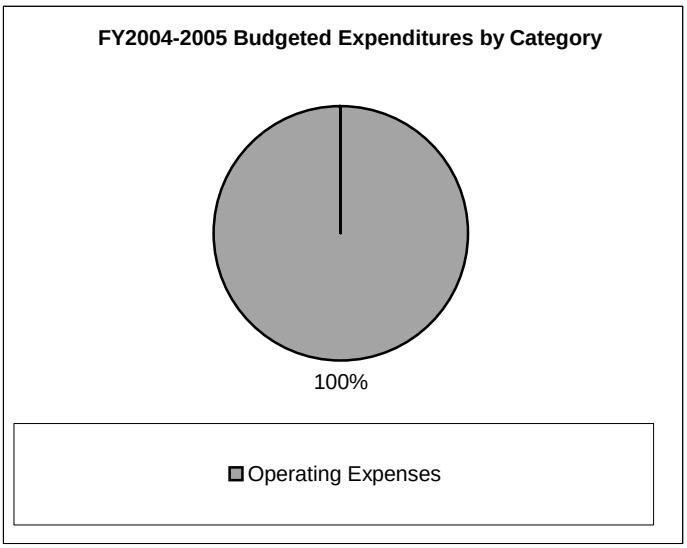
Brief Explanation Of Budget Decisions:

The Chiropractors Board is a fee-based organization that provides licensure and regulation services. Appropriations are made from the State Government Special Revenue (SGSR) fund and funding will continue at the FY 2003 level for both FY 2004 and FY 2005. The 15% reduction shown above is caused by a balance forward into FY 2002 from the previous biennium. Similar funds are not anticipated in FY 2004.

CHIROPRACTORS BOARD

Fiscal Report



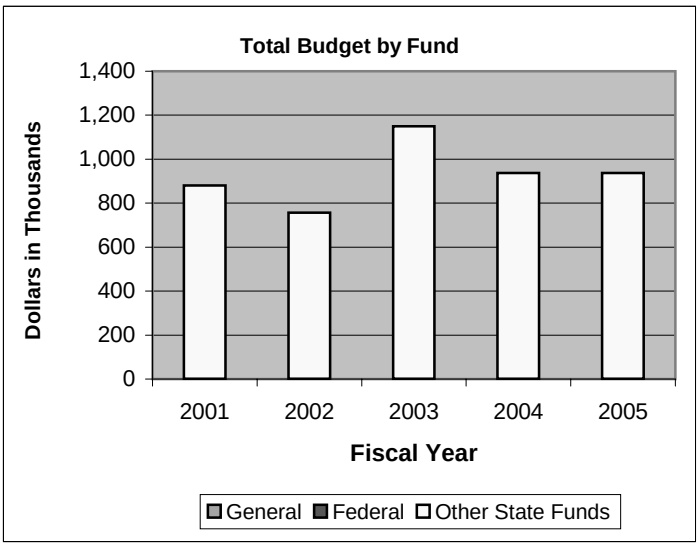


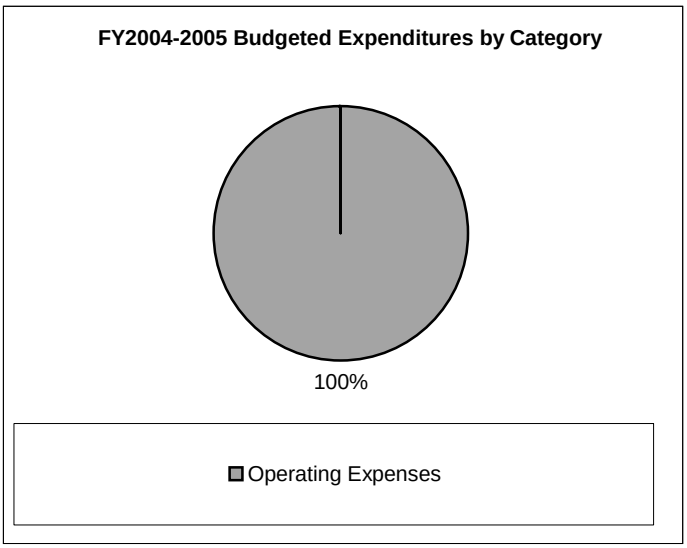
Dollars in Thousands	Actual	Actual	Preliminary	Governor's Rec		Biennium
Expenditures by Fund	**FY2001**	**FY2002**	**FY2003**	**FY2004**	**FY2005**	**2004-05**
Direct Appropriations						
State Government Special Revenue	377	424	482	384	384	768
Open Appropriations						
State Government Special Revenue	20	8	8	8	8	16
Total	**397**	**432**	**490**	**392**	**392**	**784**
Expenditures by Category						
Operating Expenses	397	432	490	392	392	784
Total	**397**	**432**	**490**	**392**	**392**	**784**
Expenditures by Program						
Chiropractors, Board Of	397	432	490	392	392	784
Total	**397**	**432**	**490**	**392**	**392**	**784**
Revenue by Type and Fund						
Non Dedicated						
State Government Special Revenue	566	594	558	591	591	1,182
Subtotal Non Dedicated	566	594	558	591	591	1,182
Total Revenue	**566**	**594**	**558**	**591**	**591**	**1,182**
Full-Time Equivalents (FTE)	**5.0**	**4.9**	**4.9**	**4.9**	**4.9**	

	FY 2004-05 Expenditures ($000s)		
	General Fund	**Other Funds**	**Total**
2003 Funding Level	0	1,896	1,896
Adjusted Base Funding	0	1,896	1,896
Change Items			
Hcaf Reduction For Dentistry Board	0	-22	-22
Governor's Recommendations	0	1,874	1,874
Biennial Change, 2002-03 to 2004-05	0	-33	-33
Percent Change	n.m	-2%	-2%

Brief Explanation Of Budget Decisions:

The Dentistry Board is a fee-based organization that provides licensure and regulation services. Appropriations are made from the State Government Special Revenue (SGSR) fund and funding will continue at the FY 2003 level for both FY 2004 and FY 2005.





Dollars in Thousands	Actual	Actual	Preliminary	Governor's Rec		Biennium
Expenditures by Fund	**FY2001**	**FY2002**	**FY2003**	**FY2004**	**FY2005**	**2004-05**
Direct Appropriations						
State Government Special Revenue	859	744	1,060	858	858	1,716
Health Care Access	0	0	75	64	64	128
Open Appropriations						
State Government Special Revenue	22	13	15	15	15	30
Total	**881**	**757**	**1,150**	**937**	**937**	**1,874**
Expenditures by Category						
Operating Expenses	881	757	1,150	937	937	1,874
Total	**881**	**757**	**1,150**	**937**	**937**	**1,874**
Expenditures by Program						
Dentistry, Board Of	881	757	1,150	937	937	1,874
Total	**881**	**757**	**1,150**	**937**	**937**	**1,874**
Revenue by Type and Fund						
Non Dedicated						
State Government Special Revenue	1,119	1,111	1,094	1,134	1,162	2,296
Subtotal Non Dedicated	1,119	1,111	1,094	1,134	1,162	2,296
Total Revenue	**1,119**	**1,111**	**1,094**	**1,134**	**1,162**	**2,296**
Full-Time Equivalents (FTE)	**8.6**	**8.8**	**8.8**	**8.8**	**8.8**	

DENTISTRY BOARD

Change Item: HCAF REDUCTION FOR DENTISTRY BOARD

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Health Care Access Fund				
Expenditures	(11)	(11)	0	0
Revenues	0	0	0	0
Net Fiscal Impact	(11)	(11)	0	0

Recommendation

The Governor recommends $64,000 in FY 2004 and $64,000 in FY 2005 from the Health Care Access fund to the Board of Dentistry, a reduction of $11,000 a year from current funding

Background

Administered by the Department of Human Services, the Health Care Access Fund (HCAF) funds MinnesotaCare and various other health-related activities. In the November 2002 forecast, the fund was projected to have an operating deficit of $89.5 million in FY 2003. In order to help address this deficiency, the Governor recommends that agencies receiving appropriations from the HCAF take a 15 percent reduction in funding.

The Board of Dentistry's appropriation funds activities related to implementing the donated dental service program.

Relationship to Base Budget

This change is a 15 percent reduction from FY 2003.

Statutory Change: Not Applicable.

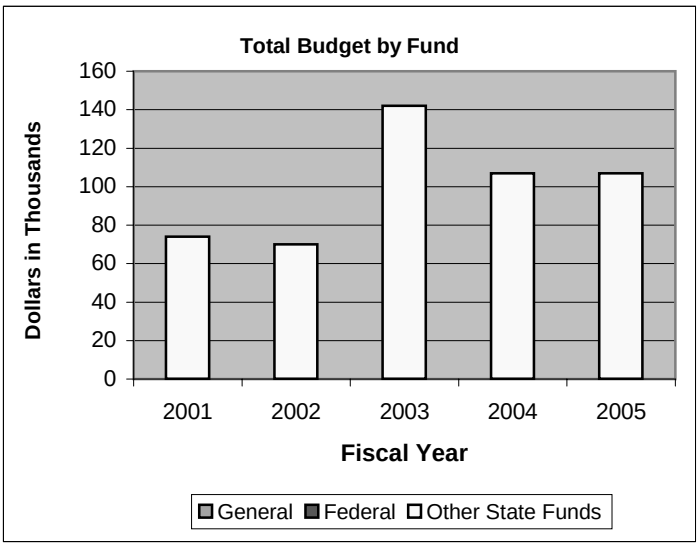
	FY 2004-05 Expenditures ($000s)		
	General Fund	Other Funds	Total
2003 Funding Level	0	214	214
Adjusted Base Funding	0	214	214
Governor's Recommendations	0	214	214
Biennial Change, 2002-03 to 2004-05	0	2	2
Percent Change	n.m	1%	1%

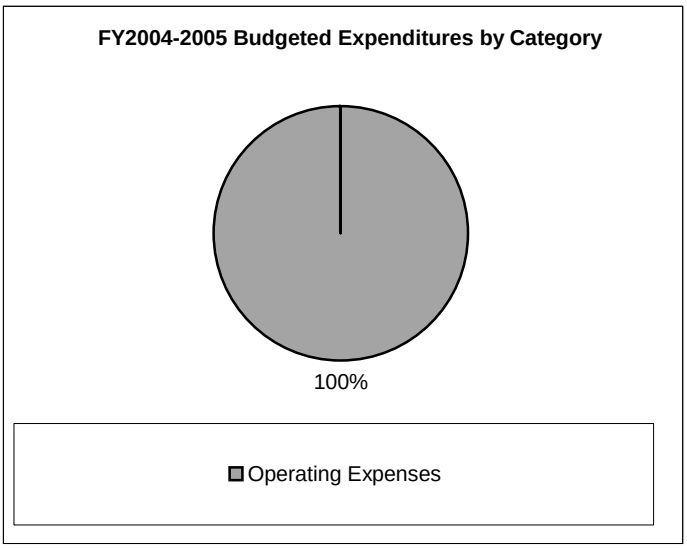
Brief Explanation Of Budget Decisions:

The Dietetics & Nutrition Practice Board is a fee-based organization that provides licensure and regulation services. Appropriations are made from the State Government Special Revenue (SGSR) fund and funding will continue at the FY 2003 level for both FY 2004 and FY 2005.

DIETETICS & NUTRITION PRACTICE

Fiscal Report



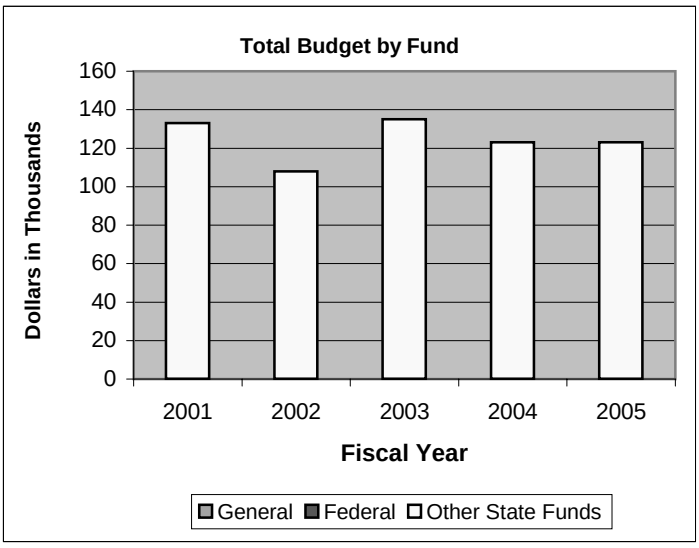


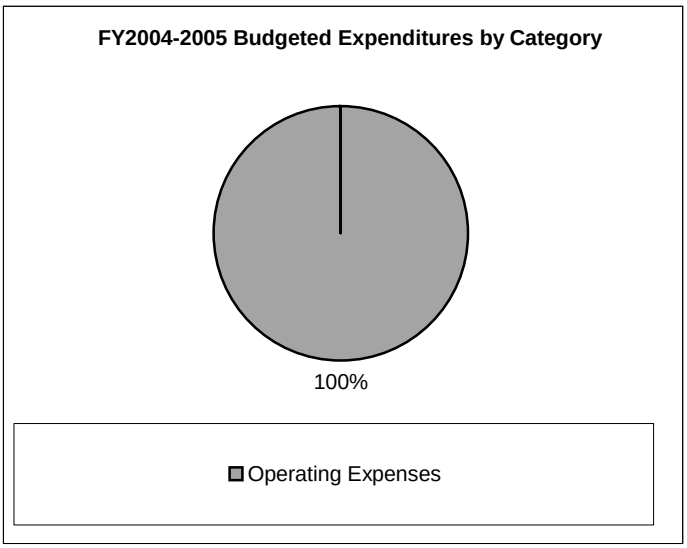
Dollars in Thousands	Actual	Actual	Preliminary	Governor's Rec		Biennium
Expenditures by Fund	**FY2001**	**FY2002**	**FY2003**	**FY2004**	**FY2005**	**2004-05**
Direct Appropriations						
State Government Special Revenue	63	63	136	101	101	202
Open Appropriations						
State Government Special Revenue	11	7	6	6	6	12
Total	**74**	**70**	**142**	**107**	**107**	**214**
Expenditures by Category						
Operating Expenses	74	70	142	107	107	214
Total	**74**	**70**	**142**	**107**	**107**	**214**
Expenditures by Program						
Dietetics & Nutrition Bd.	74	70	142	107	107	214
Total	**74**	**70**	**142**	**107**	**107**	**214**
Revenue by Type and Fund						
Non Dedicated						
State Government Special Revenue	87	97	76	76	76	152
Subtotal Non Dedicated	87	97	76	76	76	152
Total Revenue	**87**	**97**	**76**	**76**	**76**	**152**
Full-Time Equivalents (FTE)	**0.8**	**0.7**	**0.7**	**0.7**	**0.7**	

	FY 2004-05 Expenditures ($000s)		
	General Fund	**Other Funds**	**Total**
2003 Funding Level	0	246	246
Adjusted Base Funding	0	246	246
Governor's Recommendations	0	246	246
Biennial Change, 2002-03 to 2004-05	0	3	3
Percent Change	n.m	1%	1%

Brief Explanation Of Budget Decisions:

The Marriage & Family Therapy Board is a fee-based organization that provides licensure and regulation services. Appropriations are made from the State Government Special Revenue (SGSR) fund and funding will continue at the FY 2003 level for both FY 2004 and FY 2005. A fund level transfer will move funds from the SGSR fund into the General fund to cover the budget reduction for the health-related boards. Program activity will not be affected by the change, but the health-related boards should continue to collaborate with each other on ways to achieve efficiencies through consolidation or sharing of support services.





Dollars in Thousands	Actual	Actual	Preliminary	Governor's Rec		Biennium
Expenditures by Fund	**FY2001**	**FY2002**	**FY2003**	**FY2004**	**FY2005**	**2004-05**
Direct Appropriations						
State Government Special Revenue	104	102	130	118	118	236
Open Appropriations						
State Government Special Revenue	9	6	5	5	5	10
Statutory Appropriations						
Special Revenue	20	0	0	0	0	0
Total	**133**	**108**	**135**	**123**	**123**	**246**
Expenditures by Category						
Operating Expenses	133	108	135	123	123	246
Total	**133**	**108**	**135**	**123**	**123**	**246**
Expenditures by Program						
Marriage And Family Therapy, B	133	108	135	123	123	246
Total	**133**	**108**	**135**	**123**	**123**	**246**
Revenue by Type and Fund						
Non Dedicated						
State Government Special Revenue	127	138	129	149	149	298
Subtotal Non Dedicated	127	138	129	149	149	298
Dedicated						
Special Revenue	20	0	0	0	0	0
Subtotal Dedicated	20	0	0	0	0	0
Total Revenue	**147**	**138**	**129**	**149**	**149**	**298**
Full-Time Equivalents (FTE)	**1.6**	**1.6**	**1.6**	**1.6**	**1.6**	

FY 2004-05 Expenditures ($000s)

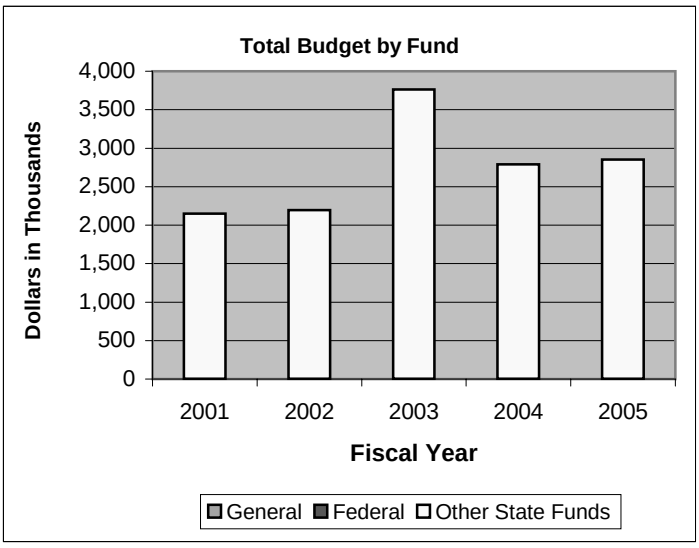
	General Fund	Other Funds	Total
2003 Funding Level	0	6,864	6,864
Legislatively Mandated Base	0	0	0
Transfers Between Agencies	0	-1,221	-1,221
Adjusted Base Funding	0	5,643	5,643
Governor's Recommendations	0	5,643	5,643
Biennial Change, 2002-03 to 2004-05	0	-316	-316
Percent Change	n.m	-5%	-5%

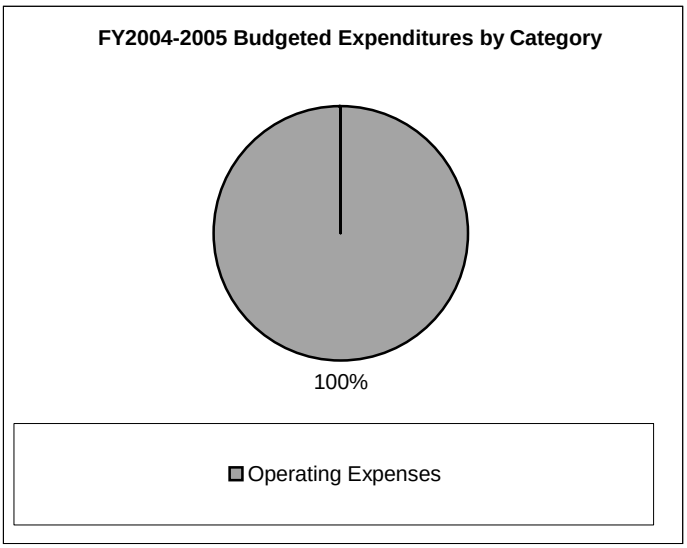
Brief Explanation Of Budget Decisions:

The Medical Practice Board is a fee-based organization that provides licensure and regulation services. Appropriations are made from the State Government Special Revenue (SGSR) fund and funding will continue at the FY 2003 level for both FY 2004 and FY 2005. The transfer indicated above moves funds to the Attorney General for legal services.

MEDICAL PRACTICE BOARD

Fiscal Report



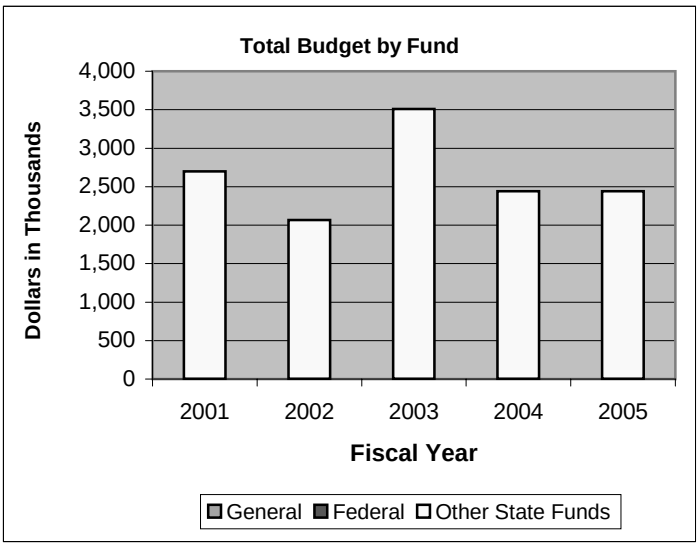


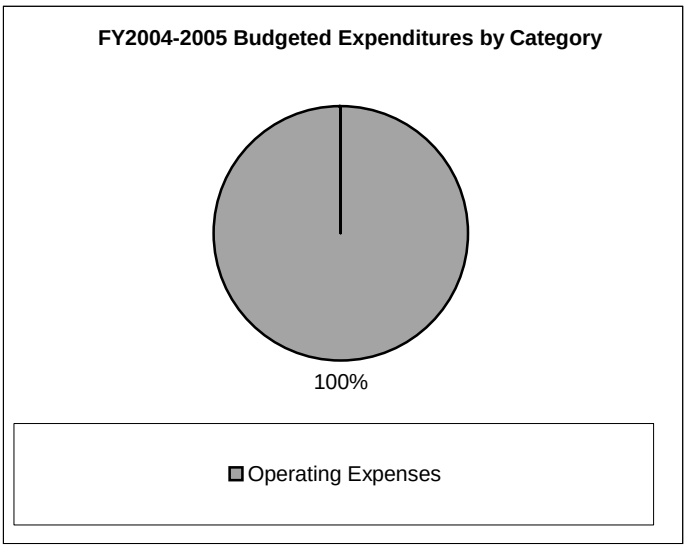
Dollars in Thousands	Actual	Actual	Preliminary	Governor's Rec		Biennium
Expenditures by Fund	**FY2001**	**FY2002**	**FY2003**	**FY2004**	**FY2005**	**2004-05**
Direct Appropriations						
State Government Special Revenue	2,071	2,174	3,734	2,764	2,823	5,587
Open Appropriations						
State Government Special Revenue	29	11	27	27	27	54
Statutory Appropriations						
Special Revenue	51	12	1	1	1	2
Total	**2,151**	**2,197**	**3,762**	**2,792**	**2,851**	**5,643**
Expenditures by Category						
Operating Expenses	2,151	2,197	3,762	3,526	3,526	7,052
Transfers	0	0	0	-734	-675	-1,409
Total	**2,151**	**2,197**	**3,762**	**2,792**	**2,851**	**5,643**
Expenditures by Program						
Medical Practice, Board Of	2,151	2,197	3,762	2,792	2,851	5,643
Total	**2,151**	**2,197**	**3,762**	**2,792**	**2,851**	**5,643**
Revenue by Type and Fund						
Non Dedicated						
State Government Special Revenue	3,801	4,112	4,046	4,132	4,199	8,331
Subtotal Non Dedicated	3,801	4,112	4,046	4,132	4,199	8,331
Dedicated						
Special Revenue	63	0	1	1	1	2
Subtotal Dedicated	63	0	1	1	1	2
Total Revenue	**3,864**	**4,112**	**4,047**	**4,133**	**4,200**	**8,333**
Full-Time Equivalents (FTE)	**22.2**	**22.6**	**22.5**	**22.5**	**22.5**	

	FY 2004-05 Expenditures ($000s)		
	General Fund	**Other Funds**	**Total**
2003 Funding Level	0	5,872	5,872
Agency Technical Reallocations	0	-1,092	-1,092
Legislatively Mandated Base	0	0	0
Transfers Between Agencies	0	98	98
Adjusted Base Funding	0	4,878	4,878
Governor's Recommendations	0	4,878	4,878
Biennial Change, 2002-03 to 2004-05	0	-701	-701
Percent Change	n.m	-13%	-13%

Brief Explanation Of Budget Decisions:

The Nursing Board is a fee-based organization that provides licensure and regulation services. Appropriations are made from the State Government Special Revenue (SGSR) fund and funding will continue at the FY 2003 level for both FY 2004 and FY 2005. The 13% reduction in funding indicated above is caused by a balance forward into FY 2002 from the previous biennium. No similar funds are expected for FY 2004.





Dollars in Thousands	Actual	Actual	Preliminary	Governor's Rec		Biennium
Expenditures by Fund	**FY2001**	**FY2002**	**FY2003**	**FY2004**	**FY2005**	**2004-05**
Direct Appropriations						
State Government Special Revenue	2,639	1,993	2,777	2,405	2,405	4,810
Open Appropriations						
State Government Special Revenue	60	25	34	34	34	68
Statutory Appropriations						
Special Revenue	0	50	700	0	0	0
Total	**2,699**	**2,068**	**3,511**	**2,439**	**2,439**	**4,878**
Expenditures by Category						
Operating Expenses	2,699	2,068	3,511	2,439	2,439	4,878
Total	**2,699**	**2,068**	**3,511**	**2,439**	**2,439**	**4,878**
Expenditures by Program						
Nursing, Board Of	2,699	2,068	3,511	2,439	2,439	4,878
Total	**2,699**	**2,068**	**3,511**	**2,439**	**2,439**	**4,878**
Revenue by Type and Fund						
Non Dedicated						
State Government Special Revenue	4,111	4,285	3,721	4,081	4,081	8,162
Subtotal Non Dedicated	4,111	4,285	3,721	4,081	4,081	8,162
Total Revenue	**4,111**	**4,285**	**3,721**	**4,081**	**4,081**	**8,162**
Full-Time Equivalents (FTE)	**32.9**	**27.6**	**27.6**	**27.6**	**27.6**	

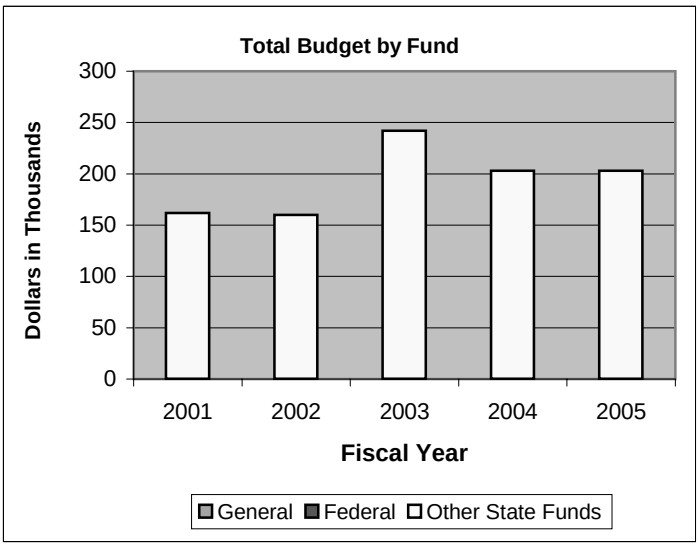
	FY 2004-05 Expenditures ($000s)		
	General Fund	Other Funds	Total
2003 Funding Level	0	406	406
Adjusted Base Funding	0	406	406
Governor's Recommendations	0	406	406
Biennial Change, 2002-03 to 2004-05	0	4	4
Percent Change	n.m	1%	1%

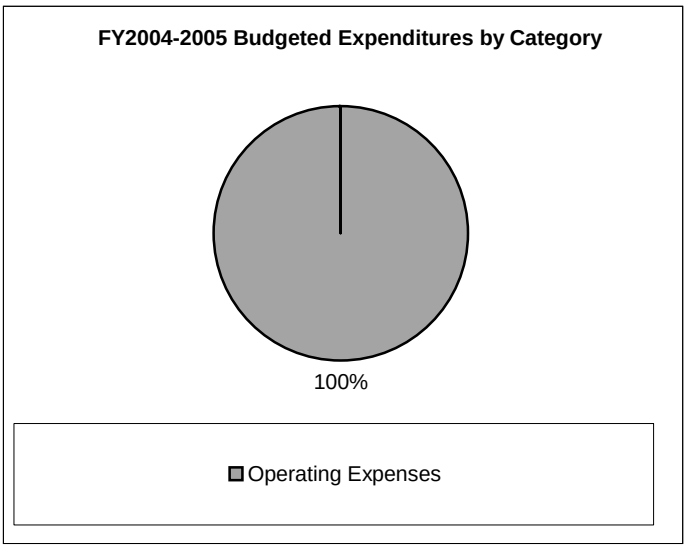
Brief Explanation Of Budget Decisions:

The Nursing Home Admin Board is a fee-based organization that provides licensure and regulation services. Appropriations as recquested from the State Government Special Revenue (SGSR) fund and funding will continue at the FY 2003 level for both FY 2004 and FY 2005.

NURSING HOME ADMIN BOARD

Fiscal Report





Dollars in Thousands	Actual	Actual	Preliminary	Governor's Rec		Biennium
Expenditures by Fund	**FY2001**	**FY2002**	**FY2003**	**FY2004**	**FY2005**	**2004-05**
Direct Appropriations						
State Government Special Revenue	153	156	242	198	198	396
Open Appropriations						
State Government Special Revenue	9	4	0	5	5	10
Total	**162**	**160**	**242**	**203**	**203**	**406**
Expenditures by Category						
Operating Expenses	162	160	242	203	203	406
Total	**162**	**160**	**242**	**203**	**203**	**406**
Expenditures by Program						
Nursing Home Admin, Board Of	162	160	242	203	203	406
Total	**162**	**160**	**242**	**203**	**203**	**406**
Revenue by Type and Fund						
Non Dedicated						
State Government Special Revenue	201	196	222	198	198	396
Subtotal Non Dedicated	201	196	222	198	198	396
Total Revenue	**201**	**196**	**222**	**198**	**198**	**396**
Full-Time Equivalents (FTE)	**1.8**	**2.0**	**2.0**	**2.0**	**2.0**	

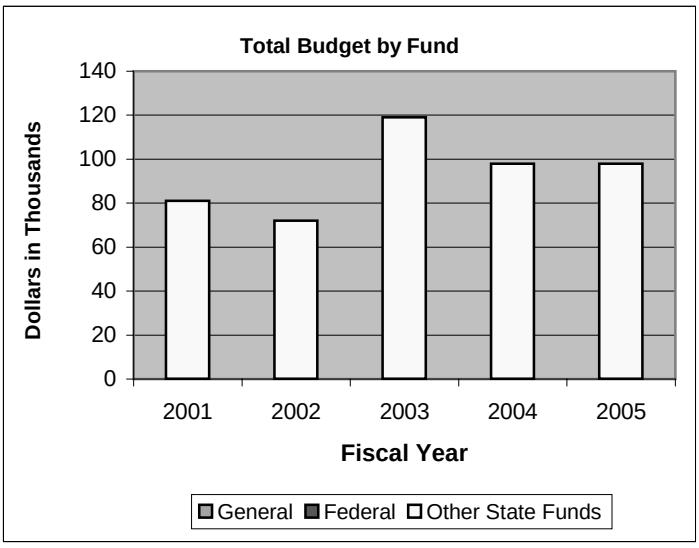
	FY 2004-05 Expenditures ($000s)		
	General Fund	**Other Funds**	**Total**
2003 Funding Level	0	196	196
Adjusted Base Funding	0	196	196
Governor's Recommendations	0	196	196
Biennial Change, 2002-03 to 2004-05	0	5	5
Percent Change	n.m	3%	3%

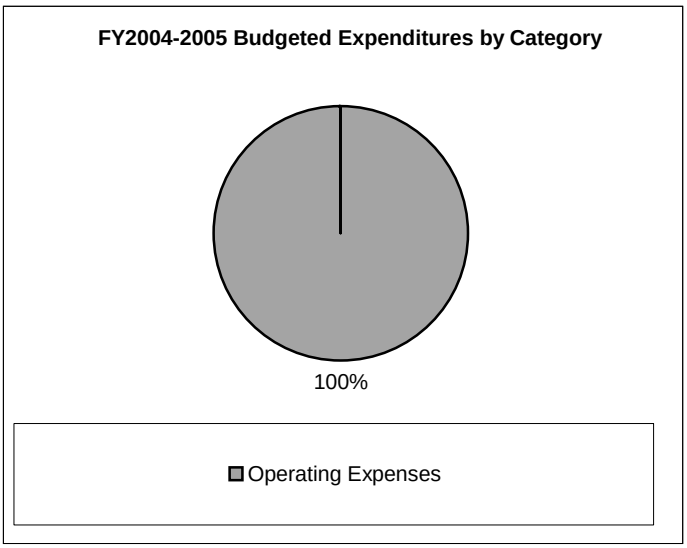
Brief Explanation Of Budget Decisions:

The Optometry Board is a fee-based organization that provides licensure and regulation services. Appropriations are made from the State Government Special Revenue (SGSR) fund and funding will continue at the FY 2003 level for both FY 2004 and FY 2005.

OPTOMETRY BOARD

Fiscal Report





Dollars in Thousands	Actual	Actual	Preliminary	Governor's Rec		Biennium
Expenditures by Fund	**FY2001**	**FY2002**	**FY2003**	**FY2004**	**FY2005**	**2004-05**
Direct Appropriations						
State Government Special Revenue	78	72	117	96	96	192
Open Appropriations						
State Government Special Revenue	3	0	2	2	2	4
Total	**81**	**72**	**119**	**98**	**98**	**196**
Expenditures by Category						
Operating Expenses	81	72	119	98	98	196
Total	**81**	**72**	**119**	**98**	**98**	**196**
Expenditures by Program						
Optometry, Board Of	81	72	119	98	98	196
Total	**81**	**72**	**119**	**98**	**98**	**196**
Revenue by Type and Fund						
Non Dedicated						
State Government Special Revenue	103	110	93	93	93	186
Subtotal Non Dedicated	103	110	93	93	93	186
Total Revenue	**103**	**110**	**93**	**93**	**93**	**186**
Full-Time Equivalents (FTE)	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	

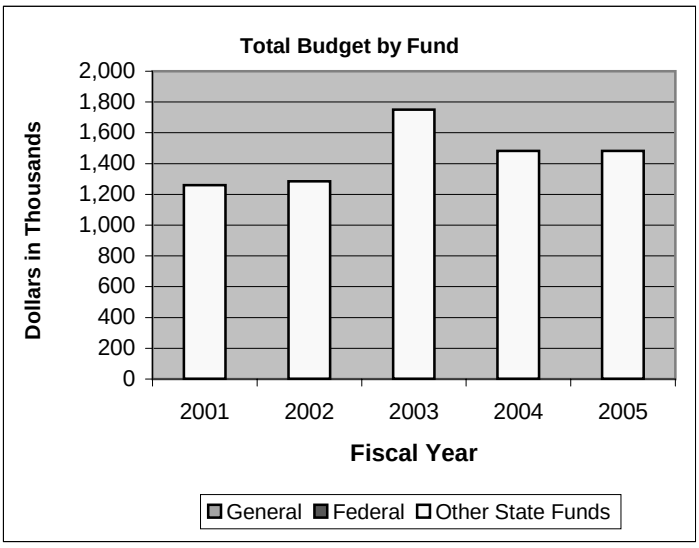
	FY 2004-05 Expenditures ($000s)		
	General Fund	**Other Funds**	**Total**
2003 Funding Level	0	3,064	3,064
One-Time Appropriations	0	-100	-100
Adjusted Base Funding	0	2,964	2,964
Governor's Recommendations	0	2,964	2,964
Biennial Change, 2002-03 to 2004-05	0	-71	-71
Percent Change	n.m	-2%	-2%

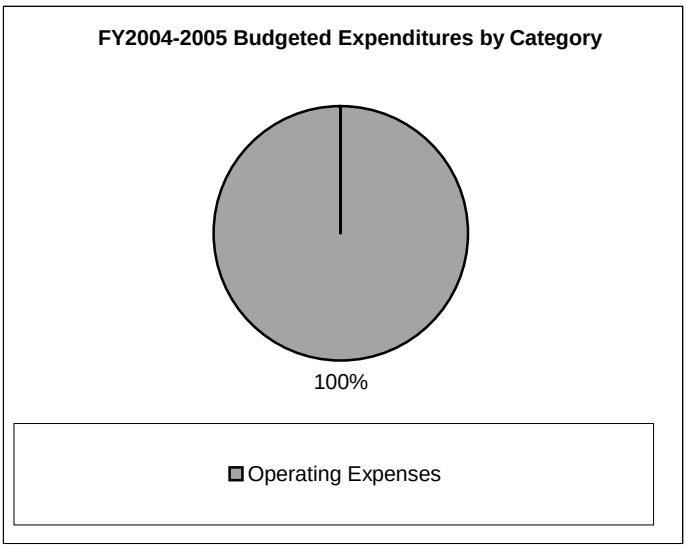
Brief Explanation Of Budget Decisions:

The Pharmacy Board is a fee-based organization that provides licensure and regulation services. Appropriations are made from the State Government Special Revenue (SGSR) fund and funding will continue at the FY 2003 level for both FY 2004 and FY 2005.

PHARMACY BOARD

Fiscal Report





Dollars in Thousands	Actual	Actual	Preliminary	Governor's Rec		Biennium
Expenditures by Fund	**FY2001**	**FY2002**	**FY2003**	**FY2004**	**FY2005**	**2004-05**
Direct Appropriations						
State Government Special Revenue	1,188	1,233	1,598	1,386	1,386	2,772
Open Appropriations						
State Government Special Revenue	29	10	23	23	23	46
Statutory Appropriations						
Special Revenue	42	42	129	73	73	146
Total	**1,259**	**1,285**	**1,750**	**1,482**	**1,482**	**2,964**
Expenditures by Category						
Operating Expenses	1,259	1,285	1,750	1,482	1,482	2,964
Total	**1,259**	**1,285**	**1,750**	**1,482**	**1,482**	**2,964**
Expenditures by Program						
Pharmacy, Board Of	1,259	1,285	1,750	1,482	1,482	2,964
Total	**1,259**	**1,285**	**1,750**	**1,482**	**1,482**	**2,964**
Revenue by Type and Fund						
Non Dedicated						
State Government Special Revenue	1,188	1,254	1,254	1,266	1,308	2,574
Subtotal Non Dedicated	1,188	1,254	1,254	1,266	1,308	2,574
Dedicated						
Special Revenue	55	71	73	73	73	146
Subtotal Dedicated	55	71	73	73	73	146
Total Revenue	**1,243**	**1,325**	**1,327**	**1,339**	**1,381**	**2,720**
Full-Time Equivalents (FTE)	**14.5**	**14.6**	**14.5**	**14.5**	**14.5**	

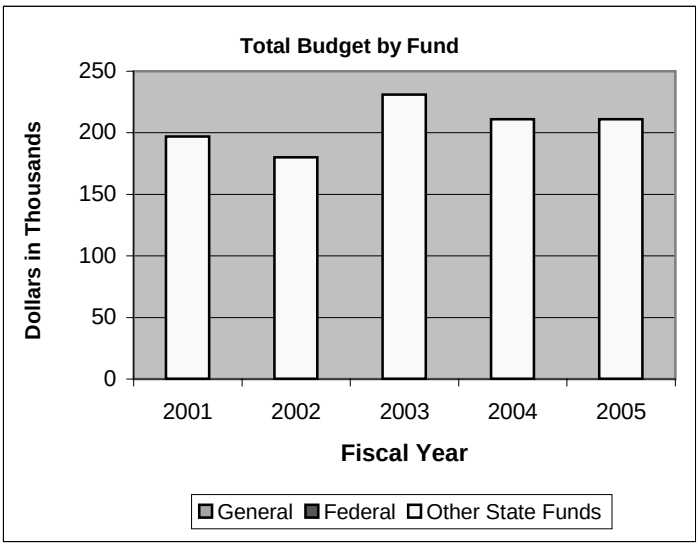
	FY 2004-05 Expenditures ($000s)		
	General Fund	**Other Funds**	**Total**
2003 Funding Level	0	422	422
Adjusted Base Funding	0	422	422
Governor's Recommendations	0	422	422
Biennial Change, 2002-03 to 2004-05	0	11	11
Percent Change	n.m	3%	3%

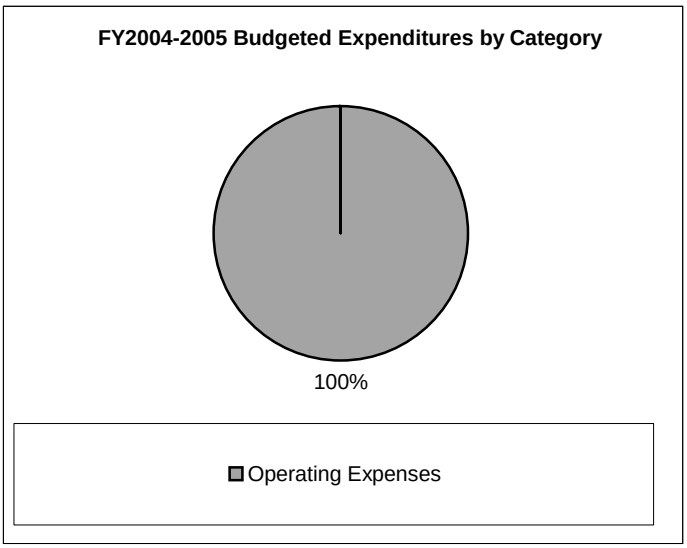
Brief Explanation Of Budget Decisions:

The Physical Therapy Board is a fee-based organization that provides licensure and regulation services. Appropriations are made from the State Government Special Revenue (SGSR) fund and funding will continue at the FY 2003 level for both FY 2004 and FY 2005.

PHYSICAL THERAPY BOARD

Fiscal Report





Dollars in Thousands	Actual	Actual	Preliminary	Governor's Rec		Biennium
Expenditures by Fund	**FY2001**	**FY2002**	**FY2003**	**FY2004**	**FY2005**	**2004-05**
Direct Appropriations						
State Government Special Revenue	197	171	217	197	197	394
Open Appropriations						
State Government Special Revenue	0	9	14	14	14	28
Total	**197**	**180**	**231**	**211**	**211**	**422**
Expenditures by Category						
Operating Expenses	197	180	231	211	211	422
Total	**197**	**180**	**231**	**211**	**211**	**422**
Expenditures by Program						
Physical Therapy Bd	197	180	231	211	211	422
Total	**197**	**180**	**231**	**211**	**211**	**422**
Revenue by Type and Fund						
Non Dedicated						
State Government Special Revenue	262	270	263	263	263	526
Subtotal Non Dedicated	262	270	263	263	263	526
Total Revenue	**262**	**270**	**263**	**263**	**263**	**526**
Full-Time Equivalents (FTE)	**1.8**	**2.2**	**2.1**	**2.1**	**2.1**	

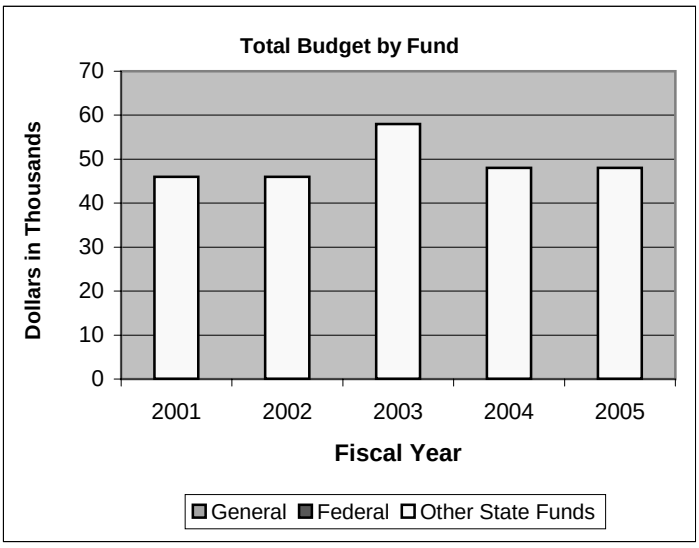
	FY 2004-05 Expenditures ($000s)		
	General Fund	**Other Funds**	**Total**
2003 Funding Level	0	96	96
Adjusted Base Funding	0	96	96
Governor's Recommendations	0	96	96
Biennial Change, 2002-03 to 2004-05	0	-8	-8
Percent Change	n.m	-8%	-8%

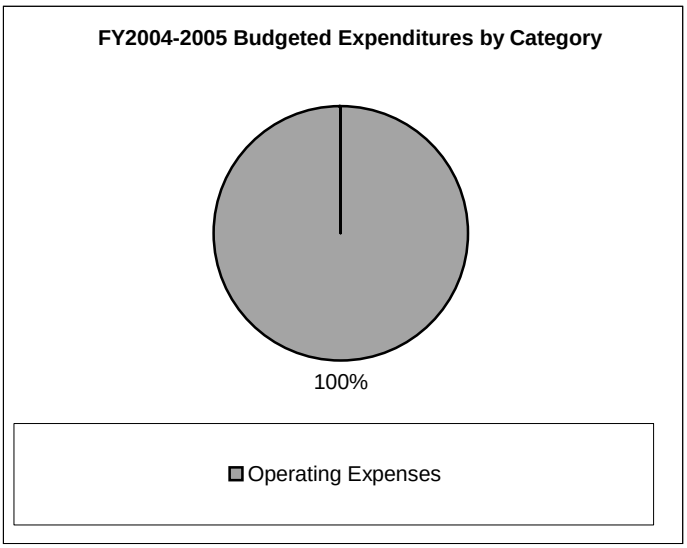
Brief Explanation Of Budget Decisions:

The Podiatry Board is a fee-based organization that provides licensure and regulation services. Appropriations are made from the State Government Special Revenue (SGSR) fund and funding will continue at the FY 2003 level for both FY 2004 and FY 2005. The 8% reduction indicated above reflects a decrease in appropriation in FY 2003. The reduced amount has been carried into the new biennium.

PODIATRY BOARD

Fiscal Report





Dollars in Thousands	Actual	Actual	Preliminary	Governor's Rec		Biennium
Expenditures by Fund	**FY2001**	**FY2002**	**FY2003**	**FY2004**	**FY2005**	**2004-05**
Direct Appropriations						
State Government Special Revenue	42	43	55	45	45	90
Open Appropriations						
State Government Special Revenue	4	3	3	3	3	6
Total	**46**	**46**	**58**	**48**	**48**	**96**
Expenditures by Category						
Operating Expenses	46	46	58	48	48	96
Total	**46**	**46**	**58**	**48**	**48**	**96**
Expenditures by Program						
Podiatry, Board Of	46	46	58	48	48	96
Total	**46**	**46**	**58**	**48**	**48**	**96**
Revenue by Type and Fund						
Non Dedicated						
State Government Special Revenue	53	77	72	76	74	150
Subtotal Non Dedicated	53	77	72	76	74	150
Total Revenue	**53**	**77**	**72**	**76**	**74**	**150**
Full-Time Equivalents (FTE)	**0.5**	**0.5**	**0.5**	**0.5**	**0.5**	

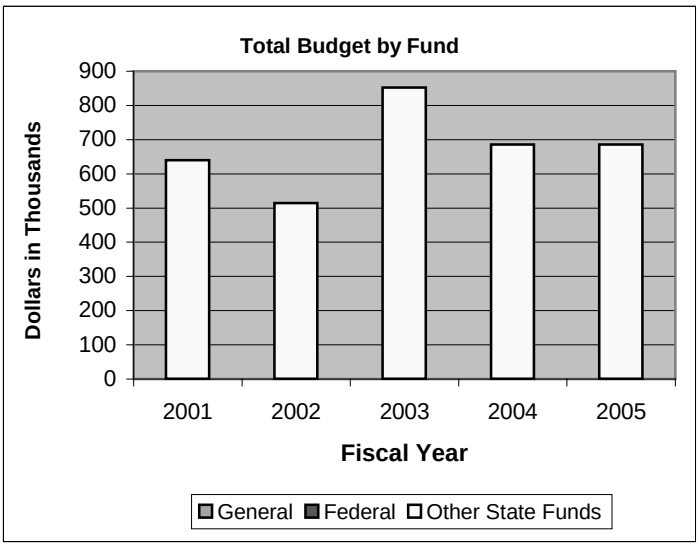
	FY 2004-05 Expenditures ($000s)		
	General Fund	**Other Funds**	**Total**
2003 Funding Level	0	1,372	1,372
Adjusted Base Funding	0	1,372	1,372
Governor's Recommendations	0	1,372	1,372
Biennial Change, 2002-03 to 2004-05	0	5	5
Percent Change	n.m	0%	0%

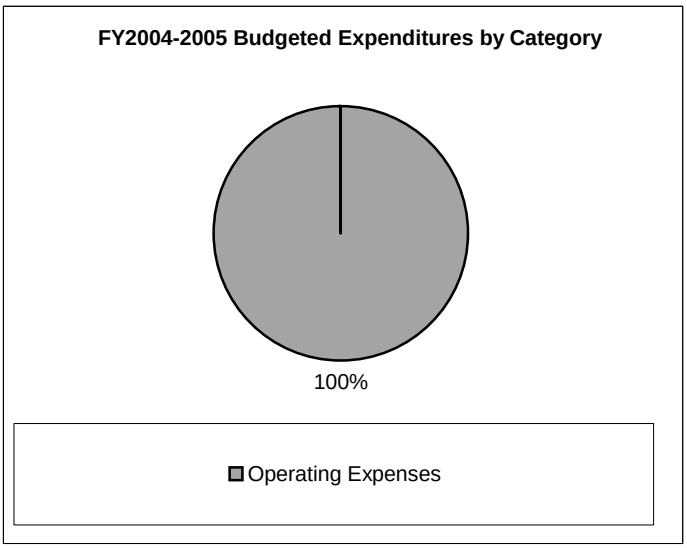
Brief Explanation Of Budget Decisions:

The Psychology Board is a fee-based organization that provides licensure and regulation services. Appropriations are made from the State Government Special Revenue (SGSR) fund and funding will continue at the FY 2003 level for both FY 2004 and FY 2005.

PSYCHOLOGY BOARD

Fiscal Report



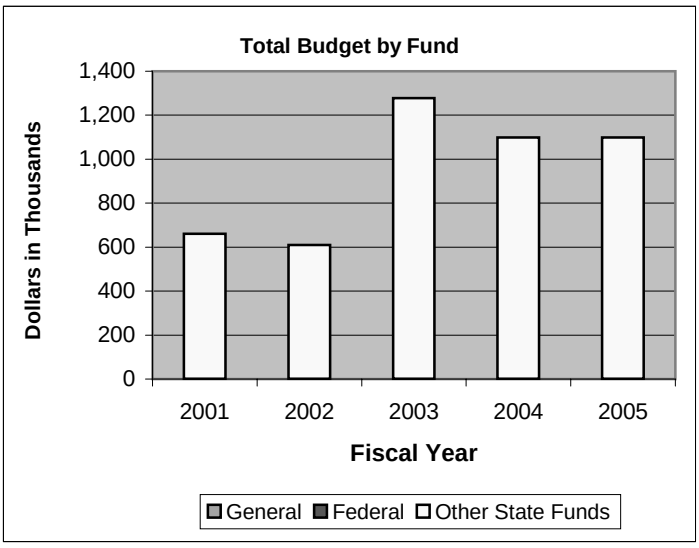


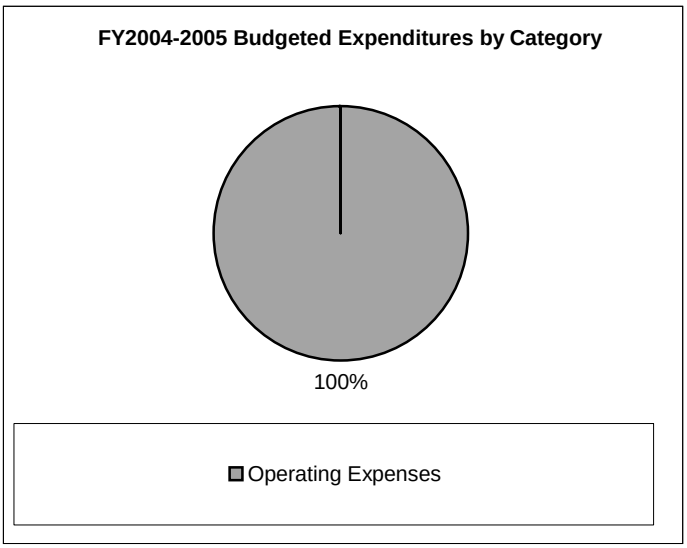
Dollars in Thousands	Actual	Actual	Preliminary	Governor's Rec		Biennium
Expenditures by Fund	**FY2001**	**FY2002**	**FY2003**	**FY2004**	**FY2005**	**2004-05**
Direct Appropriations						
State Government Special Revenue	580	503	846	680	680	1,360
Open Appropriations						
State Government Special Revenue	20	12	6	6	6	12
Statutory Appropriations						
Special Revenue	40	0	0	0	0	0
Total	**640**	**515**	**852**	**686**	**686**	**1,372**
Expenditures by Category						
Operating Expenses	640	515	852	686	686	1,372
Total	**640**	**515**	**852**	**686**	**686**	**1,372**
Expenditures by Program						
Psychology, Board Of	640	515	852	686	686	1,372
Total	**640**	**515**	**852**	**686**	**686**	**1,372**
Revenue by Type and Fund						
Non Dedicated						
State Government Special Revenue	1,066	1,139	1,136	1,100	1,027	2,127
Subtotal Non Dedicated	1,066	1,139	1,136	1,100	1,027	2,127
Dedicated						
Special Revenue	28	0	0	0	0	0
Subtotal Dedicated	28	0	0	0	0	0
Total Revenue	**1,094**	**1,139**	**1,136**	**1,100**	**1,027**	**2,127**
Full-Time Equivalents (FTE)	**7.5**	**7.0**	**7.0**	**7.0**	**7.0**	

	FY 2004-05 Expenditures ($000s)		
	General Fund	**Other Funds**	**Total**
2003 Funding Level	0	1,798	1,798
Legislatively Mandated Base	0	0	0
Transfers Between Agencies	0	400	400
Adjusted Base Funding	0	2,198	2,198
Governor's Recommendations	0	2,198	2,198
Biennial Change, 2002-03 to 2004-05	0	310	310
Percent Change	n.m	16%	16%

Brief Explanation Of Budget Decisions:

The Social Work Board is a fee-based organization that provides licensure and regulation services. No change in appropriation is requested from the State Government Special Revenue (SGSR) fund for FY 2004 and FY 2005. The biennial change in funding indicated above is due to small agency infrastructure funds from the Department of Administration.





Dollars in Thousands	Actual	Actual	Preliminary	Governor's Rec		Biennium
Expenditures by Fund	**FY2001**	**FY2002**	**FY2003**	**FY2004**	**FY2005**	**2004-05**
Direct Appropriations						
State Government Special Revenue	623	591	1,249	1,073	1,073	2,146
Open Appropriations						
State Government Special Revenue	27	10	12	12	12	24
Statutory Appropriations						
Special Revenue	11	9	17	14	14	28
Total	**661**	**610**	**1,278**	**1,099**	**1,099**	**2,198**
Expenditures by Category						
Operating Expenses	661	610	1,278	1,099	1,099	2,198
Total	**661**	**610**	**1,278**	**1,099**	**1,099**	**2,198**
Expenditures by Program						
Social Work, Board Of	661	610	1,278	1,099	1,099	2,198
Total	**661**	**610**	**1,278**	**1,099**	**1,099**	**2,198**
Revenue by Type and Fund						
Non Dedicated						
State Government Special Revenue	1,167	1,159	1,177	1,179	1,181	2,360
Subtotal Non Dedicated	1,167	1,159	1,177	1,179	1,181	2,360
Dedicated						
Special Revenue	11	10	14	14	14	28
Subtotal Dedicated	11	10	14	14	14	28
Total Revenue	**1,178**	**1,169**	**1,191**	**1,193**	**1,195**	**2,388**
Full-Time Equivalents (FTE)	**9.3**	**9.0**	**8.9**	**8.9**	**8.9**	

VETERINARY MEDICINE BOARD

CONTENTS

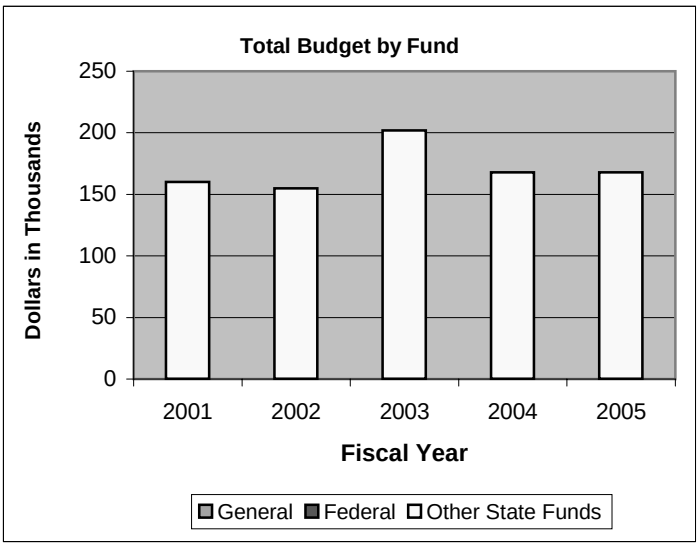
	FY 2004-05 Expenditures ($000s)		
	General Fund	Other Funds	Total
2003 Funding Level	0	388	388
One-Time Appropriations	0	-52	-52
Adjusted Base Funding	0	336	336
Governor's Recommendations	0	336	336
Biennial Change, 2002-03 to 2004-05	0	-21	-21
Percent Change	n.m	-6%	-6%

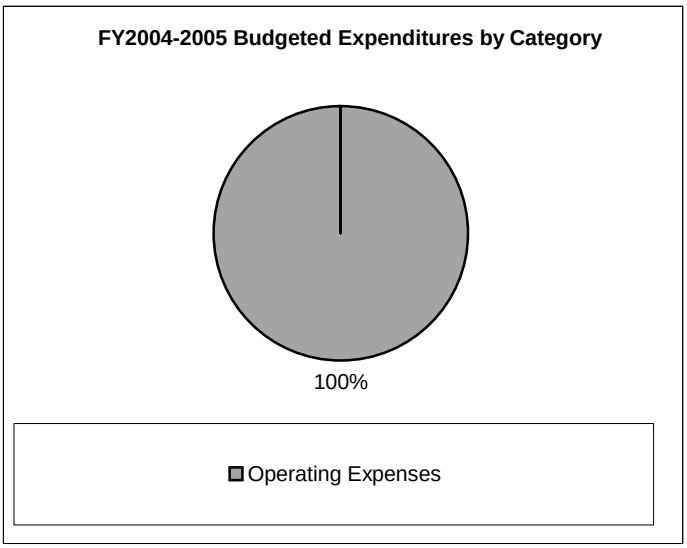
Brief Explanation Of Budget Decisions:

The Veterinary Medicine Board is a fee-based organization that provides licensure and regulation services. Appropriations are made from the State Government Special Revenue (SGSR) fund and funding will continue at the FY 2003 level for both FY 2004 and FY 2005. The 6% decrease shown above is caused by a one-time appropriation of $26 in FY 2003.

VETERINARY MEDICINE BOARD

Fiscal Report





Dollars in Thousands	Actual	Actual	Preliminary	Governor's Rec		Biennium
Expenditures by Fund	**FY2001**	**FY2002**	**FY2003**	**FY2004**	**FY2005**	**2004-05**
Direct Appropriations						
State Government Special Revenue	152	150	197	163	163	326
Open Appropriations						
State Government Special Revenue	7	5	5	5	5	10
Statutory Appropriations						
Special Revenue	1	0	0	0	0	0
Total	**160**	**155**	**202**	**168**	**168**	**336**
Expenditures by Category						
Operating Expenses	160	155	202	168	168	336
Total	**160**	**155**	**202**	**168**	**168**	**336**
Expenditures by Program						
Veterinary Medicine, Board Of	160	155	202	168	168	336
Total	**160**	**155**	**202**	**168**	**168**	**336**
Revenue by Type and Fund						
Non Dedicated						
State Government Special Revenue	293	269	270	276	276	552
Subtotal Non Dedicated	293	269	270	276	276	552
Total Revenue	**293**	**269**	**270**	**276**	**276**	**552**
Full-Time Equivalents (FTE)	**1.8**	**1.7**	**1.7**	**1.7**	**1.7**	

Change Item: SGSR TRANSFER TO THE GENERAL FUND

Fiscal Impact ($000s)	FY 2004	FY 2005	FY 2006	FY 2007
General Fund				
Expenditures	0	0	0	0
Revenues	$7,500	0	0	0
Other Fund				
Expenditures	0	0	0	0
Revenues	(7,500)	0	0	0
Net Fiscal Impact	0	0	0	0

Recommendation
The Governor recommends transferring $7.5M from the State Government Special Revenue fund to the General Fund for the health related boards. This balance will be used to help reduce the state's general fund deficit.

Background
There are a total of 14 health related boards that operate out of the State Government Special Revenue fund. The boards receive a direct appropriation from the fund but collect fees to license and regulate various groups of health professionals. Fees collected by the boards are deposited into the fund as non-dedicated revenue.

Based on information in the November forecast there will be a surplus in this fund at the end of FY 2007. The surplus is above any expected changes in spending and does not require any new fees to make up for lost balances. These monies are surplus because current law prohibits the boards from changing fees for over or under recovery of costs after a period of two or five years.

Relationship to Base Budget
This amount is based on the standard operating reduction proposed for all agencies for FY 2004-05. There will be no change in non-dedicated revenues or expenditure levels of individual appropriation accounts for the health related board.

Alternatives Considered
Individual boards could have had appropriated amounts reduced to reflect a standard budget reduction. This would have required the boards to adjust fees as they must establish a fee structure which fully recovers expenditures.

Statutory Change: Not Applicable.