Agency Purpose

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

At a Glance

Health care programs — FY 2009

- Average monthly enrollment of 707,000
- Medical Assistance — 557,000 people
- MinnesotaCare — 118,000 people
- General Assistance Medical Care — 32,000
- 118,000 health care providers and eight contracted health plans
- 52.3 million health encounters, claims and managed care capitations processed

Economic assistance programs — FY 2009

- Food Support — 315,000 people per month
- Minnesota Family Investment Program and Diversionary Work Program cases — 36,900 families
- General Assistance — almost 20,000 people
- More than 398,000 parents assisted through child support enforcement
- $629 million in child support payments collected
- 17,700 families received child care assistance for 31,400 children
- About 6,800 children were cared for by adoptive parents or relatives who receive financial assistance and support for children's special needs.
- 653 children under state guardianship were adopted

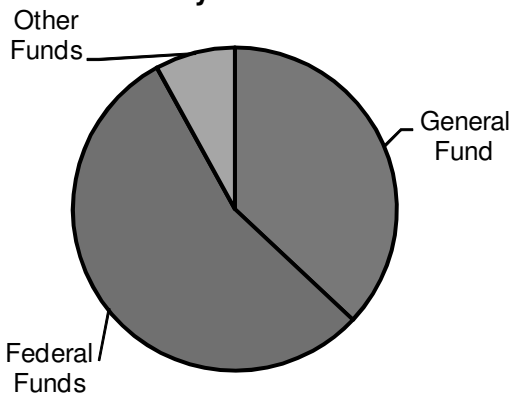
Mental health services – FY 2009

- About 137,658 adults received publicly funded mental health services
- 42,292 children received publicly funded mental health services

Operations

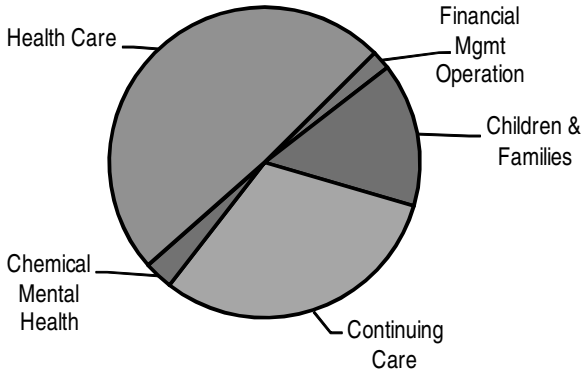
- FY 2010-11 $8.8 billion general fund budget
- FY 2010-11 $23.5 billion all funds budget
- 86% of DHS' general fund budget is spent on health care and long-term care programs and related services
- Approximately 97% of DHS' budget goes toward program expenditures, with 3% spent on Central Office administration

Est. FY 2010-11 Expenditures by Fund



Source: Consolidated Fund Statement

Est. FY 2010-11 Expenditures by Program



Source: Consolidated Fund Statement

Strategies

Strategies DHS uses to accomplish its mission are:

- Ensuring basic health care for low-income Minnesotans
- Helping Minnesotans support their families
- Aiding children and families in crisis
- Assisting people with chemical and mental health care needs
- Providing direct care services to people with disabilities
- Providing sex offender treatment
- Promoting independent living for seniors

Operations

Health care programs
DHS administers:

- Medical Assistance (MA), Minnesota's Medicaid program for low-income seniors, children and parents and people with disabilities;
- MinnesotaCare for residents who do not have access to affordable private health insurance and do not qualify for other programs; and
- General Assistance Medical Care (GAMC), primarily for adults without dependent children.

Across these three programs approximately two-thirds of all enrollees get their care through one of eight contracted health plans.

Economic assistance programs: DHS works with counties and tribes to help low-income families with children achieve economic stability through programs such as the Minnesota Family Investment Program (MFIP), the Diversionary Work Program (DWP), child support enforcement, child care assistance, food support, refugee cash assistance and employment services.

Child welfare services: DHS works with counties and tribes to ensure that children in crisis receive the services they need quickly and close to home so they can lead safe, healthy and productive lives. DHS guides statewide policy in child protection services, out-of-home care and permanent homes for children.

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

Direct care services: DHS provides an array of treatment and residential services to people with mental illness, chemical dependency, developmental disabilities or acquired brain injury, some of whom may pose a risk to society. These services are provided through programs based in Alexandria, Annandale, Anoka, Baxter, Bemidji, Carlton, Fergus Falls, Rochester, St. Peter, Wadena and Willmar, and through Minnesota State Operated Community Services, which has programs and homes for people with developmental disabilities throughout the state. DHS also provides treatment for people who have been civilly committed as mentally ill and dangerous at Minnesota Security Hospital in St. Peter and for people who are developmental disabled and present a risk to society at the Minnesota Extended Treatment Options Program in Cambridge.

Sex offender treatment: The Minnesota Sex Offender Program in Moose Lake and St. Peter provides inpatient services and treatment to people who are committed by the court as a sexual psychopathic personality or a sexually dangerous person.

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

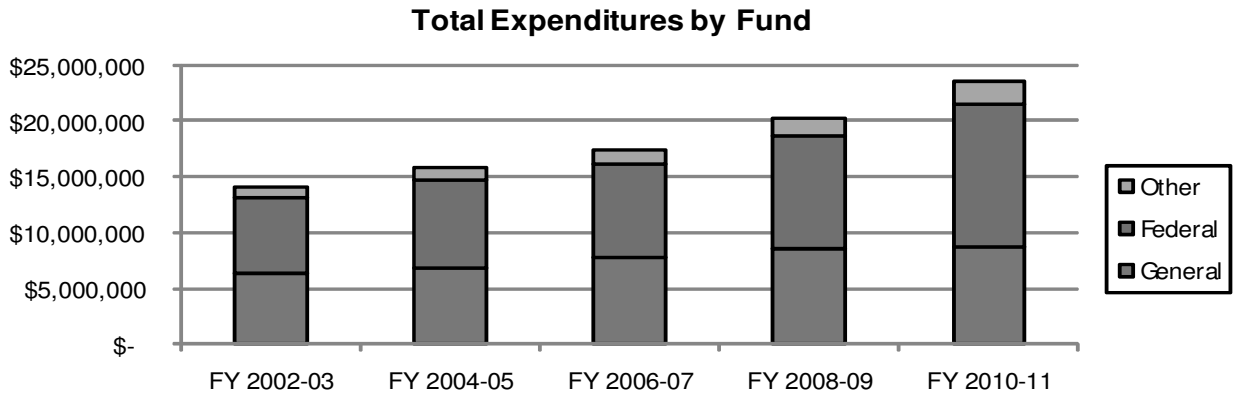
Licensing: DHS licenses about 24,300 service providers, including group homes; treatment programs for people with chemical dependency, mental illness or developmental disabilities; child care providers; and foster care providers. DHS also monitors their compliance with Minnesota laws and rules, investigates reports of possible maltreatment and completes background studies on individuals who provide direct care.

Department operations: DHS has a wide variety of customers and business partners, including the state's 87 counties, 11 tribal governments, 118,000 health care providers and eight contracted health plans. DHS provides significant operational infrastructure to Minnesota's human services programs, most of which are provided at the county level.

DHS' operations support other providers who directly serve Minnesotans. DHS oversees significant computer systems support for: MAXIS, which determines eligibility for economic assistance programs; PRISM, the child support enforcement system; the Medicaid Management Information System (MMIS), which pays medical claims

for publicly funded health care programs; the Social Service Information System (SSIS), an automated child welfare case management system for child protection, children's mental health and out-of-home placement; and MEC2, the Minnesota Electronic Child Care system.

Budget Trends Section



Source data for the previous chart is the Minnesota Accounting and Procurement System (MAPS).

The American Recovery and Reinvestment Act of 2009 (ARRA) has temporarily increased federal funding for several programs administered by DHS. The most significant impact of this federal stimulus is that it increased the federal share of spending on the MA health care program from October 2009 to December 2010.[1] As a result, federal funds have replaced $1.8 billion of state general funds that otherwise would have been spent on MA.

External factors impacting DHS' operations include: growth in the demand for human services as the economy takes its toll on people at the lower end of the economic ladder, creating additional budget pressures; changing demographics (including longer lifespans, an aging population and growth in immigrant communities and communities of color); growth in health care costs; federal health care reform; federally mandated and state-initiated expansions to health care program eligibility, with increased complexity in program eligibility requirements; significant increases in the complexity of program funding and budgeting rules; accelerated rate of change in computer technology and the movement toward electronic government services for citizens; increased expectations for the use of electronic transfers of funds among DHS business partners; and significant growth in the number of civilly committed sex offenders.

Contact

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[1] In August 2010 Congress extended an increased federal share of spending on MA for an additional six months, from January 2011 to June 2011. This federal funding is not included in the above chart; it is expected to replace an additional $230 million of FY2011 state general fund spending on MA.

Dollars in Thousands

	Current		Governor Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	4,231,138	4,532,846	4,532,186	4,532,186	9,064,372
Recommended	**4,231,138**	**4,456,079**	**5,559,184**	**5,827,731**	**11,386,915**
Change		(76,767)	1,026,998	1,295,545	2,322,543
% Biennial Change from 2010-11					31.1%
State Government Spec Revenue					
Current Appropriation	565	565	565	565	1,130
Recommended	**565**	**565**	**565**	**565**	**1,130**
Change		0	0	0	0
% Biennial Change from 2010-11					0%
Health Care Access					
Current Appropriation	507,524	534,708	534,708	534,708	1,069,416
Recommended	**507,524**	**621,639**	**830,107**	**1,012,638**	**1,842,745**
Change		86,931	295,399	477,930	773,329
% Biennial Change from 2010-11					63.2%
Federal Stimulus					
Current Appropriation	110,010	0	0	0	0
Recommended	**110,010**	**0**	**0**	**0**	**0**
Change		0	0	0	0
% Biennial Change from 2010-11					-100%
Federal Tanf					
Current Appropriation	284,940	298,491	298,491	298,491	596,982
Recommended	**284,940**	**257,591**	**261,683**	**253,253**	**514,936**
Change		(40,900)	(36,808)	(45,238)	(82,046)
% Biennial Change from 2010-11					-5.1%
Lottery Cash Flow					
Current Appropriation	1,579	1,582	1,582	1,582	3,164
Recommended	**1,579**	**1,582**	**1,665**	**1,665**	**3,330**
Change		0	83	83	166
% Biennial Change from 2010-11					5.3%

Dollars in Thousands

	Current		Governor Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Expenditures by Fund					
Direct Appropriations					
General	3,897,514	4,335,342	5,521,441	5,789,444	11,310,885
State Government Spec Revenue	551	579	565	565	1,130
Health Care Access	480,630	636,837	825,668	1,008,199	1,833,867
Federal Stimulus	109,999	1	0	0	0
Federal Tanf	250,081	257,591	261,683	253,253	514,936
Lottery Cash Flow	1,578	1,583	1,665	1,665	3,330
Statutory Appropriations					
General	6,659	0	0	0	0
Miscellaneous Special Revenue	502,467	448,249	332,123	335,341	667,464
Federal	5,066,581	5,178,827	5,663,099	5,961,354	11,624,453
Federal Stimulus	1,034,942	871,713	12,569	5,434	18,003
Miscellaneous Agency	644,786	663,139	663,644	664,279	1,327,923
Gift	36	79	45	22	67
Revenue Based State Oper Serv	79,804	79,826	79,826	79,826	159,652
Mn Neurorehab Hospital Brainer	7,267	2,073	2,073	2,073	4,146
Dhs Chemical Dependency Servs	20,379	20,256	20,256	20,256	40,512
Materials Distribution	651	750	750	750	1,500
Total	**12,103,925**	**12,496,845**	**13,385,407**	**14,122,461**	**27,507,868**
Expenditures by Category					
Total Compensation	487,698	488,041	480,980	479,765	960,745
Other Operating Expenses	300,743	348,856	314,060	313,778	627,838
Capital Outlay & Real Property	155	8	8	8	16
Payments To Individuals	9,808,793	9,988,029	10,921,007	11,667,349	22,588,356
Local Assistance	861,422	1,013,855	1,006,961	998,535	2,005,496
Other Financial Transactions	645,114	658,056	659,603	660,238	1,319,841
Transfers	0	0	2,788	2,788	5,576
Total	**12,103,925**	**12,496,845**	**13,385,407**	**14,122,461**	**27,507,868**
Expenditures by Program					
Central Office Operations	298,318	306,642	288,670	288,310	576,980
Forecasted Programs	9,137,916	9,565,874	10,548,864	11,296,541	21,845,405
Grant Programs	1,189,317	1,086,900	1,052,602	1,042,232	2,094,834
State Operated Services	305,151	317,663	306,814	306,455	613,269
Sex Offender Program	60,891	72,415	69,820	69,820	139,640
Fiduciary Activities	641,288	659,989	660,494	661,129	1,321,623
Technical Activities	471,044	487,362	458,143	457,974	916,117
Total	**12,103,925**	**12,496,845**	**13,385,407**	**14,122,461**	**27,507,868**
Full-Time Equivalents (FTE)	**6,508.5**	**6,424.5**	**6,328.2**	**6,231.7**	

Program Description

The purpose of the Central Office Operations is to combine the activities that provide department management, infrastructure, technology, and program administration in the Department of Human Services.

Budget Activities

This program includes the following budget activities:

- Finance & Management
- Children & Families
- Health Care
- Continuing Care
- Chemical & Mental Health

HUMAN SERVICES DEPT

Program: CENTRAL OFFICE OPERATIONS

Program Summary

Dollars in Thousands

	Current		Governor Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	142,350	134,937	134,577	134,577	269,154
Technical Adjustments					
Approved Transfer Between Appr			(2,417)	(2,417)	(4,834)
Current Law Base Change			(959)	(1,284)	(2,243)
Operating Budget Reduction			(249)	(249)	(498)
Transfers Between Agencies			77	77	154
Subtotal - Forecast Base	142,350	134,937	131,029	130,704	261,733
Total	**142,350**	**134,937**	**131,029**	**130,704**	**261,733**
State Government Spec Revenue					
Current Appropriation	565	565	565	565	1,130
Subtotal - Forecast Base	565	565	565	565	1,130
Total	**565**	**565**	**565**	**565**	**1,130**
Health Care Access					
Current Appropriation	34,594	34,502	34,502	34,502	69,004
Technical Adjustments					
Current Law Base Change			726	1,507	2,233
Subtotal - Forecast Base	34,594	34,502	35,228	36,009	71,237
Total	**34,594**	**34,502**	**35,228**	**36,009**	**71,237**
Federal Tanf					
Current Appropriation	718	2,382	2,382	2,382	4,764
Subtotal - Forecast Base	718	2,382	2,382	2,382	4,764
Total	**718**	**2,382**	**2,382**	**2,382**	**4,764**
Lottery Cash Flow					
Current Appropriation	151	153	153	153	306
Technical Adjustments					
Current Law Base Change			4	4	8
Subtotal - Forecast Base	151	153	157	157	314
Total	**151**	**153**	**157**	**157**	**314**
Expenditures by Fund					
Direct Appropriations					
General	98,354	99,237	92,857	92,532	185,389
State Government Spec Revenue	551	579	565	565	1,130
Health Care Access	27,844	32,784	30,789	31,570	62,359
Federal Tanf	1,909	2,382	2,382	2,382	4,764
Lottery Cash Flow	151	153	157	157	314
Statutory Appropriations					
Miscellaneous Special Revenue	144,508	146,211	140,340	140,731	281,071
Federal	24,809	25,111	21,570	20,363	41,933
Federal Stimulus	178	144	0	0	0
Gift	14	41	10	10	20
Total	**298,318**	**306,642**	**288,670**	**288,310**	**576,980**

Dollars in Thousands

	Current		Governor Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Expenditures by Category					
Total Compensation	185,331	181,307	180,286	179,315	359,601
Other Operating Expenses	112,367	125,290	112,131	112,772	224,903
Payments To Individuals	0	45	30	0	30
Local Assistance	620	0	0	0	0
Transfers	0	0	(3,777)	(3,777)	(7,554)
Total	**298,318**	**306,642**	**288,670**	**288,310**	**576,980**
Expenditures by Activity					
Finance & Management	81,882	82,263	77,195	77,194	154,389
Children & Families	96,054	97,159	94,145	94,293	188,438
Health Care	82,892	86,889	81,807	83,510	165,317
Continuing Care	28,935	29,115	24,911	22,402	47,313
Chemical & Mental Health	8,555	11,216	10,612	10,911	21,523
Total	**298,318**	**306,642**	**288,670**	**288,310**	**576,980**
Full-Time Equivalents (FTE)	**2,262.6**	**2,256.4**	**2,222.6**	**2,188.7**	

Activity at a Glance

Regulates 24,500 licensed programs and investigates 950 maltreatment allegations annually.

Conducts 251,500 background studies each year.

Conducts 8,900 administrative fair hearings per year.

Annually responds to more than 500 data privacy inquiries.

- Sets the strategic information technology and facilities management direction for the department.
- Provides facility planning, design, construction, and lease management services.
- Establishes agency-wide information security governance, risk, and compliance activities, including security policy, and risk assessment.

Develops and manages $23.7 billion biennial budget for FY 2010-2011.

Processes approximately $6.5 billion in annual receipts.

Develops financial reports and analyses for approximately 300 grant programs.

Prepares expenditure forecasts for more than 10 agency programs with state expenditures of $4.6 billion in FY 2011.

Provides human resource support to 6,100 full-time equivalent DHS employees located across the state, covered by seven labor contracts/plans.

Provides personnel services to human services agencies in 73 counties with 3,800 employees covered by 59 labor contracts.

Responds to 850 media contacts annually.

Develops or approves content for DHS web sites, which contain 36,000 pages.

Activity Description

Finance and Management provides both internal operational support and direct program services for the department. Core services include: contract management, fair hearings, program licensing, internal auditing, legal support, information and technology support, facility management, financial management, reports and program forecasting, and human resources.

Finance and Management consists of a number of offices including: Compliance Office; Chief Information Office; Chief Financial Operations Office; Human Resources; Equal Opportunity Office; Enterprise Architecture; Office of Management, Support and Development; and the Commissioner's Office.

Population Served

Finance and Management offices support all the department's program areas, virtually all agency clients, businesses, and human services providers are served directly or indirectly by the functions of the business area.

Services Provided

Compliance Office

The compliance office consists of four divisions which provide both direct services to program recipients/providers as well as department-wide operational support. The four divisions include:

Appeals and Regulations Division

- manages grants and contracts for department services;
- conducts administrative fair hearings for applicants and recipients of services whose benefits have been denied, reduced, or terminated;
- resolves appeals by applicants denied licenses or by providers whose licenses are suspended or revoked; and
- addresses appeals by Medical Assistance (MA) and General Assistance Medical Care service providers, principally MA long-term care payment rate appeals.

Licensing Division

- licenses, monitors, and investigates human services programs, including issuing approximately 2,800 new licenses annually;
- issues approximately 1,080 licensing sanctions per year;
- conducts approximately 251,500 background studies on people who provide direct contact services in programs licensed by DHS and the Minnesota Department of Health (MDH);

- investigates approximately 1,600 complaints about the quality of services provided in licensed programs, including approximately 950 investigations of abuse or neglect of children and vulnerable adults; and
- processes approximately 2,100 requests for administrative reconsideration of disqualifications based on background study information, maltreatment investigation findings, and licensing actions.

Internal Audits Office
- evaluates the department's system of internal controls, conducting management-requested operational and program evaluation reviews, and auditing counties, grantees, contractors, and vendors for fiscal and compliance requirements;
- conducts eligibility reviews of Medical Assistance (MA) and State Children's Health Insurance Program (SCHIP) enrollees for the federally mandated Payment Error Rate Measurement program; and
- conducts federally required audits of the Child Care Assistance program.

Legal Management Office
- manages the department's relationship with the Attorney General's Office;
- ensures compliance with the Minnesota Government Data Practices Act (MGDPA) and the federal Health Insurance Portability & Accountability Act (HIPAA); and
- provides support to the department and to the Attorney General's Office in handling complex litigation.

Office of the Chief Information Officer
This office provides agency-wide technology planning and support as well as administrative support functions such as facilities management and purchasing. The office
- provides strategic planning and technical expertise to DHS program areas and counties on the use of technology in serving clients better;
- manages the DHS technology infrastructure and manages all elements of the network, remote access solutions, and information technology services (ITS)-supported servers;
- provides desktop software and hardware and desktop support services such as data storage and backup, virus control, and help desk;
- develops and maintains information security and standards;
- coordinates facility planning, design, and management;
- provides physical building access controls and security;
- oversees agency inventory and property management;
- provides agency purchasing services, vendor management, and commodity contracts; and
- maintains the department's public, internal, and county web sites.

Chief Financial Operations Office
This office forecasts program expenditures and revenues, prepares reports and analyses of expenditures and revenues, and prepares fiscal notes projecting the effects of policy changes. Specific activities include
- providing oversight and strategic direction to all agency financial issues and financial operations;
- directing the agency's budget development process to produce deliverables required by the Minnesota Department of Management and Budget (MMB), including the Governor's biennial and supplemental budgets;
- managing communications with the legislature as related to the agency's budget and budget proposals;
- carrying out the full range of accounting and financial management functions for the agency, including: budgeting and accounting transactions; budget and cost allocation; payroll and accounts payable; accounts receivable; receipts center; accounting payments through major systems: MMIS (health care provider payments); MAXIS (economic assistance payments to families); MEC2 (payments to children care providers); PRISM (pass-through child support receipts and payments); accounting for grants and allocations to counties and providers, and time studies and rates;
- forecasting enrollment and expenditures in MA, MinnesotaCare, GAMC, Alternative. Care, MFIP, Child Care, GA, GRH, and MSA for state budget purposes;
- conducting fiscal analysis for fiscal notes and to support the proposal development process, including analyses of changes to federal laws;
- producing statistical and fiscal reports for federal programs;
- administering the Parental Fee Program; and

- developing and managing fiscal policies and strategies to support policy objectives, meet changing federal requirements, and ensure fiscal accountability.

Human Resource Office
This office provides centralized human resources management services for all Department of Human Services (DHS) management and staff at the state level and staff of 73 county human services agencies through the Minnesota Merit System. Specific activities include:
- workforce planning, recruitment, assessment, selection, redeployment, compensation, classification, performance management, and HR-related training;
- labor contract administration, employee misconduct investigations, disciplinary actions, grievance handling/arbitration, and negotiations of supplemental agreements and memoranda of understanding;
- health, safety, workers compensation, and business continuity planning; and
- radiological emergency preparedness and management of the nuclear generating plant emergency reception centers.

Equal Opportunity Office
This office helps the department to develop a diverse workforce, which is able to provide effective, non-discriminatory services, programs, and policies. Specific activities include
- development of a culturally competent workforce through targeted recruitment, staff development opportunities, and affirmative action plan implementation; and
- enforcement of equal employment opportunity through investigations of complaints, development of policies and procedures, and coordination of issues related to the Americans with Disabilities Act.

Enterprise Architecture Office
This office is in the development phase of a strategic plan to transform the department's business architecture, to modernize current business systems, to bring focus to those systems which are core to the department, and to align the department, using best practices, in order to accomplish the department's mission.

Office of Management, Support and Development (OMSD)
This office provides agency level support for a number of key functions such as training, organizational development, project management, and performance measures. Specific activities include
- improving organizational effectiveness through training, leadership development, and coaching;
- providing team building and consulting on employee engagement;
- providing agency-level project management in support of agency projects and priorities;
- leading agency-level coordination of performance measurement for DHS priorities, the Annual County Performance Report, and performance/metric reporting; and
- facilitating survey development and administration, administrative policy coordination, and strategic planning coordination.

Commissioner's Office
This office supports the commissioner in the work done to meet the agency priorities and to serve those individuals who meet the qualifications for the various programs operated through the department. The office serves as the agency point of contact for the media, manages data requests from the media, writes news releases, and assists in developing the agency publications. Additionally, this office coordinates the legislative process for the agency.

Historical Perspective

Compliance Office
The fair hearings function in the Appeals and Regulations Division was initially focused on hearings for applicants and recipients of DHS health care and welfare benefits. However, the number of hearings has increased significantly over time, and the nature of hearings has changed from relatively simple, single-issue eligibility appeals to more complicated medical and social services appeals. The fair hearings function has also assumed

responsibility for certain licensing and provider appeals and review of child and vulnerable adult maltreatment determinations.

In 1991, the Licensing Division assumed responsibility for developing a background study system following legislative action. In 1995 and 2001, the legislature expanded DHS' responsibility to include background studies on people providing services in programs licensed by the Minnesota Department of Health and the Minnesota Department of Corrections. In 2007, the legislature transferred responsibility for conducting background studies for child foster care from the counties to DHS and added responsibility to the Licensing Division for conducting background studies for adoptions (compliance with federal Adam Walsh requirements). In 1995, the legislature transferred responsibility for many vulnerable adult maltreatment investigations from counties to DHS and, in 1997, transferred certain responsibility for maltreatment of minors investigations from counties to DHS.

The Internal Audits Office was established in November 1995 to provide the department with an independent evaluation of its operations and to coordinate mandatory audit requirements for federal program funds. The office has developed a computer forensic service to assist DHS' Human Resources Division and other state agencies in personnel investigations. In 2009, a program evaluation function was added to provide more objective analysis of department programs and internal processes.

The department's Legal Management Office is responsible for ensuring DHS' implementation of, and compliance with, the federal Health Insurance Portability & Accountability Act (HIPAA) privacy regulations.

All aspects of the Compliance Office have been affected significantly by two trends
- more and faster-changing types of service models, which challenge traditional licensing and regulatory approaches; and
- the demands of clients, business partners, and DHS staff for increased use of electronic systems to share information and transact business.

Office of the Chief Information Officer
In 1995, the Chief Information Officer (CIO) position was established to lead DHS information technology (IT) and related strategic planning within the department. In a span of a few years, the IT organization broadened in scope and maturity. In 2003, the Chief Information Security position was established to provide leadership in overseeing DHS' successful implementation of and compliance with federal and state security regulations and policy. That same year the first DHS IT Strategic Plan was issued; it presents the business technology mission, vision, and goals for DHS IT and outlines strategies and action programs to accomplish the goals.

Within facilities management, flexibility and cost-effectiveness continue to be the vision over the next several years. In 2005-2006, DHS consolidated its primary central office workspace into facilities designed and constructed with an eye toward meeting the needs of the future workforce. The buildings were developed with flexibility to efficiently support moves and changes. Infrastructure has been designed to provide reliable and energy-efficient building systems. Automated building access controls provide timely handling of changing business needs. Sourcing systems and procurement processes are similarly designed to support a geographically distributed enterprise efficiently while providing appropriate controls.

Office of the Chief Financial Officer
The past 25 years have brought significant increases in the complexity of program funding and budgeting rules. Most recently, changes to General Assistance Medical Care (GAMC), multiple sources of federal stimulus funding, and federal health care reform are creating new challenges that impact accounting, reporting, forecasting, and fiscal analysis functions. Expectations have also increased for the use of electronic transfers of funds among DHS business partners. Financial Operations has responded by making greater use of technology. The department has developed and maintained electronic interfaces between computer systems within the department and between DHS, statewide, and county systems.

Human Resources
For human resources management, the aging workforce and labor shortages in highly skilled clinical positions (e.g., nurse practitioners, psychiatrists, licensed psychologists, and pharmacists) require that DHS continues to recruit even while staffing reductions are occurring in other areas. This results in additional complexity and the need for more creative planning efforts. Over the past few years significant transitions have also occurred in State Operated Services from large institutions to small, community-based facilities and services; these continuing efforts result in further re-evaluation and restructuring of human resource service delivery options.

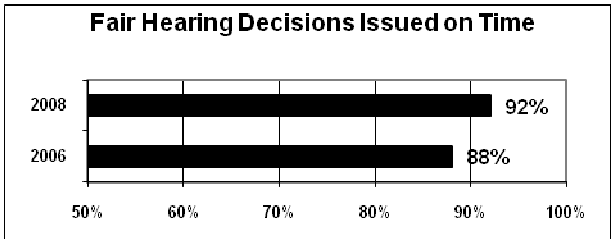
Enterprise Architecture
This office was created at the beginning of 2010 to develop the "blueprint" which identifies how all parts of the agency work together to serve the ultimate end goal which is the best service possible for its clients.

Office of Management, Supports and Development
The office was created in 2008 to support DHS management in achieving program and operational goals through improved coordination and support at an agency-wide level.

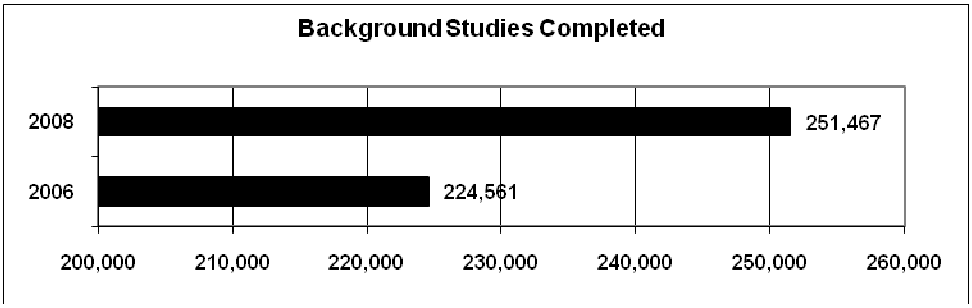
Key Activity Goals & Measures

Compliance Office
- **Improve delivery of legal and regulatory services to ensure system integrity and legal compliance.**

  - Percentage of final decisions in fair hearings issued within statutory deadlines. The department is required to issue final decisions for fair hearings within statutory deadlines. In FY 2006 and FY 2008, the department met the statutory deadline in 88% and 92% of the cases, respectively.

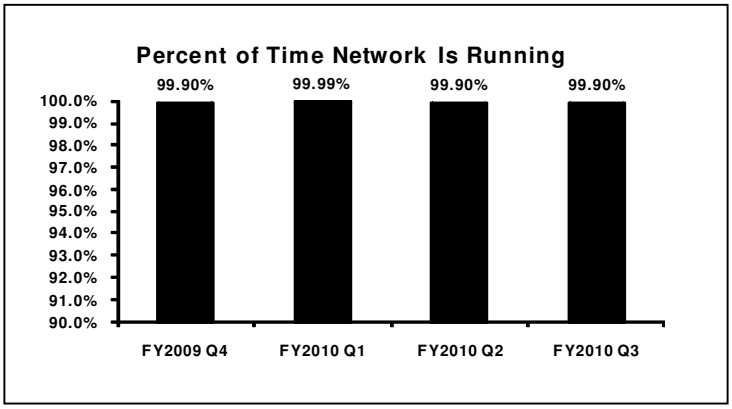


  - Number of background studies completed for individuals who have direct contact with clients.



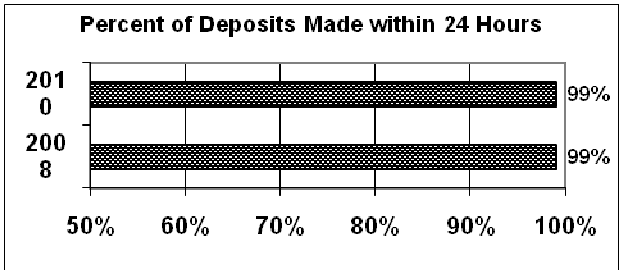
Office of the Chief Information Officer
- ***Service Delivery:*** *Make it easier to deliver quality human services.*
- ***Governance:*** *Ensure that technology resources are assigned to those projects that will meet business goals.*
- ***Workforce:*** *Develop and support a workforce to maximize technology benefits.*
- ***Operations****: Make it easier to manage processes and support people.*

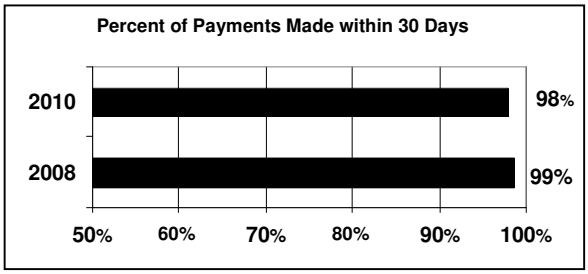
- ***Percentage of time that the department's network was up and running.*** By keeping network services up and running a very high percentage of the time, technology operations is providing stable and reliable networking services so that DHS can efficiently and effectively provide human services.



Office of the Chief Financial Officer

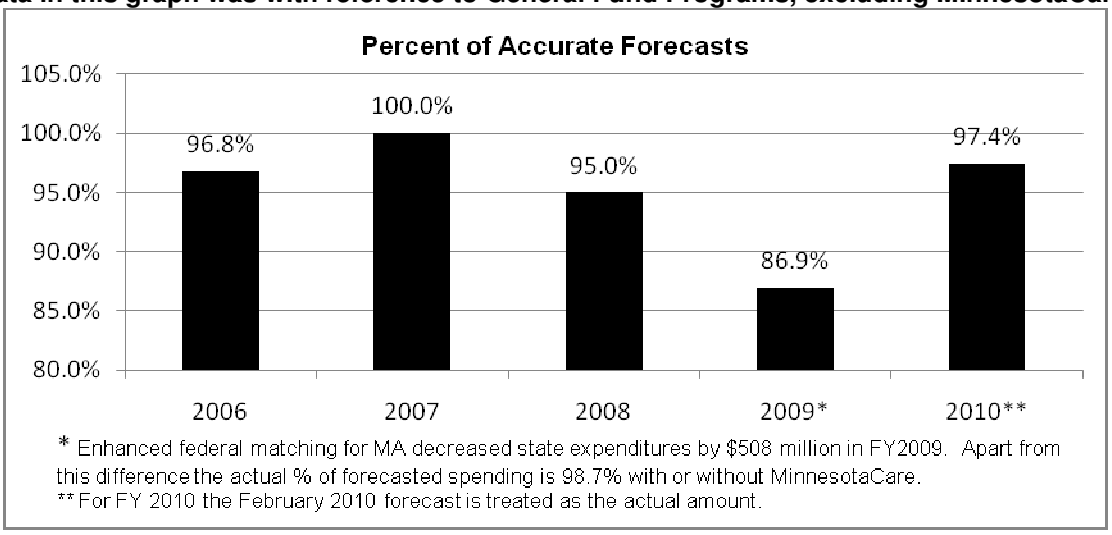
- **Ensure appropriate stewardship of public funds and maintain the highest accounting standards through DHS fiscal policies and processes.**
  - ***Percentage of receipts volume deposited within 24 hours.*** The department is required to make timely deposits. Infrequently, a check must be held longer than 24 hours because follow-up identification is required with the payee. *Of the total receipts volume in FY 2010, at least 99% were deposited within 24 hours.*
  - ***Percentage of accounts payable volume paid within 30 days.*** The department is required to make timely payments. *Of the total payment volume in FY 2010, the department made 97.9% of the payments within 30 days.*





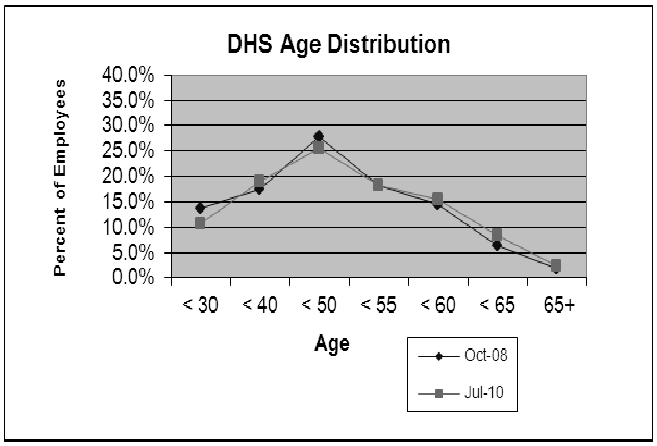
  - ***Forecast accuracy: actual expenditures compared with forecasted expenditures.*** Effective financial management requires accurate expenditure forecasts. Forecast accuracy is measured as actual expenditures (forecasted programs only) in a given year compared with the expenditures that were forecasted at the end of the legislative session that preceded the fiscal year. Forecasted programs include Medical Assistance, General Assistance Medical Care, MinnesotaCare, Minnesota Family Investment Program, Diversionary Work Program, Child Care Assistance Program, General Assistance, Group Residential Housing, Minnesota Supplemental Aid, and the Consolidated Chemical Dependency Treatment Fund.

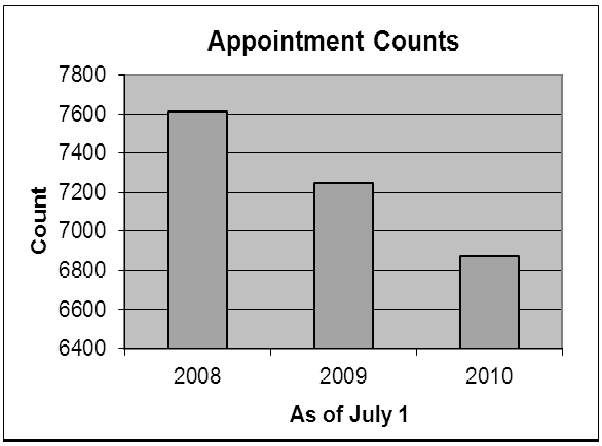
Data in this graph was with reference to General Fund Programs, excluding MinnesotaCare.



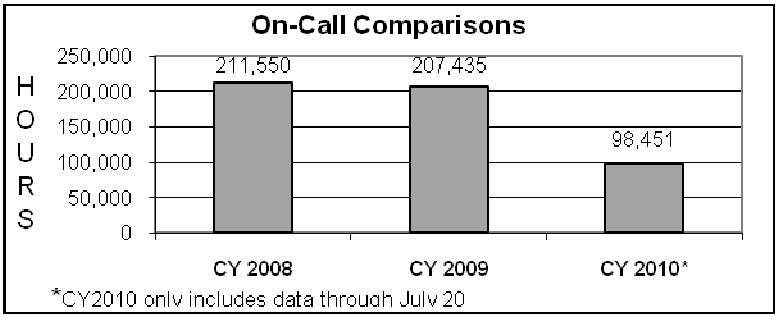
Human Resources

- **Create a flexible, efficient human resources system that meets the needs of managers and supervisors in a high-quality and timely manner.** DHS has an aging workforce and at the same time is reducing the total number of employees in active status as outlined in the following charts. This requires increased staffing utilization review to ensure human resources are used effectively.





The aging and reduced workforce has also resulted in reviewing and reducing other expenditures such as the number of hours that staff members are paid for on-call purposes.



Equal Opportunity
- *Reduce disparities in service access and outcomes for racial and ethnic populations.*
- *Improve service delivery through organizational effectiveness, cultural competency, and employee engagement.*

Office of Management Support and Development
- *Implementation of agency strategic initiatives.*
- *A results management framework consisting of outcome and performance reporting.*
- *Tools for a framework that maximizes management and leadership capacity for improved employee engagement.*

For more information on DHS performance measures, see
http://www.accountability.state.mn.us/Departments/HumanServices/index.htm

Activity Funding

Finance and Management is funded with a combination of appropriations from the General Fund, health care access fund, state government special revenue fund, and federal funds. The General Fund is the single largest funding source for this budget activity.

The Licensing Division is of special note as its operations are funded not only by appropriations but also by fees generated from the completion of background studies.

Contact

For more information about the offices within Finance and Management, please contact the following numbers:
Compliance Office
- Chief Compliance Officer (651) 431-2924
- Appeals and Regulations Office (651) 431-3600
- Internal Audits Office (651) 431-3619
- Licensing Office (651) 296-3971

Office of the Chief Information Officer (651) 431-2110
Office of the Chief Financial Officer (651) 431-3725
Human Resources (651) 431-2999
Equal Opportunity (651) 431-3037
Enterprise Architecture (651) 431-2908
Office of Management Support and Development (651) 431-4650

Information on DHS programs is on the department's Web site: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: CENTRAL OFFICE OPERATIONS
Activity: FINANCE & MANAGEMENT

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	96,507	86,681	86,681	86,681	173,362
Technical Adjustments					
Approved Transfer Between Appr			(2,567)	(2,567)	(5,134)
Current Law Base Change			1,589	1,589	3,178
Operating Budget Reduction			(249)	(249)	(498)
Subtotal - Forecast Base	96,507	86,681	85,454	85,454	170,908
Total	**96,507**	**86,681**	**85,454**	**85,454**	**170,908**
State Government Spec Revenue					
Current Appropriation	440	440	440	440	880
Subtotal - Forecast Base	440	440	440	440	880
Total	**440**	**440**	**440**	**440**	**880**
Health Care Access					
Current Appropriation	10,955	11,508	11,508	11,508	23,016
Subtotal - Forecast Base	10,955	11,508	11,508	11,508	23,016
Total	**10,955**	**11,508**	**11,508**	**11,508**	**23,016**
Federal Tanf					
Current Appropriation	222	222	222	222	444
Subtotal - Forecast Base	222	222	222	222	444
Total	**222**	**222**	**222**	**222**	**444**
Expenditures by Fund					
Direct Appropriations					
General	53,248	51,288	47,282	47,282	94,564
State Government Spec Revenue	431	454	440	440	880
Health Care Access	6,043	8,556	7,069	7,069	14,138
Federal Tanf	100	222	222	222	444
Statutory Appropriations					
Miscellaneous Special Revenue	20,816	20,451	20,890	20,889	41,779
Federal	1,244	1,292	1,292	1,292	2,584
Total	**81,882**	**82,263**	**77,195**	**77,194**	**154,389**
Expenditures by Category					
Total Compensation	48,698	45,570	45,938	45,937	91,875
Other Operating Expenses	33,181	36,693	35,034	35,034	70,068
Local Assistance	3	0	0	0	0
Transfers	0	0	(3,777)	(3,777)	(7,554)
Total	**81,882**	**82,263**	**77,195**	**77,194**	**154,389**
Full-Time Equivalents (FTE)	**572.5**	**570.8**	**562.3**	**553.7**	

Activity at a Glance

- Develops policy for children's and economic assistance programs.
- Provides administrative support to child welfare and children's mental health grantees.
- Works with counties, tribes, and other providers to implement best practices.
- Provides training and technical assistance to direct service providers.
- Implements federal changes.
- Provides benefits to more than 736,800 people through MAXIS each month.
- Provides child support services to 398,000 custodial and non-custodial parents and 252,000 children annually.
- Provides child care assistance to more than 33,700 children through MEC^2 monthly.
- Provides data support for services to 4,892 children who are determined to be victims of abuse or neglect and 11,700 children in out-of-home placements annually.
- Tracks services to 347,000 clients in 82,000 child welfare-related and 139,905 adult services cases annually through SSIS.

Activity Description

Children & Families central office operations provide policy development, program implementation, grants management, training, and technical assistance to counties, tribes, and grantees. This activity provides administrative support for programs serving children and families that are funded through the agency's Forecasted Programs and Grant Programs. The Children & Families Operations activity also provides the computer systems and quality assurance infrastructure necessary to deliver services for children and families.

Population Served

This activity supports services that are provided to:

- families and individuals who receive economic assistance;
- children who receive child support enforcement services;
- families who receive child care assistance services;
- children who are at risk of abuse or neglect, in out-of-home placements, in need of adoption, under state guardianship, or have an emotional disturbance and need mental health services; and
- direct service workers in 87 counties who receive policy assistance, technical support, and training.

The Operations section serves:

- Minnesotans who receive economic assistance benefits through MAXIS;
- families who receive child care assistance services through Minnesota Electronic Child Care System (MEC2), which is part of MAXIS;
- children who receive child support enforcement services through PRISM;
- families and children who receive social services through Social Service Information System (SSIS); and
- state and county workers, who use MAXIS, PRISM, and MEC2, and county social service workers who use SSIS.

Services Provided

Central Office Operations for Children and Families:

- provides technical support and policy interpretation for 87 county human services agencies through training, instructional manuals, policy assistance, and system support help desks;
- assists with case management;
- implements and monitors grant projects;
- conducts pilot programs to improve service delivery and outcomes;
- implements policy changes and develops and analyzes legislation;
- administers social services, cash assistance, and employment services to refugees;
- assures and documents compliance with state and federal laws;
- conducts quality assurance reviews of county practices; and
- manages intergovernmental relations.

Operations include:

- operating and maintaining the eligibility and delivery systems for Food Support, General Assistance, Minnesota Supplemental Aid, Minnesota Family Investment Program (MFIP), Diversionary Work Program, Child Care Assistance Program, Medical Assistance (MA), General Assistance Medical Care, Group Residential Housing, Minnesota Food Assistance Program, and Emergency General Assistance;

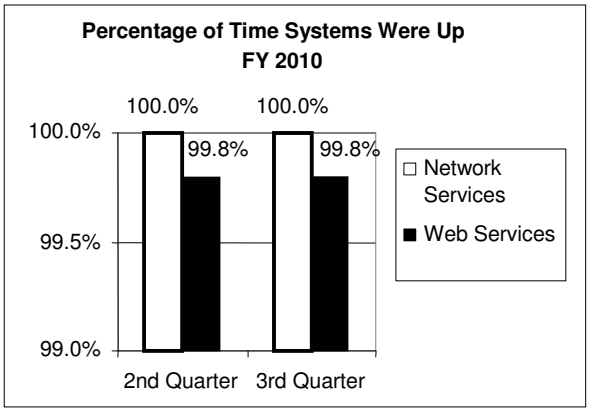
- collecting and distributing child support payments, locating absent parents, establishing paternity, and enforcing court orders;
- conducting federally mandated quality control reviews, payment accuracy assessments, and administrative evaluations for MFIP, Food Support, MA, and child support;
- administering the Electronic Benefit Transfer (EBT) system;
- providing centralized mailing of benefits, forms, and legal notices to clients;
- managing program integrity (fraud prevention) and control functions;
- collecting and analyzing data trends and activities that determine program effectiveness, establish program error levels to prevent recipient fraud, and support long-range planning;
- managing claims and recoveries of overpayments for the cash public assistance program, including the Treasury Offset Program;
- supporting county social service workers by automating routine tasks, helping determine client needs, and providing timely information on children who have been maltreated, are in out-of-home placement, or who are awaiting adoption; and
- managing and overseeing counties' work in child protection, out-of-home placement, adoption, and foster care services.

Key Activity Goals & Measures

- ***Improve outcomes for the most at-risk children.*** The department is taking steps to implement and evaluate new service approaches for the most at-risk children and their families. This goal is from the Department of Human Services' *Priority Plans* (http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4694-ENG). Working with others, the department will provide early and targeted services to children in Minnesota who are at greatest risk for poor outcomes, including those who are homeless, disabled, teenage parents, in child protection, or in deep or persistent poverty. By identifying these at-risk children, building partnerships and service networks, and implementing targeted, coordinated, and integrated services, children's lives will improve. They will also be better prepared for a healthy and productive adulthood.
- ***Service delivery:*** Make it easier to deliver quality human services.
- ***Operations:*** Make it easier to manage processes and support people.

Key measures are

- ***Percentage of time that key systems are up and running.*** For the last two quarters, the percentages of time systems were up and running ranged from 99.8% to 100.0% of the time.



For additional key measures, see the key measures for Forecasted Programs and Grant Programs.

For more information on DHS performance measures, see http://www.accountability.state.mn.us/Departments/HumanServices/index.htm.

Activity Funding

Children & Families central office operations is funded primarily with appropriations from the general fund and from federal funds. The operations section is also funded in part with appropriations from the health care access fund.

Contact

For more information, contact the Children and Family Services Administration, (651) 431-3830.

For more information on Children & Families Operations, contact:

- Child Support Enforcement Division (651) 431-4400
- Transition Support Services Division (651) 431-4101
- SSIS (651) 431-4800

Information on DHS programs is on the department's website: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: CENTRAL OFFICE OPERATIONS
Activity: CHILDREN & FAMILIES

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	9,687	9,134	9,134	9,134	18,268
Technical Adjustments					
Current Law Base Change			93	93	186
Subtotal - Forecast Base	9,687	9,134	9,227	9,227	18,454
Total	**9,687**	**9,134**	**9,227**	**9,227**	**18,454**
Federal Tanf					
Current Appropriation	496	2,160	2,160	2,160	4,320
Subtotal - Forecast Base	496	2,160	2,160	2,160	4,320
Total	**496**	**2,160**	**2,160**	**2,160**	**4,320**
Expenditures by Fund					
Direct Appropriations					
General	9,145	8,690	9,227	9,227	18,454
Federal Tanf	1,809	2,160	2,160	2,160	4,320
Statutory Appropriations					
Miscellaneous Special Revenue	76,168	75,030	73,647	73,916	147,563
Federal	8,754	11,135	9,111	8,990	18,101
Federal Stimulus	178	144	0	0	0
Total	**96,054**	**97,159**	**94,145**	**94,293**	**188,438**
Expenditures by Category					
Total Compensation	52,980	49,481	48,629	48,412	97,041
Other Operating Expenses	43,026	47,633	45,486	45,881	91,367
Payments To Individuals	0	45	30	0	30
Local Assistance	48	0	0	0	0
Total	**96,054**	**97,159**	**94,145**	**94,293**	**188,438**
Full-Time Equivalents (FTE)	**607.1**	**605.1**	**596.0**	**586.9**	

Activity at a Glance

- FY 2009, approximately 707,000 Minnesotans were enrolled in Minnesota's publicly-funded health care programs.
- Central office operations work directly with 108,000 health care providers.
- Central office operations work directly with financial and social services staff in Minnesota's 87 counties.
- The MMIS system processes 60.7 million fee-for-service encounter claims and health plan capitation payments per year.

Activity Description

The Health Care Administration and the Office of the Medicaid Director central office operations are responsible for developing and implementing health care policy for publicly-funded health care programs.

Operational activities include providing the infrastructure necessary for effective and efficient health care purchasing and delivery for health care grants. This includes administering the Medicaid Management Information System (MMIS), a centralized medical payment system. It also supports other department functions, including administering managed care contracts, conducting eligibility determinations, and conducting quality improvement and data analysis program management.

Population Served

In an average month in FY 2009, approximately 707,000 Minnesotans were enrolled in Minnesota's publicly-funded health care programs.

Central office operations work directly with many entities to serve enrollees including

- 108,000 health care providers, including inpatient and outpatient hospitals, dentists, physicians, mental health professionals, home care providers, personal care attendants, pharmacists, and eight managed health care plans;
- approximately 24 state health care professional organizations;
- financial and social services staff in Minnesota's 87 counties;
- the federal Centers for Medicare and Medicaid Services; and
- Minnesota's counties and tribes.

Services Provided

Central office operations are responsible for

- developing health care program policy and leading implementation of policy initiatives;
- developing payment policies, including fee-for-service and managed care rates, that promote cost-effective delivery of quality services to Medical Assistance (MA), General Assistance Medical Care (GAMC), and MinnesotaCare recipients;
- monitoring health plans to ensure contract compliance, value, and access;
- protecting the integrity of state health care programs through fraud prevention and cost avoidance activities;
- conducting surveys and research to monitor quality of care provided and health status of program enrollees;
- working with the federal government to ensure compliance with Medicaid laws and rules;
- negotiating waivers to federal laws and rules to allow expanded access and coverage, payment initiatives, enhanced federal matching funds, and demonstration projects to improve care and services for various enrollee groups;
- working with various partners to plan and implement changes needed to comply with federal laws including the Patient Protection and Affordable Care Act (PPACA) and Health Insurance Portability and Accountability Act (HIPAA);
- providing oversight of county and tribal administration of state policies and rules;
- planning and development of improved eligibility and enrollment systems, including an automated eligibility determination system, to make programs more accessible and administration more efficient;
- operating MMIS, a centralized payment system, for MA, MinnesotaCare, and GAMC;
- maintaining health care provider enrollment agreements;
- supporting enrollee communication and outreach efforts;

- maintaining online system availability for claims operation, customer services, and eligibility verification for 108,000 providers;
- supporting enhanced electronic claim activity to increase processing efficiency and decrease administrative costs, including maintaining a viable point-of-sale system for pharmacy;
- operating a Web-based electronic commerce environment for health care claim submission and other government-to-business electronic transactions;
- supporting the collection of premiums for MinnesotaCare and MA for Employed Persons with Disabilities (MA-EPD), spenddowns for Minnesota Senior Health Options, and development of financial control programs capable of supporting additional premium-based health care purchasing concepts;
- identifying all liable third parties required to pay for medical expenses before expenditure of state funds and recovering costs from other insurers, which includes maximizing Medicare participation in the cost of all services for dually-eligible enrollees, with emphasis on long-term care and home health services; and
- administering the medical care surcharge to ensure maximum receipt of surcharge funds from nursing care facilities and inpatient hospitals in compliance with federal laws and regulations.

Historical Perspective

Minnesota is consistently a national leader in promoting and implementing policy and payment initiatives that improve access, quality, and cost-effectiveness of services provided through publicly-funded health care programs. Federally mandated and state-initiated expansions to health care program eligibility over the past 15 years have improved access to health care for low-income, special need, and uninsured Minnesotans. At the same time, program eligibility requirements have become more complex.

Changes in approaches to purchasing services for enrollees have evolved over the past two decades from strictly fee-for-service to more managed care contracting. This has changed the nature of management in this area to include sophisticated, capitated rate setting and risk adjustment, contract management, performance measurement, and more complex federal authority mechanisms, while continuing to improve fee-for-service rate setting and service coverage definition.

In the past decade, Department of Human Services (DHS) implemented managed care demonstration programs for seniors to provide cost-effective, coordinated Medicare and Medicaid services. The Minnesota Senior Health Options incorporates home- and community-based services to reduce the need for nursing home care.

As DHS increasingly contracts for day-to-day administration of primary health care services, more attention can be given to initiatives that better manage rapidly increasing health care costs. For example, the Health Care Administration has recently implemented unique volume-based purchasing agreements within fee-for-service.

DHS has been and will continue to be engaged in work related to implementing the modifications to GAMC program enacted in 2010. This includes work related to eligibility policy, negotiating and administering contracts with hospitals serving as coordinated care delivery systems (CCDSs), and administering the GAMC prescription drug benefit.

Passage of the Patient Protection and Affordable Care Act (PPACA) on the federal level has created new challenges and opportunities for the Health Care Administration and the Office of the Medicaid Director. These include: modifications to MA policies related to covered services provider payments and program integrity; demonstration projects to change the ways services are delivered and paid for; and a required expansion in MA eligibility beginning in 2014.

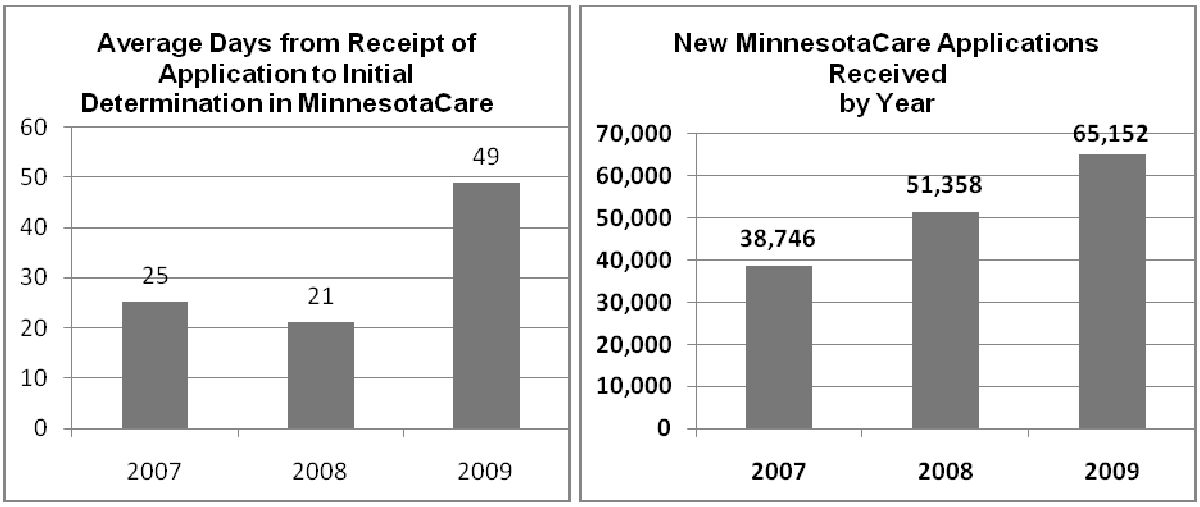
The Medicaid Management Information System (MMIS) pays medical bills and managed care capitation payments for DHS-administered Minnesota Health Care Programs (MHCP) recipients, generates DHS program data for research and forecasting, assists in detecting medical fraud, and employs technological solutions to reduce costs and improve services for health care providers. The current MMIS was implemented in 1994, replacing a system that had been operational since 1974. The current system processes 60.7 million fee-for-

service encounter claims and health plan capitation payments per year. Complexity in health care delivery strategies and in eligibility criteria to ensure focused eligibility for very specific populations has required that MMIS be flexible and scalable. In addition, the accelerated rate of change in computing technology and the movement toward electronic government services for citizens has required ongoing strategic investments in health care systems.

Key Activity Goals & Measures

- **Minnesotans will be healthy.** This goal is from Minnesota Milestones
- (http://server.admin.state.mn.us/mm/goal.html).
- **Use the state's participation in the health care market to improve health care quality, access, outcomes, and affordability for all Minnesotans.** For the health care and nursing home services that it purchases, the department will improve price and quality transparency, encourage the use of evidence-based care, and use the payment system to encourage quality and efficiency. This goal is from the Department of Human Services' Priority Plans (http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4694-ENG).

    - ***MinnesotaCare new application processing time.*** As of July 2010, the interval from application to initial determination has been reduced to 21 days. This improvement was accomplished through a short term strategy of identifying potential time savings and implementing those that appeared most effective in reducing the application backlog. Changes included simplifying verification of income and access to employer subsidized insurance.



For more information on DHS performance measures, see key measures for health care-related activities in Forecasted Grants.

For more information on DHS performance measures, see
http://www.accountability.state.mn.us/Departments/HumanServices/index.htm

Activity Funding

Health Care Operations is funded primarily with appropriations from the General Fund and health care access fund and from federal funds.

Contact

For more information on this budget activity, contact Health Care Operations, (651) 431-3050.
Information on DHS programs is available on the department's website: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: CENTRAL OFFICE OPERATIONS
Activity: HEALTH CARE

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	16,948	15,993	15,633	15,633	31,266
Technical Adjustments					
Current Law Base Change			49	(81)	(32)
Transfers Between Agencies			77	77	154
Subtotal - Forecast Base	16,948	15,993	15,759	15,629	31,388
Total	**16,948**	**15,993**	**15,759**	**15,629**	**31,388**
Health Care Access					
Current Appropriation	23,639	22,994	22,994	22,994	45,988
Technical Adjustments					
Current Law Base Change			726	1,507	2,233
Subtotal - Forecast Base	23,639	22,994	23,720	24,501	48,221
Total	**23,639**	**22,994**	**23,720**	**24,501**	**48,221**
Expenditures by Fund					
Direct Appropriations					
General	16,703	15,292	15,759	15,629	31,388
Health Care Access	21,801	24,228	23,720	24,501	48,221
Statutory Appropriations					
Miscellaneous Special Revenue	44,185	45,799	41,134	40,958	82,092
Federal	203	1,570	1,194	2,422	3,616
Total	**82,892**	**86,889**	**81,807**	**83,510**	**165,317**
Expenditures by Category					
Total Compensation	56,780	58,218	58,216	58,199	116,415
Other Operating Expenses	25,562	28,671	23,591	25,311	48,902
Local Assistance	550	0	0	0	0
Total	**82,892**	**86,889**	**81,807**	**83,510**	**165,317**
Full-Time Equivalents (FTE)	**756.1**	**754.7**	**743.4**	**732.1**	

Activity at a Glance

- Performs statewide human services planning and develops and implements policy
- Obtains, allocates, and manages resources, contracts, and grants
- Sets standards for services development and delivery and monitors for compliance and evaluation
- Provides technical assistance and training to county agencies and supports local innovation and quality improvement efforts
- Assures a statewide safety net capacity

Activity Description

Continuing Care Operations is the administrative component for the service areas funded by Continuing Care-related grants. It also coordinates with Health Care central office operations on the Medicaid-funded Continuing Care grants.

Population Served

This program serves elderly Minnesotans and citizens with disabilities who need long-term care, including persons with physical and cognitive disabilities, deafness or hearing loss, mental illness, and HIV/AIDS.

Services Provided

DHS Continuing Care staff administers programs and services that are used by over 350,000 Minnesotans. This work is accomplished by working with citizens, counties, legislators, grantees, other state agencies, and providers.

In addition to the normal administrative functions, which apply to all people served, Continuing Care staff perform unique specialized activities. Direct constituent services include:

- statewide regional service centers which help deaf, deafblind, and hard-of-hearing people access community resources and the human services system;
- the Telephone Equipment Distribution Program, which helps people with hearing loss or communication disabilities access the telephone system with specialized equipment;
- HIV/AIDS programs which help people obtain and maintain needed health care coverage; and
- ombudsman services for older Minnesotans which assist consumers in resolving complaints and preserving access to services.

Staff assistance and administrative support are also provided to a number of councils and boards including:

- The Commission Serving Deaf, Deaf/Blind and Hard of Hearing Minnesotans;
- The Minnesota Board on Aging; and
- Traumatic Brain Injury Service Integration Advisory Committee.

Historical Perspective

Historically, most people needing long-term care services received them in institutions. Over the years, priorities, values, and expectations changed. Today, people have more individualized options.

Continuing Care staff administer a broad array of services for this diverse population. In addition to administering ongoing operations of programs and services, some recent achievements include:

- redesigning highly specialized mental health services for individuals who have both a hearing loss and mental illness by shifting resources from institutional care under State Operated Services to a statewide technical assistance/consultation model;
- describing the demographic realities of the state's aging population and working with many constituencies to prepare responses to these profound changes;
- implementing strategies of the long-term care task force that reform Minnesota's long-term care system for the elderly, which includes administering the voluntary, planned closure of nursing facility beds and expanding use of home and community-based services through grants and other mechanisms to develop community capacity;
- taking actions necessary to increase flexibility, reduce access barriers, and promote consumer choice and control with the home care and waivered services covered by Medical Assistance;
- managing cost growth in home and community based waiver programs while reducing reliance on hospital and institutional care;

- working with consumers, family members, county agencies, provider organizations, and advocates to develop community options for younger persons with disabilities who are currently residing in institutional settings;
- developing the Minnesota Senior Health Options (MSHO) and Minnesota Disability Health Options (MDHO) projects that integrate health and long-term care for elderly and younger persons with disabilities who are eligible for both Medicaid and Medicare;
- publishing the Minnesota Nursing Home Report Card online, in collaboration with the Minnesota Department of Health, and;
- working with the Senior LinkAge Line and Disability Linkage Line staff to assist the Centers for Medicare and Medicaid with enrollment in Medicare Part D plans and solving problems for individuals who are dually eligible.

Key Activity Goals & Measures

- ***Reform long-term care options for elderly Minnesotans.*** DHS strives to increase the availability of non-institutional service options for older persons and their families. Competitive grants in this area promote evidence-based models that leverage local private funds and in-kind contributions to promote affordable services that are both dependable and sustainable. This goal is from *Minnesota Milestones* (http://server.admin.state.mn.us/mm/goal.html).
- ***Streamline and manage home and community-based waiver services.*** DHS will provide consistent services across all home and community-based waivers through development of a common services menu and a common screening tool. The department will target use of long-term care waivered services to the highest risk clients, strengthening program and fiscal integrity of each waiver program. This goal is from the Department of Human Services' *Priority Plans* (http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4694-ENG).

See key measures for Continuing Care-related grants in Grant Programs.

For more information on DHS performance measures, see http://www.accountability.state.mn.us/Departments/HumanServices/index.htm.

Activity Funding

The Continuing Care central office operations activity is funded with appropriations from the General Fund, state government special revenue fund, miscellaneous special revenue funds, and from federal funds.

Contact

For more information on Continuing Care Management contact (651) 431-2598.
Information on DHS programs is on the department's website: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: CENTRAL OFFICE OPERATIONS
Activity: CONTINUING CARE

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	15,621	18,935	18,935	18,935	37,870
Technical Adjustments					
Approved Transfer Between Appr			150	150	300
Current Law Base Change			(2,690)	(2,885)	(5,575)
Subtotal - Forecast Base	15,621	18,935	16,395	16,200	32,595
Total	**15,621**	**18,935**	**16,395**	**16,200**	**32,595**
State Government Spec Revenue					
Current Appropriation	125	125	125	125	250
Subtotal - Forecast Base	125	125	125	125	250
Total	**125**	**125**	**125**	**125**	**250**
Expenditures by Fund					
Direct Appropriations					
General	15,671	19,673	16,395	16,200	32,595
State Government Spec Revenue	120	125	125	125	250
Statutory Appropriations					
Miscellaneous Special Revenue	2,694	2,781	2,567	2,567	5,134
Federal	10,436	6,495	5,814	3,500	9,314
Gift	14	41	10	10	20
Total	**28,935**	**29,115**	**24,911**	**22,402**	**47,313**
Expenditures by Category					
Total Compensation	19,426	19,113	18,882	18,146	37,028
Other Operating Expenses	9,509	10,002	6,029	4,256	10,285
Total	**28,935**	**29,115**	**24,911**	**22,402**	**47,313**
Full-Time Equivalents (FTE)	**241.3**	**240.5**	**236.9**	**233.3**	

Activity at a Glance

- Provides policy oversight and administers funding for public chemical and mental health services to thousands of Minnesotans
- 35,000 people receiving publicly funded substance abuse treatment services
- 187,000 adults receiving publicly funded mental health services
- 48,000 children receiving publicly funded mental health services

Activity Description

The Chemical and Mental Health Services Administration is the central office administrative component associated with

- Chemical Dependency (CD) Entitlement Grants;
- CD Non-entitlement Grants;
- Adult Mental Health Grants; and
- Children's Mental Health Grants.

In addition, the Chemical and Mental Health Services Administration provides executive oversight of State Operated Services. The administration is also the policy lead on chemical and mental health services provided through Minnesota Health Care Programs.

Population Served

The Chemical and Mental Health Services Administration supports and influences the delivery of publicly funded chemical and mental health services to over a quarter million Minnesotans each year.

Services Provided

The Alcohol and Drug Abuse Division, Adult Mental Health Division, and Children's Mental Health Division are health care policy/program divisions which supervise and support the public chemical dependency and mental health service systems within the state. Activities of these divisions include

- setting policy and services standards for chemical dependency treatment;
- administering the Consolidated Chemical Dependency Treatment Fund and state and federal grant programs funding services which support successful treatment;
- providing oversight of methadone clinics;
- administering grants which support statewide substance abuse prevention efforts;
- administering programs which help enforce prohibitions on the sale of alcohol and tobacco products to minors;
- setting policy and service standards for mental health treatment and rehabilitative services;
- administer grants funding mental health treatment services for adults with mental illness and children with emotional disturbance, including grants supporting
  - a nearly statewide network of mental health crisis intervention services for adults and children;
  - specialized mental health treatment and rehabilitative services for adults and children;
  - school-based mental health services for children;
  - mental health screening for children in the child welfare and juvenile justice systems;
  - access to housing and supportive housing for adults with mental illness; and
  - compulsive gambling treatment;
- providing training and leadership for the adoption of best practices by chemical and mental health service providers across the state each year;
- using a variety of funding mechanisms to fund pilot projects to further service capacity and the quality of care within the state; and
- managing the intergovernmental and stakeholder relationships necessary to facilitate an up-to-date, effective, and valued system of chemical and mental health services.

The Chemical and Mental Health Services Administration also provides executive leadership for State Operated Services. State Operated Service provides a large array of services to 9,000 Minnesotans with some of the most complex behavioral health service needs.

Historical Perspective

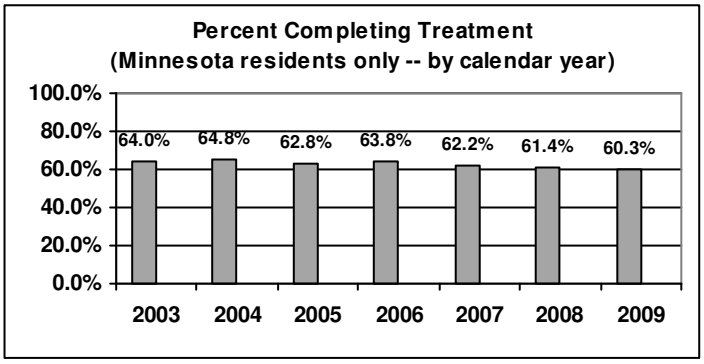
The Chemical and Mental Health Services Administration (CMHS) was formed within the Department of Human Services in 2003 in order to provide a common leadership focus to the behavioral health programs administered by the commissioner of human services. This alignment of vision and purpose remains a primary goal of the

Chemical and Mental Health Services Administration. Currently, CMHS has used the adoption of eight "points of excellence" as a means of providing a common focus and direction for the state's behavioral health system. These eight points are:

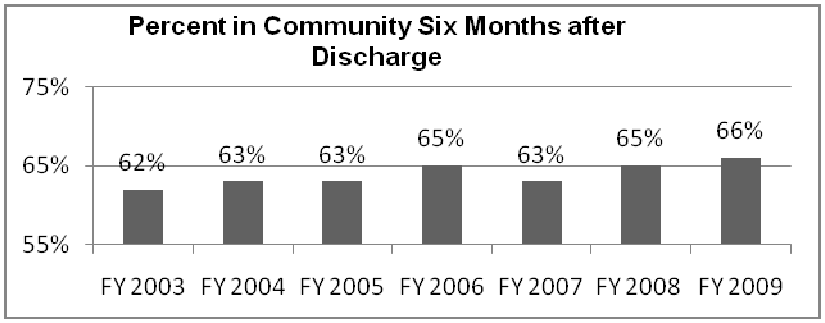
1. We must eradicate the stigma, misunderstandings, and misperceptions of mental illness and addictions.
2. We must improve access to the right care at the right time for all Minnesotans suffering from a mental illness and/or addictions.
3. We must establish best practices and quality standards of care and practice across all providers.
4. We must break down the silo walls and integrate mental health care and substance abuse treatment services with primary care, education, law enforcement, courts, corrections, social services, housing, and employment.
5. We must reduce the overall cost of care for mental illness and addictions as well as work to reduce the full cost of untreated mental illness and addictions. [W]e can accomplish this if we have successfully strived to eradicate stigma, improve access to the right care at the right time, improve quality standards of care, and integrate care effectively across services.
6. We must promote and expand those activities that improve wellness and ultimately can prevent mental illness and addictions.
7. We must reduce the severe, wide-ranging consequences of mental illness and addictions.
8. We must celebrate diversity and reduce disparity in access and outcomes for racial and ethnic populations.

Key Activity Goals & Measures

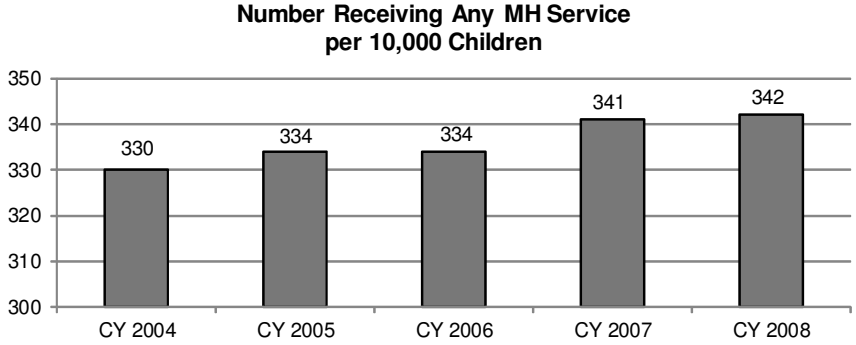
- ***Percentage of clients completing chemical dependency treatment.*** Treatment completion has been found to be a strong indicator of continued sobriety after treatment. DHS' Drug and Alcohol Abuse Normative Evaluation System (DAANES) collects a number of data elements from all chemical dependency programs regardless of the admission's funding source. Below are completion results of all statewide treatment admissions in 2003-09.



- **Percent of adults with serious mental illness who remained in the community six months after discharge from an inpatient psychiatric setting.** This measure gives an indication of the effectiveness of the community-based system to provide the range of services that allow individuals to be as independent as possible in the community.



- ***Service Penetration Rate.*** One indicator of service utilization is to measure how deeply into the general population of Minnesota's children does the utilization of publicly-financed mental health services reach. By comparing this measure over a number of years, some indication is given as to whether use of mental health services is changing over time. By measuring service utilization per 10,000 children in the general population, year-to-year population shifts are taken out of consideration and use of services can be compared across years. This is not an indicator of need for services.



For more information on DHS performance measures, see
http://www.accountability.state.mn.us/Departments/HumanServices/index.htm.

Activity Funding

Chemical and Mental Health Services central office operations is funded with appropriations from the General Fund, special revenue fund, lottery fund and from federal funds.

Contact

For more information on Chemical and Mental Health Services Administration, contact the office of the assistant commissioner, (651) 431-2323.

Information on DHS programs is on the department's Web-site: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: CENTRAL OFFICE OPERATIONS
Activity: CHEMICAL & MENTAL HEALTH

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	3,587	4,194	4,194	4,194	8,388
Subtotal - Forecast Base	3,587	4,194	4,194	4,194	8,388
Total	**3,587**	**4,194**	**4,194**	**4,194**	**8,388**
Lottery Cash Flow					
Current Appropriation	151	153	153	153	306
Technical Adjustments					
Current Law Base Change			4	4	8
Subtotal - Forecast Base	151	153	157	157	314
Total	**151**	**153**	**157**	**157**	**314**
Expenditures by Fund					
Direct Appropriations					
General	3,587	4,294	4,194	4,194	8,388
Lottery Cash Flow	151	153	157	157	314
Statutory Appropriations					
Miscellaneous Special Revenue	645	2,150	2,102	2,401	4,503
Federal	4,172	4,619	4,159	4,159	8,318
Total	**8,555**	**11,216**	**10,612**	**10,911**	**21,523**
Expenditures by Category					
Total Compensation	7,447	8,925	8,621	8,621	17,242
Other Operating Expenses	1,089	2,291	1,991	2,290	4,281
Local Assistance	19	0	0	0	0
Total	**8,555**	**11,216**	**10,612**	**10,911**	**21,523**
Full-Time Equivalents (FTE)	**85.6**	**85.3**	**84.0**	**82.7**	

Program Description

The purpose of Forecasted Programs is to include all programs that are an entitlement or otherwise share the characteristic of being forecasted in one program in the DHS budget.

MinnesotaCare, General Assistance Medical Care (GAMC), and Medical Assistance (MA) purchase preventive and primary health care services, such as physician services, medications, and dental care, for low-income families with children, pregnant women, elderly people, and people with disabilities. More than 707,000 Minnesotans receive health care assistance through this grant area each year. Medical Assistance and MinnesotaCare receive both state and federal funds. Medical Assistance is financed and operated jointly by the state and the federal government. The federal share of MA costs for the state, known as the federal medical assistance percentage (FMAP), is based on the state's per capita income and is recalculated annually.

Budget Activities

This program includes the following budget activities

- MFIP/DWP Grants
- MFIP Child Care Assistance Grants
- General Assistance Grants
- Minnesota Supplemental Aid Grants
- Group Residential Housing Grants
- MinnesotaCare Grants
- GAMC Grants
- Medical Assistance Grants
- Alternative Care Grants
- CD Entitlement Grants

Information Item: Presentation of MA Optional Expansion in Biennial Budget Document

Background
The federal Affordable Care Act, P.L. 111-148, which was enacted March 23, 2010, expands Medicaid – known as Medical Assistance or MA in Minnesota -- by creating a new eligibility group for all non-disabled single adults age 21 to 65 with incomes up to 133% of the federal poverty guidelines (FPG). This mandatory expansion is effective January 1, 2014. At that time the federal government will pay the entire cost for a state to cover low income single adults through Medicaid for three years.

Until January 2014, states like Minnesota that have created state-funded health care programs to cover low-income single adults have a new option to use Medicaid to cover those people. The federal government will match the state's cost of covering this optional early expansion group at the state's regular Federal medical assistance percentage (FMAP); Minnesota's regular FMAP is 50%. States can set the income standard for this new optional group at any level up to 133% FPG.

The 2010 legislature authorized the current or next governor to expand Medicaid eligibility to adults without children with incomes at or below 75% FPG. The authorization was effective July 1, 2010, contingent on an executive order by January 15, 2011. The legislature provided funding to pay the state cost of the optional MA expansion; those appropriations are also contingent on the executive order. As of November 30, 2010, the Governor had not ordered the state to elect the optional MA expansion.

Analysis
In analyzing the impact of an early MA Optional Expansion on the state's public health care programs (MA, MinnesotaCare and General Assistance Medical Care, or GAMC) shortly after the federal law was enacted, the department's analysis estimates that about 100,000 single adult Minnesotans who are at or below 75% FPG would enroll in the new Medicaid option. Some who are eligible are currently served by the state General Assistance Medical Care (GAMC) program, and others are served by the state MinnesotaCare program. If the Governor issues an executive order for the state to elect the optional MA expansion the state GAMC program will end, and it is assumed that those currently on GAMC would move to the new Medicaid option. It is also assumed that MinnesotaCare recipients who are eligible for the optional MA expansion will prefer the more extensive MA benefit coverage, and will transition off of MinnesotaCare to the new Medicaid option.

Presentation of Fiscal Impacts in DHS Base Budget
Consistent with the approach taken at the end of session, and since the current Governor has not elected the optional MA expansion, the contingent appropriations for an early MA expansion are not included in DHS's base budget and are not included in the fiscal pages presented here. For more information about the estimated fiscal impacts of an early MA optional expansion, please refer to the November 2010 economic forecast available from Minnesota Management & Budget (www.mmb.state.mn.us) on December 2, 2010.

Dollars in Thousands

	Current		Governor Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	3,628,406	3,853,742	3,853,742	3,853,742	7,707,484
Technical Adjustments					
Current Law Base Change			1,085,974	1,344,269	2,430,243
November Forecast Adjustment		(76,767)	(92,666)	(83,336)	(176,002)
Subtotal - Forecast Base	3,628,406	3,776,975	4,847,050	5,114,675	9,961,725
Total	**3,628,406**	**3,776,975**	**4,847,050**	**5,114,675**	**9,961,725**
Health Care Access					
Current Appropriation	448,647	499,376	499,376	499,376	998,752
Technical Adjustments					
Current Law Base Change			168,678	306,308	474,986
November Forecast Adjustment		86,931	125,885	170,005	295,890
Subtotal - Forecast Base	448,647	586,307	793,939	975,689	1,769,628
Total	**448,647**	**586,307**	**793,939**	**975,689**	**1,769,628**
Federal Tanf					
Current Appropriation	90,598	99,922	99,922	99,922	199,844
Technical Adjustments					
Current Law Base Change			(14,007)	(21,864)	(35,871)
November Forecast Adjustment		(40,422)	1,830	925	2,755
Subtotal - Forecast Base	90,598	59,500	87,745	78,983	166,728
Total	**90,598**	**59,500**	**87,745**	**78,983**	**166,728**
Expenditures by Fund					
Direct Appropriations					
General	3,373,803	3,666,782	4,847,479	5,114,560	9,962,039
Health Care Access	445,846	586,307	793,939	975,689	1,769,628
Federal Tanf	72,937	59,500	87,745	78,983	166,728
Statutory Appropriations					
General	6,659	0	0	0	0
Miscellaneous Special Revenue	226,163	225,369	124,565	128,472	253,037
Federal	4,110,189	4,204,689	4,695,136	4,998,837	9,693,973
Federal Stimulus	902,319	823,227	0	0	0
Total	**9,137,916**	**9,565,874**	**10,548,864**	**11,296,541**	**21,845,405**

Dollars in Thousands

	Current		Governor Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Expenditures by Category					
Other Operating Expenses	17	0	0	0	0
Payments To Individuals	9,108,786	9,443,685	10,413,708	11,158,761	21,572,469
Local Assistance	28,726	122,189	135,156	137,780	272,936
Other Financial Transactions	387	0	0	0	0
Total	**9,137,916**	**9,565,874**	**10,548,864**	**11,296,541**	**21,845,405**
Expenditures by Activity					
Mfip/Dwp Grants	323,730	336,556	341,411	338,465	679,876
Mfip Child Care Assistance Gr	113,780	120,259	120,142	118,269	238,411
General Assistance Grants	42,748	49,674	50,961	51,043	102,004
Minnesota Supplemental Aid Gr	33,299	36,936	39,083	40,001	79,084
Group Residential Housing Gr	112,993	116,009	123,085	130,993	254,078
Minnesotacare Grants	664,057	832,523	1,047,907	1,293,159	2,341,066
Gamc Grants	296,607	155,024	117,804	117,260	235,064
Medical Assistance Grants	7,390,951	7,745,468	8,524,293	9,007,698	17,531,991
Alternative Care Grants	30,144	29,104	28,947	30,592	59,539
Cd Entitlement Grants	129,607	144,321	155,231	169,061	324,292
Total	**9,137,916**	**9,565,874**	**10,548,864**	**11,296,541**	**21,845,405**

Activity at a Glance

- Provides assistance for 36,900 low-income families (or 100,400 people) a month, two-thirds of whom are children.
- Aims at moving parents quickly into jobs and out of poverty.

Activity Description

Minnesota Family Investment Program (MFIP), the Diversionary Work Program (DWP) and Work Benefit Grants pay for cash grants for families participating in the MFIP, DWP, and Work Benefit Program and for food assistance for MFIP families. MFIP is Minnesota's federal Temporary Assistance for Needy Families (TANF) program. DWP is a short-term, work-focused program to help families avoid longer term assistance. The Work Benefit is a small monthly cash grant given to families who exit MFIP or DWP to help them stay off assistance.

Population Served

To be eligible for MFIP, a family must include a minor child or a pregnant woman and meet citizenship, income, and asset requirements. MFIP is aimed at moving parents quickly into jobs and out of poverty. Most parents are required to work; through MFIP, they receive help with basic needs, health care, child care, and employment services.

Most parents with minor children are eligible to receive cash assistance for a total of 60 months in their lifetime. Families reaching the 60-month time limit are eligible for extensions if they meet certain categorical requirements. Most families reaching the 60-month limit are those with multiple and serious barriers to employment. Families of color are disproportionately represented in this group.

DWP is a short-term, work-focused program. Families applying for DWP must develop and sign an employment plan before they can receive any assistance. After families have an employment plan, they can receive cash assistance to pay for rent, utilities, personal needs, and other supports, such as food, child care, and health care. Shelter and utilities costs are paid directly to landlords, mortgage companies, or utility companies. Participation in the program does not count against the 60-month life-time limit on cash assistance. Families who are likely to need longer term assistance are excluded from DWP; this includes adults and children with disabilities, adults over 60 years old, teen parents finishing high school, child-only cases, and families who have received TANF or MFIP in the past 12 months or for 60 months.

The Work Benefit is a monthly grant of $25 that is issued to families who exit MFIP or DWP while working the number of hours required to meet the federal work participation rate. Eligible families can receive the Work Benefit for up to 24 months.

Services Provided

This activity funds the cash assistance grants of the MFIP, DWP, and Work Benefit programs and food assistance for MFIP. Supports outside the welfare system, such as health care, child care, child support, housing, and tax credits, are important additional components to Minnesota's welfare approach. Working families on MFIP receive earning disregards, leaving assistance when their income is approximately 15% above the federal poverty level.

Parents on MFIP who fail to work or follow through with activities to support their families will have their assistance cut by 10% or more. Depending upon how long they have been out of compliance, their cases may also be closed for non-compliance. Parents on DWP who do not cooperate with their employment plan will have their cases closed. No further cash assistance can be approved until the participant complies with requirements or their four months of DWP ends. Families receiving the Work Benefit must continue to work the required number of hours to continue to receive the benefit.

Historical Perspective

MFIP was initially piloted in seven counties as a state welfare reform effort. After passage of the federal welfare reform law which converted Aid to Families with Dependent Children (AFDC) to TANF, MFIP was implemented statewide in 1998 as the state's TANF program. MFIP includes employment and training and food support. In February 2006, Congress reauthorized the TANF program through 2010 with the passage of the Deficit Reduction Act of 2005 (Public Law 109-171). The new provisions made it more difficult for states to meet work participation rates and required the U. S. Department of Health and Human Services to issue regulations that define work activities and procedures for verifying and monitoring work activities.

DWP, which began July 01, 2004, includes many of the families who would have in the past applied for MFIP. Each month more than 1,000 cases are diverted from MFIP long-term assistance to DWP, with a monthly average caseload of 3,900 families. Some of these families are expected to transition to MFIP after completing four months of DWP.

Beginning in February 2008, families who are not making significant progress with MFIP or DWP due to employment barriers, such as physical disability, mental health, or provision of care for a household member with a disability will receive family stabilization services (FSS) through a case management model. Funding for these families is provided using state funds that are not counted toward the federal maintenance-of-effort requirement and, therefore, are not included in the state work participation rate.

The Work Benefit began in October 2009 as a flat grant of $50 per month. The benefit was reduced to $25 per month in October of 2010. Participants receiving this benefit help the state meet federal work participation requirements.

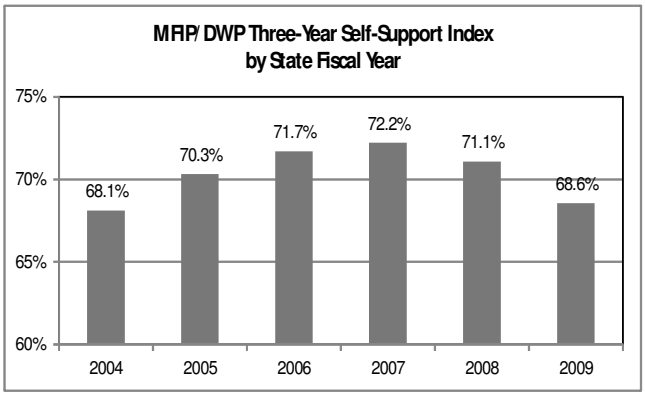
Minnesota has received national recognition for its success with MFIP. In December 2007, more than 70% of MFIP families followed over a three-year period had either left assistance or were on MFIP and were working 30 or more hours per week.

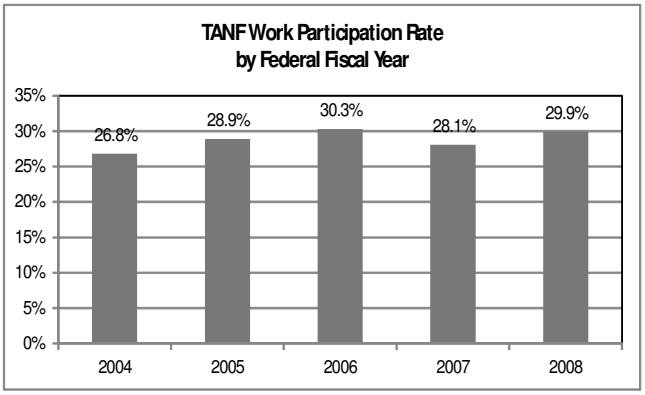
Key Activity Goals & Measures

- **Ensure Minnesotans will have the economic means to maintain a reasonable standard of living.** This goal is from Minnesota Milestones (http://server.admin.state.mn.us/mm/goal.html).
- **Improve outcomes for the most at-risk children.** MFIP and DWP grants help stabilize families and enable parents to meet their children's basic needs. This goal is from the Department of Human Services' Priority Plans (http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4694-ENG).

Measures

- **Percentage of adults working 30 or more hours or off MFIP three years after a baseline reporting period (MFIP Self-Support Index).** The MFIP Self-Support Index is a performance measure that tracks whether or not adults in MFIP are either: 1) working an average of 30 or more hours per week or 2) no longer receiving MFIP cash payments three years after a baseline measurement quarter. Participants who leave MFIP due to the 60-month time limit are not counted as meeting the criteria for success on this measure unless they are working 30 or more hours per week or qualified for Social Security disability payments before they reach the time limit.
- **Percentage of MFIP adults participating in work activities for specified hours per week. (TANF Work Participation Rate).** The TANF Work Participation Rate is the percentage of MFIP cases in which the parent is fully engaged in employment or employment-related activities (according to federal TANF program rules, usually 130 hours per month). The TANF WPR is determined by the federal government based on monthly program data for the federal fiscal year.





2009 data pending federal release

For more information on DHS performance measures, see
http://www.accountability.state.mn.us/Departments/HumanServices/index.htm.

Activity Funding

MFIP/DWP and Work Benefit grants are funded primarily with appropriations from the General Fund and the federal TANF block grant, which replaced AFDC in 1996.

Contact

For more information on the Minnesota Family Investment Program/Diversionary Work Program Grants, contact The Transition to Economic Stability Division, (651) 431-4000.

Information on DHS programs is on the department's website: http://www.dhs.state.mn.us.

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	71,121	72,969	72,969	72,969	145,938
Technical Adjustments					
Current Law Base Change			20,289	21,189	41,478
November Forecast Adjustment		20,946	(9,208)	(2,576)	(11,784)
Subtotal - Forecast Base	71,121	93,915	84,050	91,582	175,632
Total	**71,121**	**93,915**	**84,050**	**91,582**	**175,632**
Federal Tanf					
Current Appropriation	90,598	99,922	99,922	99,922	199,844
Technical Adjustments					
Current Law Base Change			(14,007)	(21,864)	(35,871)
November Forecast Adjustment		(40,422)	1,830	925	2,755
Subtotal - Forecast Base	90,598	59,500	87,745	78,983	166,728
Total	**90,598**	**59,500**	**87,745**	**78,983**	**166,728**
Expenditures by Fund					
Direct Appropriations					
General	70,544	93,915	84,050	91,582	175,632
Federal Tanf	72,937	59,500	87,745	78,983	166,728
Statutory Appropriations					
Miscellaneous Special Revenue	1,172	3,100	3,100	3,100	6,200
Federal	140,932	158,814	166,516	164,800	331,316
Federal Stimulus	38,145	21,227	0	0	0
Total	**323,730**	**336,556**	**341,411**	**338,465**	**679,876**
Expenditures by Category					
Payments To Individuals	317,950	331,021	335,805	332,927	668,732
Local Assistance	5,393	5,535	5,606	5,538	11,144
Other Financial Transactions	387	0	0	0	0
Total	**323,730**	**336,556**	**341,411**	**338,465**	**679,876**

Activity at a Glance

- Helps MFIP and Transition Year families pay for child care so that parents may pursue employment or education leading to employment.
- Purchases child care for more than 15,500 children in 8,500 families each month.

Activity Description

The Minnesota Family Investment Program (MFIP) Child Care Assistance Grants provides financial subsidies to help low-income families pay for child care so that parents may pursue employment or education leading to employment and so that children are well-cared for and ready to learn. This program is supervised by the Minnesota Department of Human Services (DHS) and administered by county social services agencies.

Population Served

Families who participate in MFIP and the Diversionary Work Program (DWP) of the state's Temporary Assistance for Needy Families (TANF) program are served through the MFIP child care program, which includes MFIP and Transition Year (TY) subprograms.

Services Provided

The following families are eligible to receive MFIP or TY child care assistance:

- MFIP and DWP families who are employed, pursuing employment, or participating in employment, training, or social services activities authorized in an approved employment services plan; and
- employed families who are in their first year off MFIP or DWP (the transition year). As family income increases, so does the amount of child care expenses paid by the family in the form of co-payments.

Child care must be provided by a legal child care provider over the age of 18 years. Providers include legal, non-licensed family child care, license-exempt centers, licensed family child care, and licensed child care centers. Family child care and child care centers operate under separate laws and rules and exist as separate markets.

As directed by law, DHS establishes maximum payment rates for Child Care Assistance Grants by county, type of provider, age of child, and unit of time covered.

Historical Perspective

MFIP child care was called AFDC (Aid to Families with Dependent Children) child care and was funded by federal Title IV(A) funds prior to the 1996 federal welfare reform act. Demand for child care assistance has increased as parents participating in welfare reform are required to work or look for work. The 2003 legislature made reforms to the Child Care Assistance Program (CCAP) to focus on the lowest-income working families and control future growth in the program, while helping balance the state budget. (CCAP is comprised of MFIP child care for families on MFIP or DWP and Basic Sliding Fee child care for other low-income families.)

In 2007, the legislature appropriated $1 million for CCAP for the FY2008-09 biennium to provide funding for incentives for parents and providers to promote skills and abilities that children need to succeed in school. A pilot project, School Readiness Connections, was extended in 2009-10 with an appropriation of $1.3 million. Child care providers selected by the department are eligible for a higher maximum payment and children are allowed to remain in care with the provider on a full-time basis as long as the family remains eligible for CCAP. The department is using the project evaluation to consider options for recommending changes to CCAP policy that could link ongoing incentives to child care programs that support school readiness.

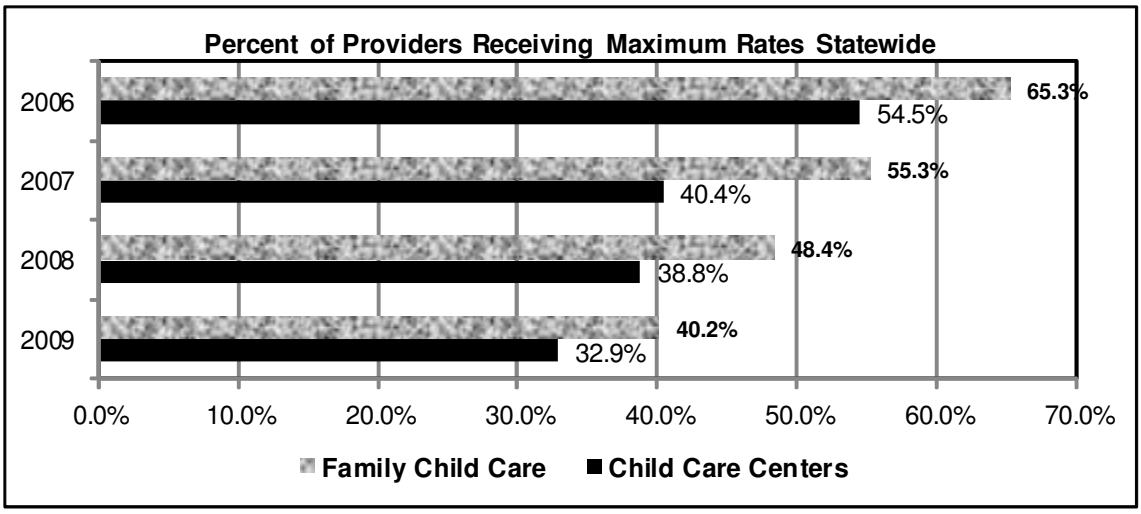
Key Activity Goals & Measures

- ***Ensure that all children will start school ready to learn.*** This goal is from *Minnesota Milestones* (http://server.admin.state.mn.us/mm/goal.html).
- ***Improve outcomes for the most at-risk children.*** The MFIP Child Care Assistance Program improves outcomes for at-risk children by providing financial assistance to help low-income families pay for child care. Parents may pursue employment or education leading to employment while children attend child care where they are well cared for and become better prepared to enter school ready to learn. This goal is from the Department of Human Services' *Priority Plans* (http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4694-ENG).

Key measures are:

- ***Percentage of child care providers covered by maximum rates.*** As required by federal regulations, an annual child care market rate survey assesses whether or not families receiving child care assistance have access to all types of care available to the private market. Access is an important measure for two reasons. The first is that it presents the portion of rates in the child care market that can be fully paid with a CCAP subsidy. Second, access to child care providers may impact whether or not at-risk children are able to attend high-quality child care programs, which national research shows are associated with better child outcomes in low-income communities with children experiencing risk-factors. Therefore the level at which maximum rates are set may differentially affect access to high-quality child care programs.

  The following chart compares the percentage of child care center providers who receive maximum rates of payment with the percentage of family child care providers who receive maximum rates.



- **Percentage of children receiving child care assistance through the School Readiness Connections Pilot project who are ready for school.** The School Readiness Connections Pilot project targets resources to low-income families by reimbursing selected, qualified providers at higher rates for providing comprehensive services to improve the school readiness of at-risk children ages 0-5. The results of the evaluation indicate that the project goals were met and that the majority of children assessed prior to kindergarten entry were proficient in the skills and abilities necessary for school readiness. For the complete evaluation, see http://www.dhs.state.mn.us/dhs16 147885.pdf.

For more information on DHS performance measures, see
http://www.accountability.state.mn.us/Departments/HumanServices/index.htm

Activity Funding

MFIP Child Care Assistance Grants is funded with appropriations from the General Fund and from federal funds.

Contact

For more information on MFIP Child Care Assistance Grants, contact the Transition to Economic Stability Division, (651) 431-4000.

Information on DHS programs is on the department's website: http://www.dhs.state.mn.us.

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	53,339	67,793	67,793	67,793	135,586
Technical Adjustments					
Current Law Base Change			4,050	3,606	7,656
November Forecast Adjustment		(22,850)	(1,696)	(3,125)	(4,821)
Subtotal - Forecast Base	53,339	44,943	70,147	68,274	138,421
Total	**53,339**	**44,943**	**70,147**	**68,274**	**138,421**
Expenditures by Fund					
Direct Appropriations					
General	53,339	44,943	70,147	68,274	138,421
Statutory Appropriations					
Federal	45,857	75,316	49,995	49,995	99,990
Federal Stimulus	14,584	0	0	0	0
Total	**113,780**	**120,259**	**120,142**	**118,269**	**238,411**
Expenditures by Category					
Payments To Individuals	107,765	19,916	8,500	8,500	17,000
Local Assistance	6,015	100,343	111,642	109,769	221,411
Total	**113,780**	**120,259**	**120,142**	**118,269**	**238,411**

Activity at a Glance

- Provides monthly cash assistance grants for almost 20,000 people
- Average cash assistance grant is $173.53

Activity Description

General Assistance (GA) Grants provides monthly cash supplements for individuals and childless couples, who cannot fully support themselves, usually due to illness or disability, to help meet some of their monthly maintenance and emergency needs. GA is a state-funded program and an important safety net for low-income Minnesotans.

Population Served

Program participants must fit into one of 15 categories of eligibility specified in state statutes, which are primarily defined in terms of inability to work and disability, and meet income and resource limits. Applicants or recipients are generally required to apply for benefits from federally-funded disability programs for which they may qualify.

Services Provided

GA grants currently provide cash assistance of $203 for single people and $260 for married couples. Once a year, special funding may be available when a person or family lacks basic need items for emergency situations, which threaten health or safety, most often housing or utilities. GA recipients are usually eligible for payment of medical costs through the General Assistance Medical Care (GAMC) or Minnesota Care programs.

Historical Perspective

The Minnesota Legislature established the General Assistance Program in 1974. The original program provided assistance to low-income people who did not qualify for federal assistance. In the 1980s, the legislature changed the program by increasing the GA grant to the current $203 for single people and $260 for married couples and by targeting assistance to people who meet certain standards of un-employability as determined and certified by a licensed physician, licensed consulting psychologist, licensed psychologist, or vocational specialist.

In 1998, families with children were moved from GA to the Minnesota Family Investment Program, immediately reducing the number of people served on GA each month from 15,000 to 11,000. Since that time, the average number of people served on GA has ranged from a low of roughly 7,800 a month in FY 2000 to the current average of 19,965 a month with an average payment of $173.53 per person for FY 2010.

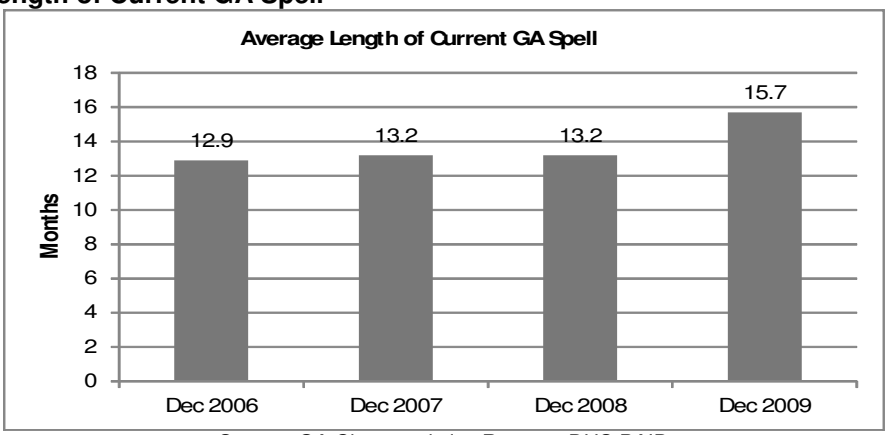
In FY 2001, room and board payments for women staying in battered women's shelters were transferred out of the GA program into the Department of Public Safety's Crime Victims Services.

Key Activity Goals & Measures

- ***Provide integrated services to at-risk adults who are without children and struggling to meet their basic needs.*** GA is temporary for some recipients while they overcome an emergency situation, a temporary problem, or are waiting for approval for other forms of assistance. For others, with more intractable barriers to self-support, assistance is needed for longer periods of time. This goal is from the Department of Human Services' *Priority Plans* (http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4694-ENG).

  Key measures include:

  - **Average Length of Current GA Spell**



Source: GA Characteristics Reports, DHS PAID

For more information on DHS performance measures, see http://www.accountability.state.mn.us/Departments/HumanServices/index.htm.

Activity Funding

General Assistance Grants is funded with appropriations from the state's General Fund.

Contact

For more information on General Assistance Grants, contact the DHS Community Partnerships Division, (651) 431-3809.
Information on DHS programs is on the department's website: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: FORECASTED PROGRAMS
Activity: GENERAL ASSISTANCE GRANTS

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	43,823	49,947	49,947	49,947	99,894
Technical Adjustments					
Current Law Base Change			(275)	(58)	(333)
November Forecast Adjustment		(373)	1,189	1,054	2,243
Subtotal - Forecast Base	43,823	49,574	50,861	50,943	101,804
Total	**43,823**	**49,574**	**50,861**	**50,943**	**101,804**
Expenditures by Fund					
Direct Appropriations					
General	42,712	49,574	50,861	50,943	101,804
Statutory Appropriations					
Miscellaneous Special Revenue	36	100	100	100	200
Total	**42,748**	**49,674**	**50,961**	**51,043**	**102,004**
Expenditures by Category					
Payments To Individuals	42,748	49,674	50,961	51,043	102,004
Total	**42,748**	**49,674**	**50,961**	**51,043**	**102,004**

Activity at a Glance

- Provides 28,780 people with disabilities or over age 65 with a $95.09 cash supplement each month.

Activity Description

Minnesota Supplemental Aid (MSA) Grants provides a state-funded monthly cash supplement to people who are eligible for federal Supplemental Security Income (SSI) benefits and are disabled, aged, or blind.

Population Served

To receive MSA benefits, a person must be

- age 65 or older;
- blind or have severely impaired vision; or
- disabled and age 18 or older; and
- eligible for SSI.

Services Provided

MSA standards are adjusted by the amount of the cost of living adjustment (COLA) in SSI, if any. The monthly MSA grant is based on the difference between the recipient's monthly SSI benefit rate and the appropriate MSA standard. As of 1-1-09, MSA standards are $735 each month to individuals living alone and $1,102 each month to couples. Additional amounts may be available for persons with emergency or special needs. Federal SSI funds are deducted from the MSA standards, significantly reducing the actual MSA payment amount. MSA monthly grants averaged $95.09 in SFY 2010.

Historical Perspective

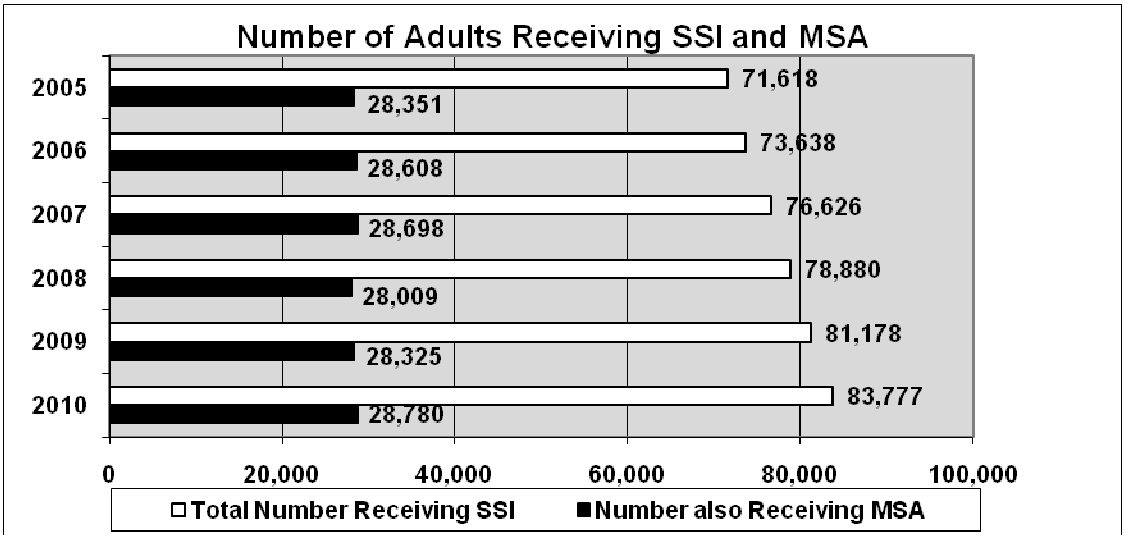
The legislature established the MSA program in 1974. The program serves as the federally mandated supplement to Minnesota recipients of the SSI program.

Key Goals & Measures

- ***Provide integrated services to at-risk adults who are without children and struggling to meet their basic needs***. At-risk adults who are without children and struggling to meet their basic needs will receive a seamless continuum of financial, employment, health care, housing, social service, and other supports from the department and its partners. This goal is from the Department of Human Services' *Priority Plans* (http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4694-ENG).

  Key activity measures include

  - **Number of adults receiving SSI who are also receiving MSA.**



For more information on DHS performance measures, see http://www.accountability.state.mn.us/Departments/HumanServices/index.htm.

Activity Funding

Minnesota Supplemental Aid Grants is funded with appropriations from the state General Fund.

Contact

For more information on MSA Grants, contact the Minnesota Supplemental Aid Office at (651) 431-4049.
Information on DHS programs is on the department's website: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: FORECASTED PROGRAMS
Activity: MINNESOTA SUPPLEMENTAL AID GR

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	35,651	39,034	39,034	39,034	78,068
Technical Adjustments					
Current Law Base Change			(1,964)	(1,241)	(3,205)
November Forecast Adjustment		(2,148)	1,963	2,158	4,121
Subtotal - Forecast Base	35,651	36,886	39,033	39,951	78,984
Total	**35,651**	**36,886**	**39,033**	**39,951**	**78,984**
Expenditures by Fund					
Direct Appropriations					
General	33,297	36,886	39,033	39,951	78,984
Statutory Appropriations					
Miscellaneous Special Revenue	2	50	50	50	100
Total	**33,299**	**36,936**	**39,083**	**40,001**	**79,084**
Expenditures by Category					
Payments To Individuals	33,299	36,936	39,083	40,001	79,084
Total	**33,299**	**36,936**	**39,083**	**40,001**	**79,084**

Activity at a Glance

- Provides room and board in 5,200 settings for an average of 17,500 recipients a month.
- Pays the basic GRH room and board rate of $846 per month.
- Serves a variety of people, including people with developmental disabilities, mental illness, chemical dependency, physical disabilities, advanced age, or brain injuries.

Activity Description

Group Residential Housing (GRH) Grants provides income supplements for room, board, and other related housing services for people whose illnesses or disabilities prevent them from living independently. In order for its residents to be eligible for GRH payments, a setting must be licensed by the Minnesota Department of Human Services (DHS) as an adult foster home or by the Minnesota Department of Health as a board and lodging establishment, a supervised living facility, a boarding care home, or, in some cases, registered as a housing-with-services establishment.

Population Served

- There are more than 5,200 GRH settings serving a monthly average of 17,500 recipients who are unable to live independently in the community due to illness or incapacity.
- GRH settings serve a variety of people, including people with developmental disabilities, mental illness, chemical dependency, physical disabilities, advanced age, or brain injuries.
- People receiving GRH often also receive services through Medical Assistance (MA) Home Care, a MA home and community-based waiver under Title XIX of the Social Security Act, or mental health grants. In these cases, the GRH rate is restricted to the room and board rate only. The combination of GRH room and board supports and Medical Assistance services enables people to live in their communities rather than in institutions.

Services Provided

- GRH separately identifies housing costs from services and provides a standard payment rate for housing for aged, blind, and disabled people in certain congregate settings.
- GRH is a supplement to a client's income to pay for the costs of room and board in specified licensed or registered settings.
- Currently, the basic GRH room and board rate is $846 per month, which is based on a statutory formula. The maximum additional GRH payment rate for settings that provide services in addition to room and board is $459.85 per month. In limited cases, and upon county and state approval, GRH will also fund up to $459.85 per month (based on documented costs) for people whose needs require specialized housing arrangements.
- Although GRH is 100% state-funded, these rates are offset by the recipient's own income contribution (usually Supplemental Security Income or Social Security Retirement or Disability Insurance contributions of at least $674).
- GRH also pays for basic support services, such as oversight and supervision, medication reminders, and appointment arrangements, for people who are ineligible for other service funding mechanisms, such as home and community-based waivers or home care.

Historical Perspective

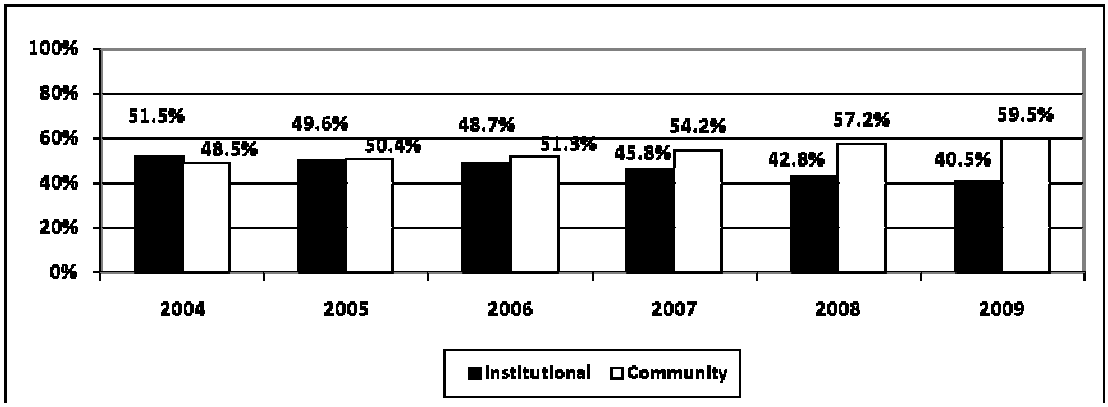
GRH was once part of the Minnesota Supplemental Aid (MSA) Program but was made a separate program in the mid-1990s. There is currently a moratorium on the addition of GRH beds with a rate that exceeds the base rate of $846 per month.

Key Activity Goals & Measures

- ***People in need will receive support that helps them live as independently as possible***. This goal is from *Minnesota Milestones* (http://server.admin.state.mn.us/mm/goal.html).
- ***Provide integrated services to at-risk adults who are without children and struggling to meet their basic needs***. At-risk adults who are without children and struggling to meet their basic needs will receive a seamless continuum of financial, employment, health care, housing, social service, and other supports from the department and its partners. This goal is from the Department of Human Services' *Priority Plans* (http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4694-ENG).

Key activity measures include:

- **Proportion of elderly receiving publicly-funded services living in institutional versus community settings.**



For more information on DHS performance measures, see http://www.accountability.state.mn.us/Departments/HumanServices/index.htm.

Activity Funding

Group Residential Housing Grants is funded with appropriations from the state General Fund.

Contact

For more information on Group Residential Housing, contact Community Living Supports, (651) 431-3885.
Information on DHS programs is on the department's website: http://www.dhs.state.mn.us.

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	112,387	115,992	115,992	115,992	231,984
Technical Adjustments					
Current Law Base Change			7,028	14,298	21,326
November Forecast Adjustment		(1,633)	(1,585)	(947)	(2,532)
Subtotal - Forecast Base	112,387	114,359	121,435	129,343	250,778
Total	**112,387**	**114,359**	**121,435**	**129,343**	**250,778**
Expenditures by Fund					
Direct Appropriations					
General	111,322	114,359	121,435	129,343	250,778
Statutory Appropriations					
Miscellaneous Special Revenue	1,671	1,650	1,650	1,650	3,300
Total	**112,993**	**116,009**	**123,085**	**130,993**	**254,078**
Expenditures by Category					
Payments To Individuals	112,533	115,549	124,210	131,480	255,690
Local Assistance	460	460	(1,125)	(487)	(1,612)
Total	**112,993**	**116,009**	**123,085**	**130,993**	**254,078**

Activity at a Glance

- Purchases health care for 118,000 enrollees per month (FY 2009 average)
- Assists low-income, working families and adults who cannot afford health insurance
- Invests in preventive health care that makes Minnesota one of the healthiest states in the country
- Supports families that have transitioned from welfare to work

Activity Description

MinnesotaCare Grants pay for health care services for Minnesotans who do not have access to affordable health insurance. There are no health condition barriers but applicants must meet income and other program guidelines to qualify. Enrollees pay a premium based on income.

Population Served

Enrollees typically are working families and people who do not have access to affordable health insurance:

- Children, parents with children under 21, and pregnant women must have household incomes at or below 275% of the federal poverty guidelines (FPG). Parents with household incomes over $50,000 are not eligible. In FY 2009, an average of 70,000 people was enrolled under these categories each month.
- Adults (age 21 and over) without children must have household incomes at or below 250% of FPG. In FY 2009, the average monthly enrollment of adults without children was 48,000.
- Except for certain low-income children, applicants are not eligible if they have other health insurance (including Medicare), have access to coverage through their employer and the employer's share of the premium is 50% or more, have had access to such coverage in the past 18 months, or have had other insurance within the past four months.

Income as a percent of federal poverty guidelines (FPG)	Percent of MinnesotaCare households in 2009
≤ 100%	44.1%
101% - 150%	29.3%
151% - 175%	11.4%
176% - 200%	7.8%
201% - 275%	7.2%
> 275%	0.2%

The average enrollee premium for FY 2009 was $24 per person per month. The premium for some low-income children is $4 per month.

Adults (except pregnant women) must also meet asset limits. A household size of one can own up to $10,000 in assets; a household size of two or more can own up to $20,000. Some assets, such as homestead property and burial funds, are not counted.

Services Provided

MinnesotaCare pays for many basic health care services. The Department of Human Services (DHS) contracts with managed care health plans to provide services. Covered services include:

- medical transportation (emergency use only for non-pregnant adults);
- chemical dependency treatment;
- chiropractic care, with a $3 co-pay for non-preventive visits for adults (pregnant women do not have a copay);
- physician and health clinic visits, with a $3 co-pay for non-preventive visits for adults (except for pregnant women, who do not have a copay);
- limited adult dental services;
- nonemergency visits to a hospital-based emergency room, with a co-pay (For services provided through 12-31-10 the co-pay is $6. The co-pay will be reduced to $3.50 effective 1-1-11);
- eye checkups and prescription eyeglasses (some restrictions apply), with a $25 co-pay on eyeglasses for adults, except for pregnant women;

- home care, such as a nurse visit or home health aide;
- hospice care;
- immunizations;
- laboratory and X-ray services;
- medical equipment and supplies;
- mental health services;
- most prescription drugs (there is a $3 co-pay for adults, except for pregnant women);
- rehabilitative therapies; and
- inpatient hospital services, with:
  - no dollar limit for children under 21 and pregnant women;
  - no dollar limit for adults who have a child under 21 in their home and whose income is equal to or less than 200% FPG; and
  - a $10,000 limit per year, with a 10% co-pay (up to $1,000 co-pay per adult per year), for all other adults.

For admissions occurring on or after 7-1-11, MinnesotaCare payment for inpatient hospital services for adults without children must be fee-for-service, up to the MA payment rate, and up to the $10,000 annual inpatient benefit limit, minus any copayment.

Children under 21 and pregnant women also have coverage for the following services:
- personal care attendant services;
- nursing home or intermediate care facilities;
- private duty nursing;
- non-emergency medical transportation;
- case management services; and
- full dental services.

Historical Perspective

MinnesotaCare was enacted in 1992 to provide health care coverage to low-income people who do not have access to affordable health care coverage.

The program was implemented in October 1992 as an expansion of the Children's Health Plan. The Children's Health Plan began in July 1988 and provided comprehensive outpatient health care coverage for children ages one through 17 years. MinnesotaCare initially covered families with children whose income was at or below 185% of FPG. In January 1993, the program was expanded to cover families with children whose income was at or below 275% of FPG. In October 1994, MinnesotaCare became available to adults without children whose income was at or below 125% of FPG. The income standard for adults without children was raised to 135% of FPG in July 1996, to 175% in July 1997, to 200% in January 2008, and to 250% in July 2009.

In 1995, the federal government approved an amendment to the Prepaid Medical Assistance Program §1115 Waiver (known as PMAP+ Waiver) allowing for the provision of federal Medicaid matching funds for children and pregnant women in MinnesotaCare with incomes at or below 275% of FPG. This was followed by an amendment approved in 1999 that allows federal Medicaid matching funds for MinnesotaCare parents and other adult caretakers with incomes up to 275% of FPG. The waiver also allows for different cost-sharing and benefits for parents and caretakers in MinnesotaCare than in Medical Assistance.

In May 2005, Minnesota received approval from the federal Centers for Medicare and Medicaid Services for a three-year extension. Another three-year extension was approved in 2008, and the waiver is due to be renewed again 7-1-11.

Minnesota also uses funds from the Children's Health Insurance Program (CHIP), which was created by Congress in 1997 to help states cover more low-income children and families. The PMAP+ Waiver, in combination with an S-CHIP §1115 Waiver, has been an essential component of Minnesota's effort to develop

innovative ways to achieve its long standing goal of continuously reducing the number of Minnesotans who do not have health insurance.

Between 2003 and 12-31-07, MinnesotaCare benefits for adults without children with income over 75% of FPG but no greater than 175% of FPG were limited to certain core services and capped at $5,000 per year. The $5,000 cap was lifted in 2005, and coverage for diabetic supplies and equipment and mental health services was added to the MinnesotaCare benefit set for adults without children.

Beginning in September 2006, certain General Assistance Medical Care (GAMC) applicants and enrollees were required to transition to MinnesotaCare. These applicants and enrollees moved from GAMC coverage to MinnesotaCare coverage with a six-month transition period. County agencies paid MinnesotaCare premiums for these enrollees during the transition period. At the end of the six-month period, enrollees were re-determined for MinnesotaCare and the county agency's obligation to pay the MinnesotaCare premium ended. This Transitional MinnesotaCare program was eliminated effective 4-1-10.

The 2007 legislature enacted a law that provides children ages one through 18 who become ineligible for MA due to excess income, with two additional months of MA coverage followed by automatic MinnesotaCare eligibility until the next MinnesotaCare renewal. These children will be exempt from the MinnesotaCare income limit and from the MinnesotaCare insurance barriers until their MinnesotaCare renewal. These children will be required to pay the standard MinnesotaCare sliding scale premiums to enroll and remain enrolled.

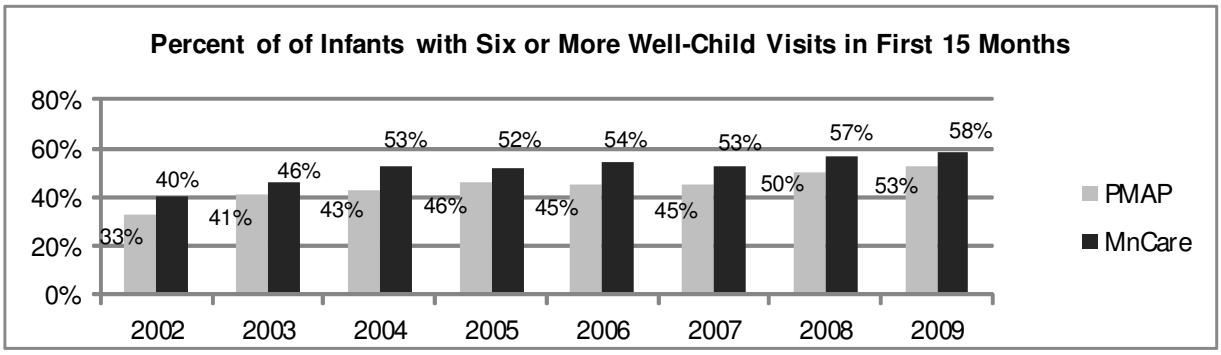
The 2008 legislature enacted provisions to permit MinnesotaCare enrollees who fail to submit renewal forms and related documentation continued eligibility for an additional month beyond their current eligibility period, and to provide enrollees who fail to pay premiums timely one additional month of coverage, before closure for failure to pay premiums.

The 2009 legislature enacted provisions that:
- eliminate the 275% FPG income limit on eligibility for children;
- exempt children with family income up to 200% FPG from the employer-subsidized insurance (ESI) barrier, the four-month other health coverage barrier and premiums;
- provide automatic eligibility and exemption from premiums for children who are residing in foster care or a juvenile residential correctional facility on their 18th birthday, with eligibility beginning on the first day of the month following their termination from foster care or release from the residential correctional facility; and
- continue eligibility for children in families with income equal to or below 275% of FPG who fail to submit renewal forms and related documentation necessary for verification in a timely manner, unless the commissioner determines that there has been a change of income that affects premiums.

These changes are effective upon federal approval, which has not yet been received.

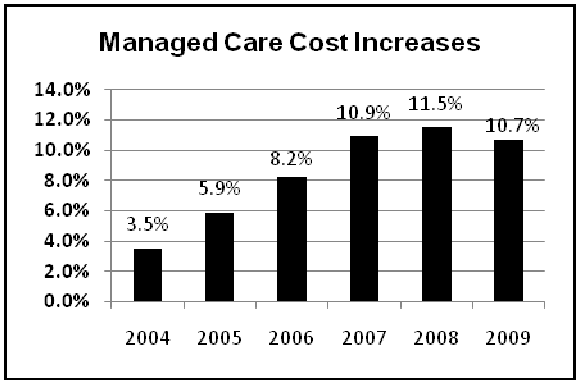
Key Activity Goals & Measures

- **Minnesotans will be healthy.** This goal is from Minnesota Milestones (http://server.admin.state.mn.us/mm/goal.html).
    - ***Percentage of children enrolled in Minnesota health care programs who receive the expected number of well-child visits.*** The 2009 data for this measure indicate that for children enrolled in the managed care Prepaid Medical Assistance Programs (PMAP), 53.0% of those in the first 15 months of life received the recommended number of well-child visits for their age group. The comparable figure for children enrolled in the MinnesotaCare managed care program is 58.0%. DHS aims to increase these rates.



- **Use the state's participation in the health care market to improve health care quality, access, outcomes, and affordability for all Minnesotans.** For health care and nursing home services that it purchases, the department will improve price and quality transparency, encourage the use of evidence-based care, and use the payment system to encourage quality and efficiency. This goal is from the Department of Human Services' Priority Plans (http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4694-ENG).

  - ***Improve public health care program value.*** Basic health care costs account for approximately half of the Department of Human Services' (DHS') state funding. At a time of lean budgets, it is critical that DHS look at all possible measures to reduce costs. In addition, it is important that the department improve price and quality transparency, encourage the use of evidence-based care, and use the payment system to encourage quality and efficiency. These strategies will improve quality, access, outcomes and affordability for all Minnesotans. The measure tracked is managed care cost increases in Minnesota health care programs.
    http://www.accountability.state.mn.us/Departments/HumanServices/Goals.htm



For more information on DHS performance measures, see http://www.accountability.state.mn.us/Departments/HumanServices/index.htm.

Activity Funding

MinnesotaCare Grants is funded with appropriations from the health care access fund, from federal funds, and from enrollee premiums.

Contact

For more information on MinnesotaCare Grants, contact Health Care Administration, (651) 431-3050.
Information on DHS programs is available on the department's website: http://www.dhs.state.mn.us.

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
Health Care Access					
Current Appropriation	448,647	499,376	499,376	499,376	998,752
Technical Adjustments					
Current Law Base Change			165,494	299,315	464,809
November Forecast Adjustment		86,931	126,144	170,432	296,576
Subtotal - Forecast Base	448,647	586,307	791,014	969,123	1,760,137
Total	**448,647**	**586,307**	**791,014**	**969,123**	**1,760,137**
Expenditures by Fund					
Direct Appropriations					
Health Care Access	445,846	586,307	791,014	969,123	1,760,137
Statutory Appropriations					
Miscellaneous Special Revenue	24,681	34,402	39,949	41,186	81,135
Federal	193,530	211,814	216,944	282,850	499,794
Total	**664,057**	**832,523**	**1,047,907**	**1,293,159**	**2,341,066**
Expenditures by Category					
Payments To Individuals	664,057	832,523	1,047,907	1,293,159	2,341,066
Total	**664,057**	**832,523**	**1,047,907**	**1,293,159**	**2,341,066**

Activity at a Glance

- Had an average monthly enrollment of 32,000 in FY 2009
- Since 6-1-10, has delivered most services through coordinated care delivery systems (CCDS). Grants pay for certain health care services for Minnesotans not eligible for Medical Assistance
- Serves primarily low-income adults without children

Activity Description

General Assistance Medical Care (GAMC) Grants pays for health care services for low-income Minnesotans who are ineligible for Medical Assistance (MA) or other state or federal health care programs.

Population Served

GAMC serves:

- primarily single adults who are between ages 21 and 64 and who do not have dependent children; and
- people receiving General Assistance (GA) cash grants.

Local county agencies determine eligibility for GAMC within state guidelines. Eligibility criteria include:

- household income may not exceed 75% of the federal poverty guidelines (FPG) and
- assets may not exceed $1,000 per household (Some assets, such as homestead property and burial funds, are not counted.)

Persons not eligible for GAMC include: persons in correctional facilities; persons residing in the Minnesota Sex Offender Program (MSOP); persons with other health insurance; persons not cooperating with disability determinations; and adults living in households with children.

Services Provided

Most GAMC services are now delivered through hospital-based coordinated care delivery systems (CCDS). A CCDS is a hospital or group of hospitals that contracts with the state to provide covered services as approved by the Commissioner. CCDSs can contract with providers and clinics to deliver covered services and must contract with essential community providers to the extent practicable.

As of 9-1-10, there are four delivery systems contracting with the state to serve GAMC enrollees. Services that are covered for all GAMC recipients, regardless of CCDS enrollment, are:

- outpatient prescription drugs dispensed by pharmacies;
- medication therapy management services performed by pharmacists; and
- alcohol and drug treatment through the county.

Services available at all CCDSs include:

- inpatient and outpatient hospital;
- doctor or clinic visits;
- emergency room care (ER);
- medical transportation (ambulance);
- mental health services; and
- physician-administered drugs.

Additional services may vary by CCDS. Chemical dependency treatment services may be available to GAMC-eligible individuals through the Consolidated Chemical Dependency Treatment Fund.

Copays for GAMC include a $25 copay on nonemergency ER visits and a $3 or $1 copay on prescription drugs, up to a maximum $7 per month.

For services provided on or after 6-1-10, and to 2-28-11, non-CCDS hospitals choosing to serve GAMC clients who are not enrolled in a CCDS can submit claims for reimbursement through a temporary uncompensated care pool.

GAMC also covers outpatient prescription drugs on a fee-for-service basis through a prescription drug pool, subject to limits on available funding. Copays on prescription drugs include $3 for brand name and $1 for generics subject to a $7 per month maximum. Copayments do not apply to anti-psychotic drugs used to treat mental illness or to prescription drugs used for family planning.

Historical Perspective

The legislature established the state-funded GAMC program in 1976. GAMC paid for the same broad range of medical services as MA until 1981, when coverage was restricted to seven major services: inpatient hospital care, outpatient hospital care, prescription drugs, physician services, medical transportation, dental care, and community mental health center day treatment. Many services were later added back into coverage.

In 1989, provisions were added that made a person who gives away certain property ineligible for GAMC for a designated penalty period. In 1995, the time during which such transfers are examined was increased from 30 to 60 months prior to application.

Through 1990, the state paid 90% of the GAMC costs and counties paid 10%. Beginning in 1991, the state began covering the 10% county share.

In 2003, the following coverages were eliminated:

- coverage for people with incomes over 75% of the FPG who incurred medical bills exceeding the difference between their income and this limit (this provision, known as spenddown, was replaced with a hospital-only coverage option up to 175% of the FPG income cap);
- coverage for bills incurred in the month before the application, and;
- coverage for undocumented and non-immigrant people.

Beginning in September 2006, certain GAMC applicants and enrollees were required to transition to MinnesotaCare. These applicants and enrollees moved from GAMC coverage to MinnesotaCare coverage during a six-month transition period. County agencies paid MinnesotaCare premiums for these enrollees during the transition period. GAMC applicants and enrollees were exempt from the requirement to transition to MinnesotaCare if they met specified criteria. The Transitional MinnesotaCare Program was eliminated for persons who applied for GAMC on or after 4-1-10.

Effective 6-1-10, GAMC services were made available through CCDSs, with the exception of outpatient prescription drugs and medication therapy management. Hospitals contracting as CCDSs receive an allocation based on the hospital's calendar year 2008 fee-for-service payments for GAMC services. Prescription drugs are delivered on a fee-for-service basis from a prescription drug pool. (Hospital-only GAMC coverage for adults over 75% FPG and equal to or less than 175% of FPG was also eliminated.)

Key Activity Goals & Measures

- ***Use the state's participation in the health care market to improve health care quality, access, outcomes, and affordability for all Minnesotans.*** For the health care and nursing home services that it purchases, the department will improve price and quality transparency, encourage the use of evidence-based care, and use the payment system to encourage quality and efficiency. This goal is from the Department of Human Services' Priority Plans (http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4694-ENG).

  The new GAMC program, with CCDSs, began operations in June 2010. Although its name is still GAMC the new program is significantly different from the GAMC program that it replaced. The development of appropriate outcome measures for the new program is under consideration by the department.

For more information on DHS performance measures, see http://www.accountability.state.mn.us/Departments/HumanServices/index.htm.

Activity Funding

General Assistance Medical Care Grants is funded with appropriations from the General Fund.

Contact

For more information on General Assistance Medical Care Grants, contact Health Care Administration,
Phone: (651) 431-2478.
Information on DHS programs is available on the department's website: http://www.dhs.state.mn.us.

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	340,441	145,837	145,837	145,837	291,674
Technical Adjustments					
Current Law Base Change			(28,462)	(28,462)	(56,924)
Subtotal - Forecast Base	340,441	145,837	117,375	117,375	234,750
Total	**340,441**	**145,837**	**117,375**	**117,375**	**234,750**
Expenditures by Fund					
Direct Appropriations					
General	296,607	155,024	117,804	117,260	235,064
Total	**296,607**	**155,024**	**117,804**	**117,260**	**235,064**
Expenditures by Category					
Payments To Individuals	296,607	155,024	117,804	117,260	235,064
Total	**296,607**	**155,024**	**117,804**	**117,260**	**235,064**

Activity at a Glance

- 662,000 Minnesotans receive health care assistance through this grant area each year.
- Eligible Minnesotans receive long-term care services through this grant area each year.

MA coverage of Basic Health Care for Families and Children
- Purchases preventive and primary health care for a monthly average of 395,000 enrollees (in FY 2009)
- Acts as a safety net health care program for the lowest income Minnesotans
- Is the state's largest publicly-funded health care program

MA coverage of Basic Health Care for Elderly and Disabled
- Purchases health care for an average of approximately 55,600 elderly Minnesotans and 106,500 people with disabilities (in FY 2009)
- Helps an average of 11,100 elderly and people with disabilities with paying Medicare premiums and co-payments

MA coverage of Long-Term Care Facilities Services
- Nursing facility and boarding care home services provide services to 30,000 people per month, 19,000 of whom are on MA
- Provides ICF/MR services to 1,800 residents per month
- Provides DT&H services to 13,200 people per year

MA coverage of LTC Waivers and Home Care
- Supports 48,900 people per month who are at risk of placement in an institution in the community through long-term care waivers
- Provides MA personal care and private duty nursing to 15,300 people per month
- Provides home health care services to 5,000 people per month

Activity Description

Medical Assistance (MA) is Minnesota's Medicaid program. MA purchases preventative and primary health care services for low-income Minnesotans. This budget activity also covers long-term care (LTC) services for individuals at risk of nursing facility (NF) care and intermediate care facilities for people with developmental disabilities (ICFs/MR), as well as home care services and the home and community-based option of long-term care waivers.

Population Served

Primary and preventative health care services are provided to pregnant women, children, parents/caregivers of children under age 20, people with disabilities, and blind and elderly Minnesotans.

Services Provided

In general, local county agencies determine eligibility for MA within federal and state guidelines. See additional MA Focus pages (following) for more information about the MA services provided to families and children, people with disabilities, and the elderly.

A few MA services (e.g. non-emergency Emergency Room visits, prescription drugs) require copayments. Federal regulations limit the amounts that can be required as copayments and limit who can be charged copayments. For example, the following people do not have to pay co-pays: pregnant women, children under age 21, people residing in or expecting to reside for more than 30 days in a long-term care facility, people receiving hospice care, Minnesota Family Planning Program enrollees, and people in the Refugee Medical Assistance Program. Co-pays for enrollees with income at or below 100% of the federal poverty guidelines are limited to 5% of their monthly income.

Historical Perspective

In 1966, less than a year after Congress established the Medicaid program under Title XIX of the Social Security Act, Minnesota began receiving federal matching funds for the state's MA program. By accepting federal matching funds, states are subject to federal regulations, but have some flexibility concerning coverage of groups, covered services, and provider reimbursement rates.

Home and community-based waivers were established under section 1915 of the federal Social Security Act of 1981. These waivers are intended to correct the institutional bias in Medicaid by allowing states to offer a broad range of home and community-based services to people who may otherwise be institutionalized.

Minnesota's MA program has expanded since the mid-1980s. The expansions have focused primarily on low-income, uninsured, or under-insured children, as well as eligibility changes to better support seniors and people

with disabilities in their own homes or in small, community-based settings. During this same timeframe a moratorium was placed on nursing facilities and intermediate care facilities for people with developmental disabilities (ICFs/MR) and efforts to develop home and community-based alternatives gained momentum.

The American Recovery and Reinvestment Act (ARRA), enacted in February 2009, prohibits states from restricting eligibility (standards, methodologies, and procedures) beyond eligibility as it existed on 7-1-08. Restrictions on eligibility include reducing income or asset standards, increasing premiums, adding verifications, requiring more frequent eligibility renewals, and some changes to long term care programs that would have the effect of reducing the number of people eligible for Medicaid. The penalty for violating the maintenance of effort (MOE) is loss of the temporary enhanced federal matching funds made available in the ARRA. The ARRA MOE requirement was to expire on 1-1-11, but it has recently been extended to 7-1-11.

The Affordable Care Act, enacted in March of 2010, created a new MOE requirement that requires states to maintain eligibility standards, methodologies, and procedures no more restrictive than those in effect on 3-23-10. This requirement is in effect until the new Health Benefit Exchanges are operational (January of 2014 for adults, and January of 2019 for children). The penalty for violating this requirement can affect all federal matching funds in Medicaid. The federal Centers for Medicare and Medicaid Services (CMS) agency has not yet issued guidance on the topic of the MOE requirement in the Affordable Care Act.

Key Activity Goals & Measures

See additional Focus pages (following) for specific goals and measures for the MA program with respect to families and children, people with disabilities, and the elderly.

Activity Funding

MA Grants are funded with appropriations from the General Fund and from federal Medicaid funds.

Contact

For information about DHS contacts for the MA program, see the contact information at the end of each of the following Focus sections.

Information on DHS programs is on the department's website: http://www.dhs.state.mn.us.

Focus: MA Basic Health Care for Families & Children

MA Basic Health Care coverage for Families and Children purchases health care services for the poorest Minnesotans. It differs from MinnesotaCare in that its income guidelines are lower, it does not have premiums, and it pays retroactively for medical bills incurred. MA Basic Health Care for Families and Children includes funding for the Minnesota Family Planning Program (MFPP), a program that provides coverage of family planning and related health care services for people who are not currently enrolled in any other Minnesota Health Care Programs.

Population Served

MA serves

- pregnant women with incomes at or below 275% of the federal poverty guidelines (FPG);
- infants under age two with incomes at or below 280% of the FPG;
- children ages two through 18 at or below 150% of the FPG; and
- parents, relative caretakers, and children ages 19 and 20 at or below 100% of the FPG.

Families and children with income over the MA limits may qualify through a spend-down provision if incurred medical bills equal or exceed the difference between their income and 100% of the FPG.

Adults (except pregnant women) must also meet asset limits. A household size of one can own up to $10,000 in assets; a household size of two or more can own up to $20,000. Some assets, such as homestead property and

burial funds, are not counted. Enrollees who become ineligible for MA because of increased earned income or child/spousal maintenance may be eligible for transitional MA for four to 12 months.

MA provides retroactive coverage for medical bills incurred up to three months before the date of application.

DHS determines eligibility for the Minnesota Family Planning Program (MFPP). Certified providers may determine temporary eligibility. The MFPP serves men and women between ages 15 and 50 with incomes at or below 200% of the FPG.

MA Basic Health Care Services Provided to Families and Children
DHS purchases most services for this population through capitated rate contracts with health plans. In most areas of the state, MA parents and children have multiple health plans from which to choose. Covered services include:

- physician services;
- ambulance and emergency room services, with a $6 co-pay on non-emergency, emergency room visits before 1-1-11, and effective on or after 1-1-11, a $3.50 co-pay on non-emergency room visits;
- laboratory and X-ray services;
- rural health clinics;
- chiropractic services;
- early periodic screening, diagnosis, and treatment;
- chemical dependency treatment;
- mental health services;
- inpatient and outpatient hospital care;
- eyeglasses and eye care;
- immunizations;
- medical transportation, supplies, and equipment;
- prescription drugs, with $3 co-pay on brand names, $1 co-pay on generic, and a $7 per month maximum;
- dental care;
- home care;
- hospice care, effective retroactive from 3-23-10 a recipient of MA, age 21 or under, who elects to receive hospice care does not waive coverage for services related to the treatment of the condition for which a diagnosis of terminal illness has been made;
- nursing home; and
- rehabilitative therapies.

Historical Perspective

Minnesota's MA program has expanded since the mid-1980s. The expansions have focused primarily on low-income, uninsured, or under-insured children, as well as eligibility changes to better support seniors and people with disabilities in their own homes or in small, community-based settings. In 2002, the income limit for children was increased for children ages two through 18 to 175% of the FPG. This limit was reduced in 2003 to 150% of FPG.

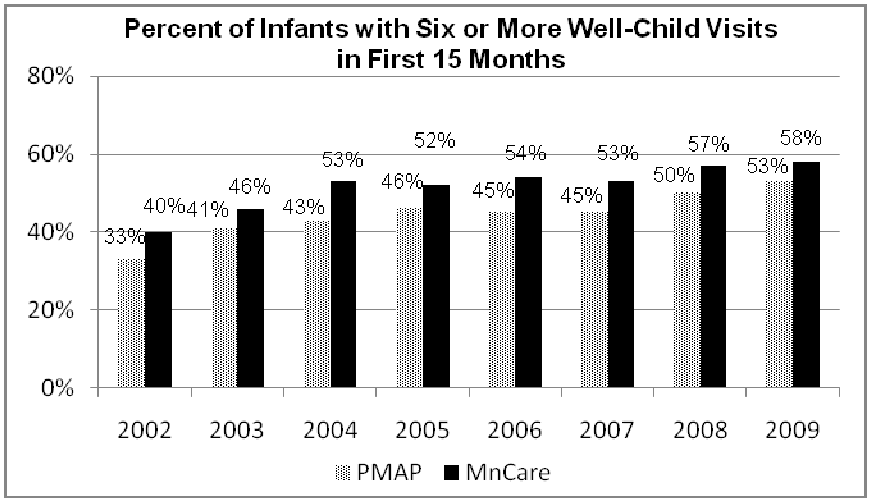
Since the 1970s, Minnesota's approach to purchasing basic health care benefits under MA has evolved from strictly fee-for-service to increased use of contracts with health plans to deliver care for a fixed, or capitated, amount per person. Capitated contracts provide incentive for cost-effective and coordinated care and extend access to the same health care providers as the general public.

Key Activity Goals & Measures – MA Basic Health Care for Families and Children

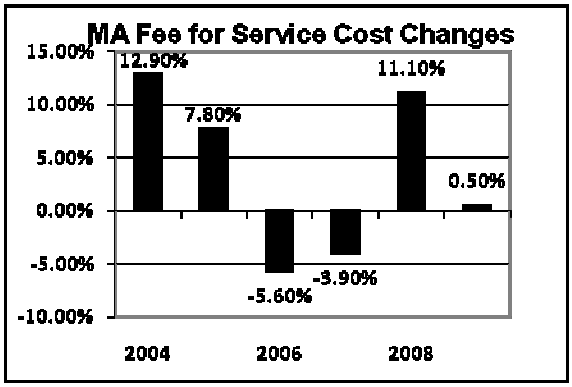
- **Minnesotans will be healthy.** This goal is from Minnesota Milestones (http://server.admin.state.mn.us/mm/goal.html).

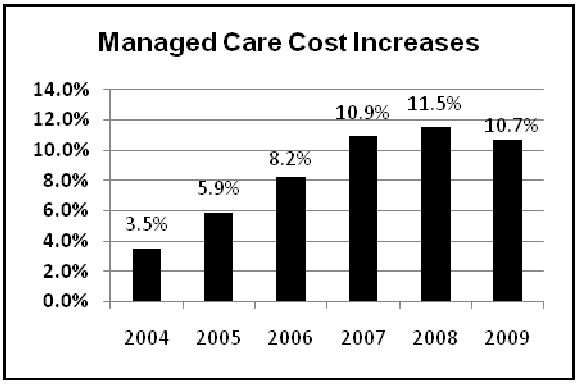
    - ***Percentage of children enrolled in Minnesota health care programs who receive the expected number of well-child visits.*** The 2009 data for this measure indicate that for children enrolled in the managed care Prepaid Medical Assistance Programs (PMAP), 53% of those in the first 15 months of life

received the recommended number of well-child visits for their age group. (The comparable number for children enrolled in the MinnesotaCare managed care program is 58%.) DHS aims to increase these rates.



- **Use the state's participation in the health care market to improve health care quality, access, outcomes, and affordability for all Minnesotans.** For the health care and nursing home services that it purchases, the department will improve price and quality transparency, encourage the use of evidence-based care, and use the payment system to encourage quality and efficiency. This goal is from the Department of Human Services' Priority Plans (http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4694-ENG).
  - **Improve public health care program value.** Basic health care costs account for approximately half of the Department of Human Services' (DHS') state funding. At a time of lean budgets, it is critical that DHS look at all possible measures to reduce costs. In addition, it is important that the department improve price and quality transparency, encourage the use of evidence-based care, and use the payment system to encourage quality and efficiency. These strategies will improve quality, access, outcomes and affordability for all Minnesotans. The measure tracked is cost increases in Minnesota health care programs. http://www.accountability.state.mn.us/Departments/HumanServices/Goals.htm





For more information on DHS performance measures, see
http://www.accountability.state.mn.us/Departments/HumanServices/index.htm.

Contact – MA Basic Health Care for Families and Children

For more information about MA coverage for this population, contact Health Care Administration, (651) 431-2478.

Focus: MA Basic Health Care for Elderly and Disabled

MA Basic Health Care Grants–Elderly and Disabled purchases preventive and primary health care services for Minnesota's low-income elderly (65 years or older), and for people who are blind or have a disability. These funds also help many low-income Minnesotans pay Medicare premiums and co-payments.

Population Served

Elderly and disabled Minnesotans eligible for full MA coverage include

- elderly people and people with disabilities who have incomes at or below 100% of the federal poverty guidelines (FPG) and
- people with incomes over the MA limit who may qualify if their incurred medical bills exceed the difference between their income and the spend-down standard of 75% of the FPG.

The applicable asset limit is $3,000 for a single person and $6,000 for a couple. Some assets, such as homestead property and burial funds, are not counted. MA provides coverage for medical bills incurred up to three months before the date of application.

Additionally, several thousand Minnesotans receive help paying Medicare costs only (rather than comprehensive MA coverage). MA covers all Medicare Part A and B cost-sharing, including premiums, for Medicare enrollees with incomes at or below 100% of the FPG. MA covers the Medicare Part B premium for Medicare enrollees with incomes between 100% and 120% of the FPG.

Medicare enrollees with incomes between 120% and 135% of the FPG, receive coverage of the Part B premium only. Higher asset limits apply to these enrollees: $10,000 for a single person and $18,000 for a couple.

Over 7,400 working people with disabilities receive full MA coverage under the Medical Assistance for Employed Persons with Disabilities (MA-EPD) program. To be eligible for MA-EPD, an individual must:

- be certified disabled by either the Social Security Administration or the State Medical Review Team;
- have gross monthly wages or countable self-employment earnings greater than $65 per month and have Medicare, Social Security, and applicable state and federal income taxes withheld by the employer or paid by the self-employed enrollee;
- be at least 16 but under 65 years of age;
- meet the $20,000 asset limit;
- pay a premium based on the enrollee's earned and unearned monthly income and family size; and
- pay an unearned income obligation equal to 0.5% of gross unearned income.

Since January 2004, all MA-EPD eligible enrollees pay premiums. The average monthly premium billed to MA-EPD enrollees was $63.70 in months of January through June 2010. In June 2010, a majority of enrollees had a monthly gross earned income of less than $720 per month.

Basic Health Care Services Provided to Elderly and Disabled

MA services for elderly and disabled Minnesotans include:

- physician services, with a $3 co-pay on non-preventive services;
- ambulance and emergency room services, with a $6 co-pay on non-emergency, emergency room visits before 1-1-11, and effective on or after 1-1-11, a $3.50 co-pay on non-emergency room visits;
- rural health clinics;
- chiropractic services;
- early periodic screening, diagnosis, and treatment;
- mental health services;
- chemical dependency treatment;
- inpatient and outpatient hospital care;

- eyeglasses and eye care;
- immunizations;
- medical supplies and equipment;
- prescription drugs, with a $3 brand name co-pay, $1 generic co-pay, and a $7 per month maximum;
- dental care;
- medical transportation;
- rehabilitation therapies, and
- hospice care, effective retroactive from 3-23-10 a recipient of MA, age 21 or under, who elects to receive hospice care does not waive coverage for services related to the treatment of the condition for which a diagnosis of terminal illness has been made.

Historical Perspective

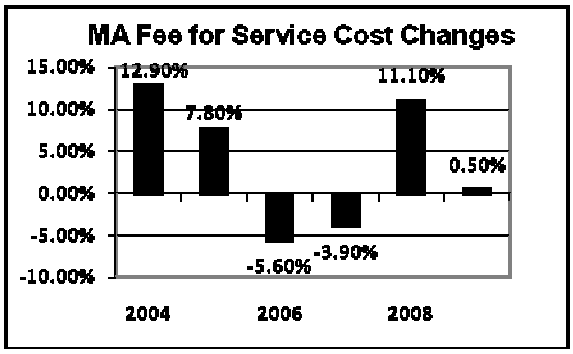
Since the 1980s, Minnesota's approach to purchasing basic health care benefits for seniors enrolled in MA has evolved from strictly fee-for-service to increased use of contracts with health plans to deliver care for a fixed, or capitated, amount per person. Purchasing with capitated contracts provides more incentive for cost-effective and coordinated care. Enrollment in a health plan is mandatory for most MA seniors under Minnesota Senior Care Plus (MSC+), Minnesota's 1915(b)(c) waiver. MSC+ also includes home and community based waiver services and some nursing home care. Starting in 1995 DHS began contracting with Medicare plans to coordinate both Medicare and MA services for seniors under the same health plan under Minnesota Senior Health Options (MSHO). Except for Medicare, MA benefits are the same under both MSHO and MSC+. Together both programs serve over 48,000 seniors. Coordinated Medicare and MA programs are now available statewide and most seniors have voluntarily enrolled in MSHO.

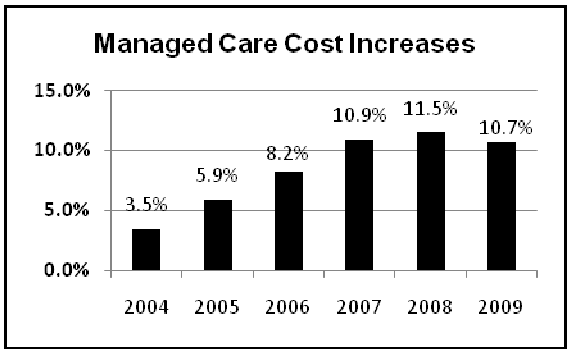
In July 1999, Minnesota added the MA-EPD program that allows people with disabilities to earn income and still qualify for or buy into MA. As of December 2005, 90% of enrollees have Medicare as their primary health care coverage, while MA-EPD covers additional services, such as dental, home care, and personal care services.

In 2008 DHS established Medicare and MA coordinated health plan options for people with disabilities (Special Needs Basic Care) which also has been operating statewide, serving about 4,500 people. For people with disabilities enrollment in health plans remains voluntary.

Key Activity Goals & Measures – MA Basic Health Care for Elderly and Disabled

- **Use the state's participation in the health care market to improve health care quality, access, outcomes, and affordability for all Minnesotans.** For the health care and nursing home services that it purchases, the department will improve price and quality transparency, encourage the use of evidence-based care, and use the payment system to encourage quality and efficiency. This goal is from the Department of Human Services' Priority Plans (http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4694-ENG).
  - **Improve public health care program value.** Basic health care costs account for approximately half of the Department of Human Services' (DHS') state funding. At a time of lean budgets, it is critical that DHS look at all possible measures to reduce costs. In addition, it is important that the department improve price and quality transparency, encourage the use of evidence-based care, and use the payment system to encourage quality and efficiency. These strategies will improve quality, access, outcomes and affordability for all Minnesotans. The measure tracked is cost increases in Minnesota health care programs. http://www.accountability.state.mn.us/Departments/HumanServices/Goals.htm.





For more information on DHS performance measures, see http://www.accountability.state.mn.us/Departments/HumanServices/index.htm.

Contact

For more information about MA Basic Health Care Grants–Elderly and Disabled, contact the Health Care Administration of DHS at (651) 431-2670.

Focus: MA - Long-Term Care Facilities

MA Long-Term Care (LTC) Facilities coverage pays for nursing facility (NF) care, intermediate care facilities for people with developmental disabilities (ICFs/MR), and day training and habilitation services for people who are ICF/MR residents.

Population Served

MA enrollees who require nursing facility or ICF/MR services must apply and be deemed eligible for LTC services. There are 599 participating long-term care facilities in the state that serve about 31,825 people per month. The following data are from reporting year 2009 for nursing facilities and from FY 2009 for ICFs/MR:

- There are 381 MA-certified NF and boarding care homes with 32,342 beds serving an average of 30,000 people. Of the 30,000 people, almost 19,000 are on MA at an average monthly rate of $4,890. Looking at NF residents as a whole, 58% receive Medical Assistance and 42% privately pay for their care, receive Medicare, or have other payment means.
- There are 218 MA-certified ICFs/MR. Of these facilities, 151 are six beds or fewer and 67 have more than six beds. ICFs/MR served an average of 1,825 recipients per month, receiving an average monthly payment of $6,491 per resident. In FY 2009, three ICFs/MRs were closed and 28 additional beds were decertified due to downsizing.

There are 299 DHS-licensed Day Training and Habilitation (DT&H) services sites in Minnesota serving approximately 13,182 people with developmental disabilities. These sites served an average of 1,489 ICF/MR recipients per month receiving an average MA monthly payment of $1,843 per person.

People who reside in an ICF/MR have the flexibility and choice to receive an alternative option to DT&H, called "service during the day." This means that recipients with developmental disabilities have a choice of day services, as do people who receive a home and community-based waiver.

LTC Facilities Services Provided

Nursing facilities provide 24-hour care and supervision in an institutional-based setting. Housing and all other services are provided as a comprehensive package including, but not limited to, nursing care, help with activities of daily living and other care needs, housing, meals, medication administration, activities and social services, supplies and equipment, housekeeping, linen and personal laundry, and therapy services (at an extra cost).

ICFs/MR, located in 59 of the state's 87 counties, provide 24-hour care, active treatment, training, and supervision to persons with developmental disabilities. The goal of ICF/MR programs in Minnesota is to assess individuals to

determine what they are capable of doing, help individuals acquire the skills necessary for maximum independence, and maintain optimal health of individuals through active treatment. They range in size from four beds to 64 beds. Some ICFs/MR are less medically oriented than nursing facilities and provide outcome-based services for personal needs. Many facilities now provide services for persons with aging conditions, such as Alzheimer's, and also contract for in-home hospice care. All ICFs/MR must provide functional skill development, opportunities for development of decision making skills, opportunities to participate in the community, and reduced dependency on care providers. Like nursing facilities, an ICF/MR provides a package of services which includes housing and food.

DT&H services are licensed supports providing persons with developmental disabilities help to develop and maintain life skills, participate in the community, and engage in productive and satisfying activities. DT&H services include supervision, training, and assistance in self-care; communication, socialization, and behavior management; supported employment and work-related activities; training in community survival skills and money management; therapeutic activities that increase adaptive living skills; and community-based activities including the use of leisure and recreation time. DT&Hs provide an average of 230 days of service per year.

Historical Perspective

Nursing facility usage grew rapidly with the establishment of the federal Medicaid program in the 1960s. Federal matching funds for the state's publicly-funded health care programs provided an incentive for investment in the development of nursing homes. Medicaid expenditures grew as people who qualified for NF services accessed this service. In the 1980s, a moratorium was placed on development of new NFs and efforts were made to develop home and community-based alternatives that are preferred by the elderly and are less expensive. NF utilization has been declining and NFs are more often used for short-term care and rehabilitation following hospitalization. Recent efforts to "right size" the industry and to provide financial stability include provisions for bed layaway, higher rates for short lengths of stay, planned bed closures, and creation of single-bed rooms.

Efforts to improve the quality of nursing facility services have now expanded beyond the historic regulatory approach and include measuring quality, publicly disclosing rankings based on those measures, and tying the quality measures to payment. The quality measures used include:

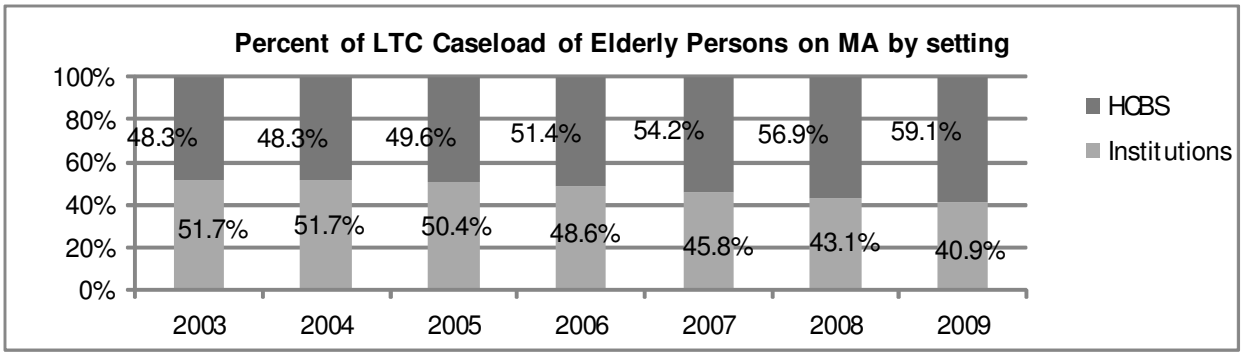
- quality of life and satisfaction based on resident face-to-face interviews;
- Minnesota quality indicators based on assessments of residents;
- deficiency finding from Minnesota Department of Health inspections;
- level of direct care staffing;
- retention of direct care staff;
- use of staff from temporary agencies; and
- proportion of beds in single-bed rooms.

ICFs/MR are another Medicaid-funded entitlement service. Before the 1970s, virtually all public services for people with developmental disabilities were paid for with state funds and delivered in large state institutions. In 1971, Congress authorized Medicaid funding for ICF/MR services. To qualify for Medicaid reimbursement, ICFs/MR had to be MA-certified and comply with federal standards. Smaller ICFs/MR developed in the 1970s and early 1980s to aid in deinstitutionalizing people with disabilities from large state-run institutions. After a moratorium was placed on the development of new ICFs/MR in the mid-1980s, people began receiving services in their own homes through home and community based services. Since that time, the number of people served in ICFs/MR has been steadily declining.

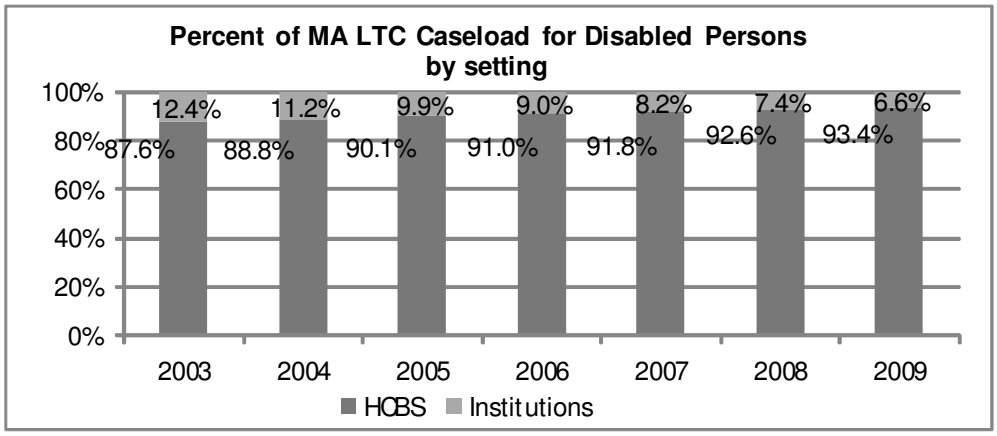
Key Activity Goals &Measures – MA Long-Term Care Facilities

- ***To manage an equitable and sustainable long-term care system that maximizes value***. Reduce the oversupply of nursing home beds while ensuring sufficient access to nursing home services in all regions of the state. Support policies that allow older Minnesotans and Minnesotans with disabilities to live in their homes as long as possible and use non-institutional settings when living in their residence is no longer possible.

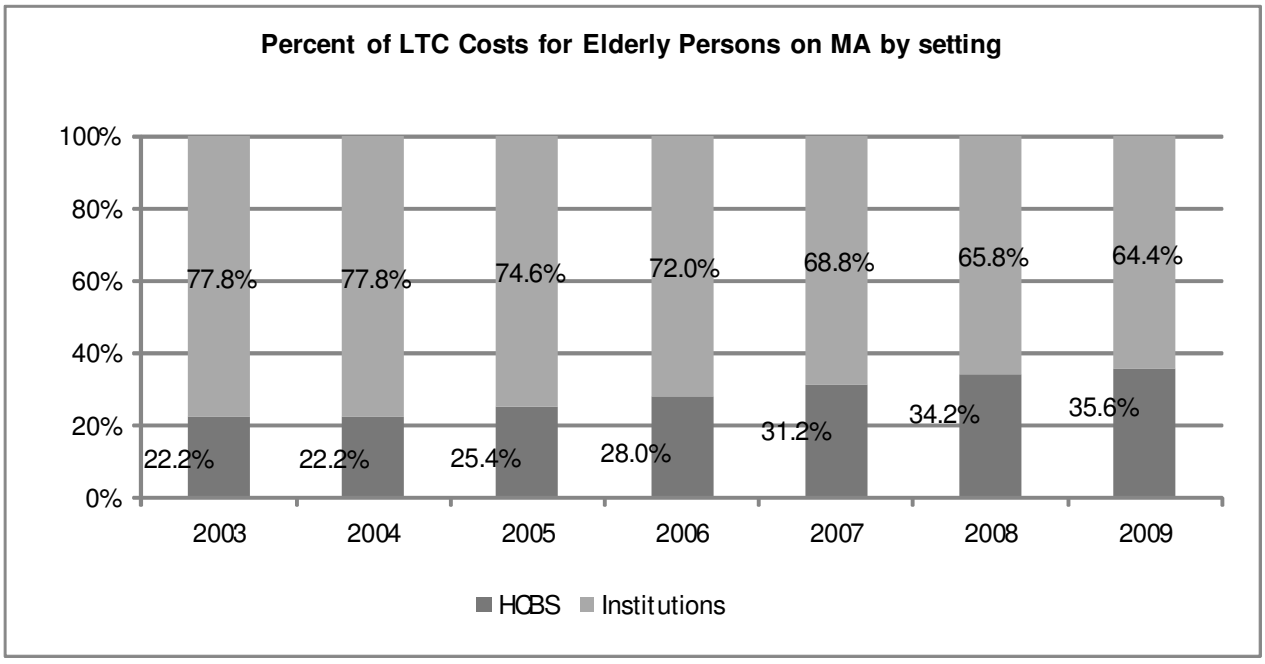
- ***To support and enhance quality of life for older people and people with disabilities.*** Improve clinical quality of care and quality of life for nursing facility residents. These goals are derived from the Continuing Care Administration's mission, goals, and results statements.
  - ***Percentage of elderly receiving publicly-funded long-term care that live in the community versus an institutional setting.*** In the following chart, "HCBS" refers to home and community based services which are designed to help elderly people remain in their own community. LTC for the Elderly includes the EW-Fee for Service, EW-Manage Care, FFS Homecare for 65+, and Alternative Care Program.



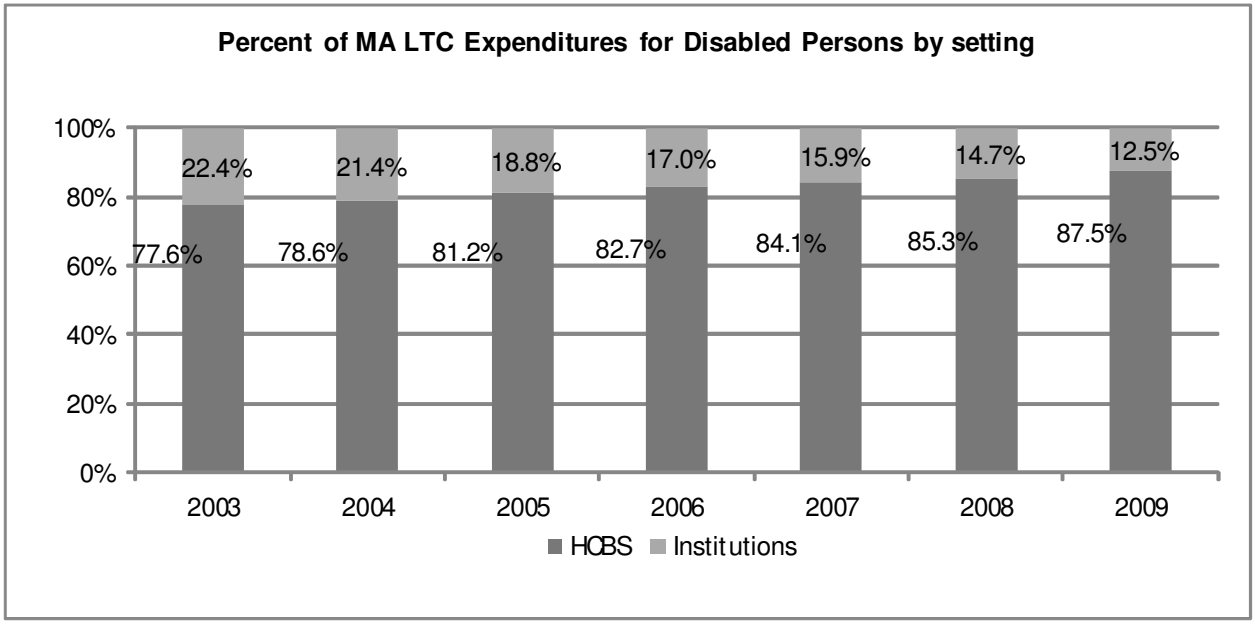
  - Percentage of people with disabilities receiving publicly-funded long-term care who live in the community versus institutional settings. In the following chart, "HCBS" refers to home and community based services which are designed to help people with disabilities live in their own community. LTC programs include nursing facilities under 65, ICFs/MR, HCBS Waivers, and Home Care.



  - ***Percentage of public long-term care dollars expended for the elderly in community versus institutional settings.*** In the following chart, "HCBS" refers to home and community based services which are designed to help elderly people remain in their own community. LTC for the Elderly includes the EW-Fee for Service, EW-Manage Care, FFS Homecare for 65+ and Alternative Care Program.

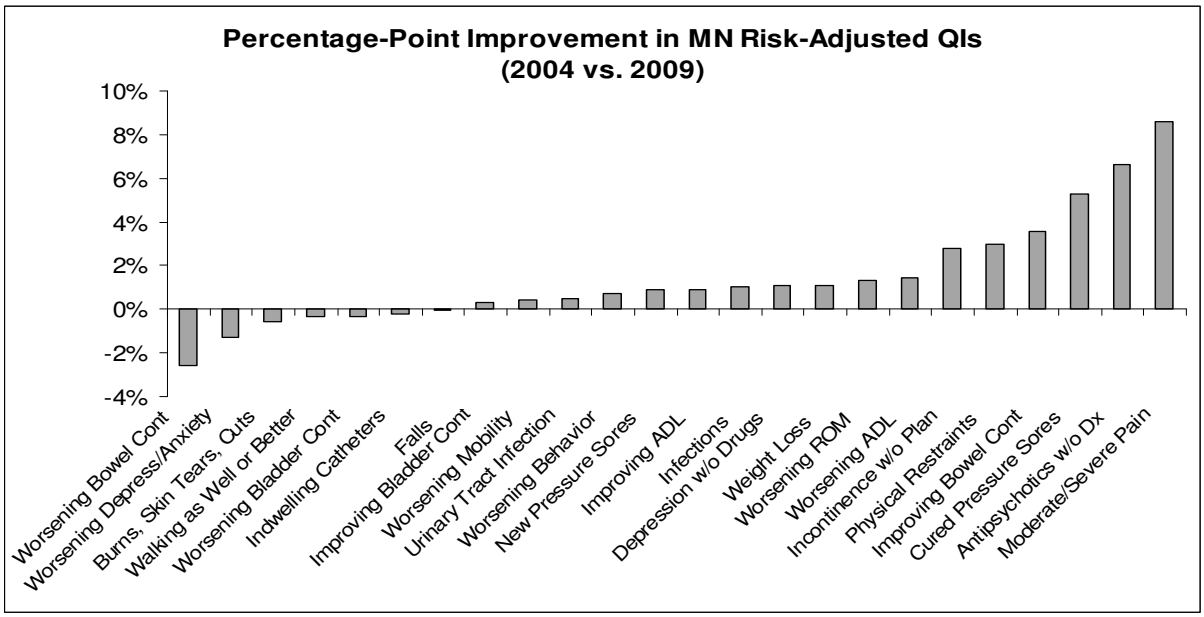


- ***Percentage of public long-term care dollars expended in community versus institutional settings for people with disabilities***. In the following chart, "HCBS" refers to home and community based services which are designed to help people with disabilities live in their own community. LTC programs include nursing facilities under 65, ICFs/MR, HCBS Waivers, and Home Care. LTC programs include nursing facilities under 65, ICFs/MR, HCBS Waivers, and Home Care.



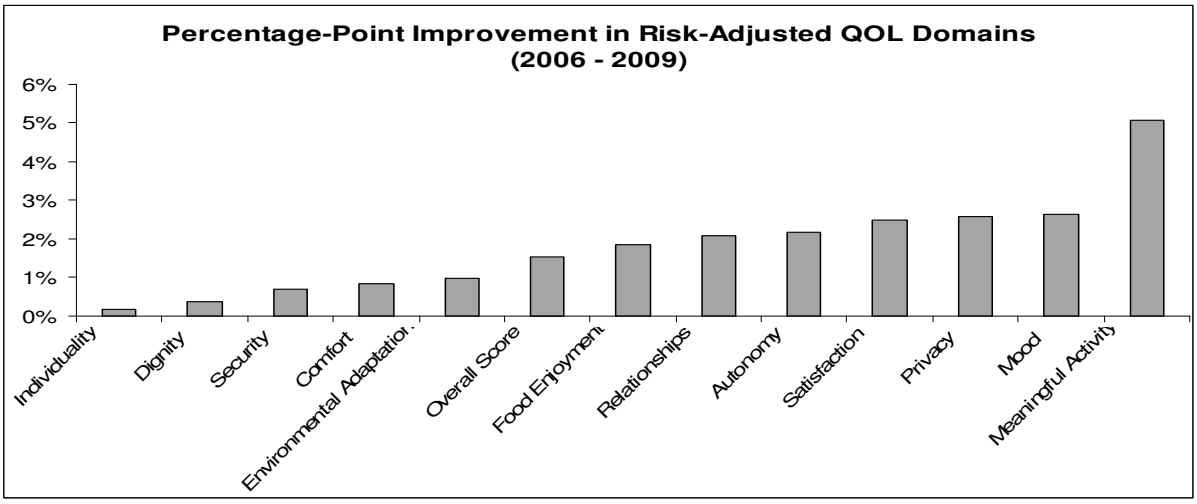
The above measures capture the extent to which the long-term care system is able to support the elderly and people with disabilities in the community and allow them to live independently.

Trend in Minnesota Quality Indicators.



Every nursing home resident is assessed to determine the level of care they need. This assessment is known as the Minimum Data Set (MDS). The above quality indicators are derived from items in the MDS. The chart reports the change in the quality indicators from 2004 to 2009.

Trend in Quality of Life



Resident satisfaction/quality of life (QOL) ratings is a measure based on actual interviews of nursing home residents. A sample of residents in each home is interviewed on an annual basis. (Approximately 14,000 interviews statewide.) The above QOL ratings are derived from items in the MDS. The chart reports the change in the ratings from 2006 to 2009.

For more information on DHS performance measures, see http://www.accountability.state.mn.us/Departments/HumanServices/index.htm.

Contact – MA LTC Facilities

For more information on MA LTC Facility Grants, contact:

- Nursing Facilities Rates and Policy, (651) 431-2280
- Disabilities Services Division, (651) 431-2400.

Focus on: MA LTC Waivers and Home Care

Medical Assistance (MA) Long-Term Care (LTC) waivers and home care pay for a collection of continuing care and health care-related support services that enable low-income Minnesotans, who are elderly or who have disabilities, to live as independently as possible in their communities. LTC waivers refer to home and community-based services available under a federal Medicaid waiver as an alternative to institutional care. Home care pays for personal care assistance, private duty nursing, home health aides, and skilled nursing, as well as physical, occupational, speech, and respiratory therapy.

Population Served

LTC waivers and home care serve MA-enrolled people of all ages, including infants and older adults. These programs serve an average of 69,157 people per month.

To receive LTC waivers, a person must be eligible for MA and would otherwise receive care in an institution. Each of the LTC waivers is targeted to a certain group of recipients. To participate, individuals must meet the specific eligibility criteria for that waiver. DHS administers five MA LTC waivers:

- *Community Alternative Care (CAC)*: The CAC waiver serves individuals who are chronically ill and need the level of care provided at a hospital. In FY 2009, the waiver served 300 recipients monthly at a cost of $5,386 per month.
- *Community Alternatives for Disabled Individuals (CADI)*: The CADI waiver serves individuals who have a disability and require the level of care provided in a nursing home. In FY 2009, the waiver served 13,330 recipients monthly at a cost of $2,294 per month.
- *Developmental Disabilities (DD)*: The DD waiver is for individuals with developmental disabilities who need the level of care provided at intermediate care facilities for people with mental retardation or related condition (ICF/DD). In FY 2009, the waiver served an average of 14,182 recipients monthly at a cost of $5,671 per month.
- *Elderly Waiver (EW)*: The Elderly Waiver is for individuals who are over 65 years old and need the level of care provided at a nursing facility. In 2009, the waiver served 2,764 recipients monthly at a cost of $1,521 per month and 16,889 managed care recipients monthly at a cost of $1,146 per month.
- *Traumatic Brain Injury (TBI[1])*: The TBI waiver is for individuals with a traumatic or acquired brain injury who need the level of care provided in a nursing facility or neurobehavioral hospital. In FY 2009, the waiver served 1,357 recipients monthly at a cost of $5,890 per month.

LTC Waivers and Home Care Services Provided

LTC waivers, which are also known as home and community-based waiver programs, provide a variety of services that help people live in the community instead of going into or staying in an institutional setting. Waivers can offer in-home, residential, medical, and behavioral supports; customized day services, including employment supports; Consumer-Directed Community Supports (CDCS); transitional services when leaving an institution; transportation; home modifications; case management; caregiver supports; and other goods and services based upon the assessed needs of the person.

Home care includes a range of medical care and support services provided in a person's home and community. MA home care services are authorized based on medical necessity. MA home care services include assessments; home health aide visits; nurse visits; private duty nursing services; personal care services; occupational, physical, speech, and respiratory therapies; and medical supplies and equipment.

[1] The department is in the process of changing the name of this waiver to the Brain Injury waiver.

Historical Perspective

Home and community-based waivers were established under section 1915 of the federal Social Security Act of 1981. These waivers are intended to correct the institutional bias in Medicaid by allowing states to offer a broad range of home and community-based services to people who may otherwise be institutionalized.

In 1999, the United States Supreme County in Olmstead v. L. C. clarified that Title II of the Americans with Disabilities Act (ADA) includes supporting people in the most integrated settings possible. The decision applies to people of any age who have a disability, including mental illness. During 2007, CADI and TBI waivers helped 12,900 individuals either to relocate from an institution to the community or to remain in their homes or communities with support services. This number includes almost 5,200 individuals with a mental health diagnosis who might otherwise receive supports in an institution. Also in 1999, the legislature required the state to increase the DD waiver caseload until all forecasted funds appropriated to the waiver were expended. In accordance with this legislation, the state allowed "open enrollment" for a three-month period in FY 2001. Over 5,000 recipients were added to the program during the open enrollment period.

In 2003, the legislature required a phase-in of Elderly Waiver services and 180 days of nursing facility care to the basic Medicaid managed care package. The resulting product for seniors is named Minnesota Senior Care Plus.

In 2004, the federal Centers for Medicare and Medicaid Services (CMS) approved statewide expansion of Minnesota Senior Health Options (MSHO). MSHO, which has been operating in Minnesota since 1997, is a voluntary alternative for dual eligible seniors ages 65 and older. MSHO plans assume full risk for both Medicare and Medicaid services: primary, acute, and long-term care (including 180 days of nursing home care); the full menu of EW services in the community; and more recently the Medicare Part D drug benefit. As of June 2009, 86% of EW recipients are receiving services through MSHO or Minnesota Senior Care Plus, both of which are managed by health plans. Fee-for-services EW services, which are managed by the counties, comprise 14% of EW clients.

Consumer-Directed Community Supports (CDCS) is a waiver service that provides Minnesotans increased flexibility in determining and designing supports that best meet their needs. In March 2004, the Centers for Medicare and Medicaid Services approved the CDCS service for all LTC waivers. Implementation in all Minnesota counties began in April 2005.

The 2006 legislature provided additional CADI and TBI slots for eligible individuals who were receiving personal care assistance services from a provider who was billing for a service delivery model other than individual or shared care on 3-1-06. With this legislation, 114 individuals moved from using PCA services to either the CADI or TBI waiver.

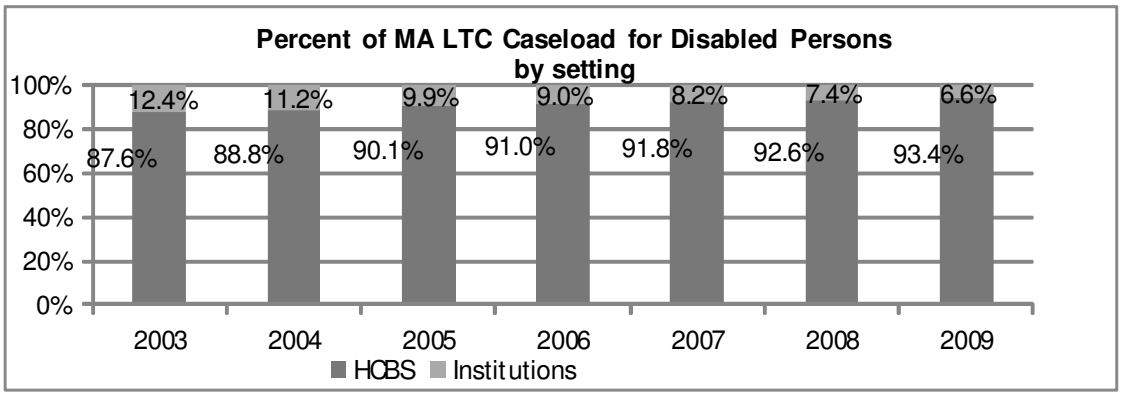
The 2009 legislature passed a moratorium on the licensure of child and adult corporate foster care, in an effort to limit the growth of the most expensive model of residential services and provide an opportunity to expand less costly, more independent options. The 2009 legislature also passed reform of home care services, which included changes to improve consumer protection and assure consumer health and safety, increase accountability, strengthen provider standards, and simplify and clarify requirements.

Key Activity Goals & Measures – MA LTC Waivers and Home Care

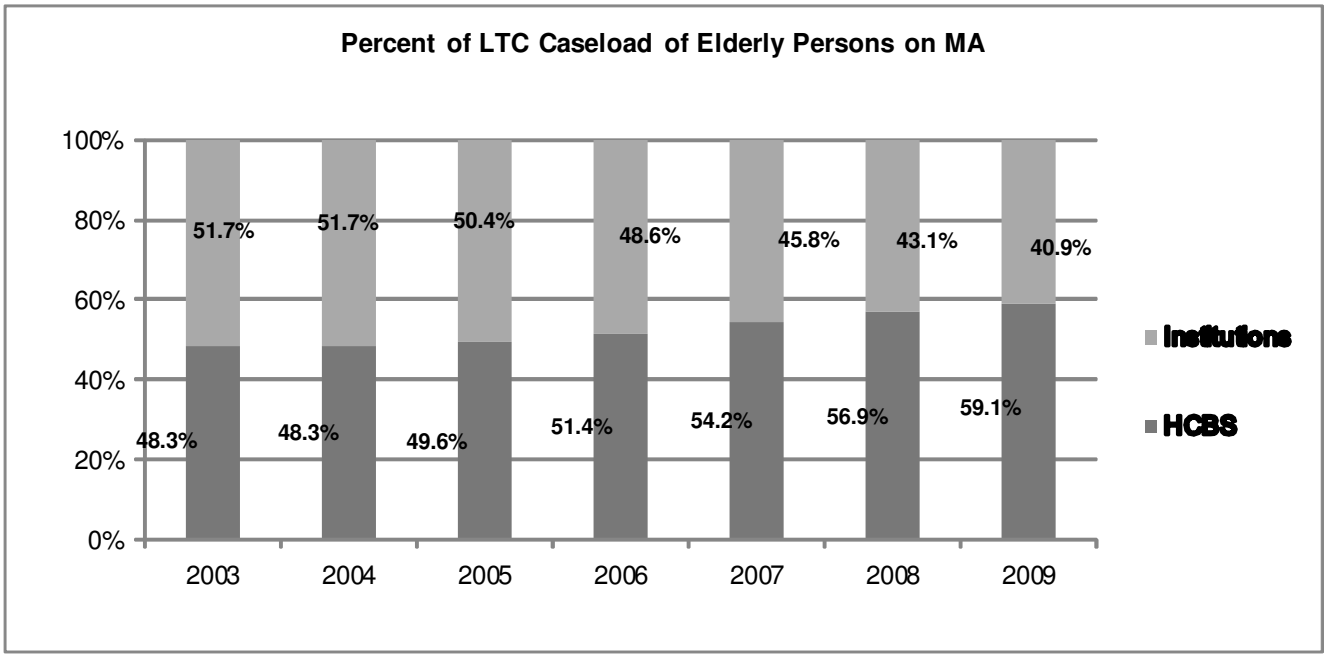
- ***The Continuing Care Administration strives to improve the dignity, health, and independence of the people it serves.*** By doing so, Minnesotans will live as independently as possible, enjoy health, with quality access to health care; have safe, affordable places to live; be contributing and valued members of their communities; and participate in rewarding daily activities, including gainful employment. This goal is derived from the Continuing Care Administration's mission and vision statements.
- ***Support and enhance the quality of life for older people and people with disabilities.*** Minnesota's long-term care service programs support older people and people with disabilities who do not have the resources to meet their own needs. These supports keep people safe and healthy so they can have a good quality of life and live with dignity. This goal is from the Continuing Care Administration's Strategic Plan.

- ***Improve home and community-based services for the elderly and people with disabilities by establishing and using provider performance measures and standards.*** Efforts in this area include integration of all quality activities statewide into a comprehensive quality system for home and community-based services. This goal is from the Department of Human Services' *Priority Plans* (http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4694-ENG).

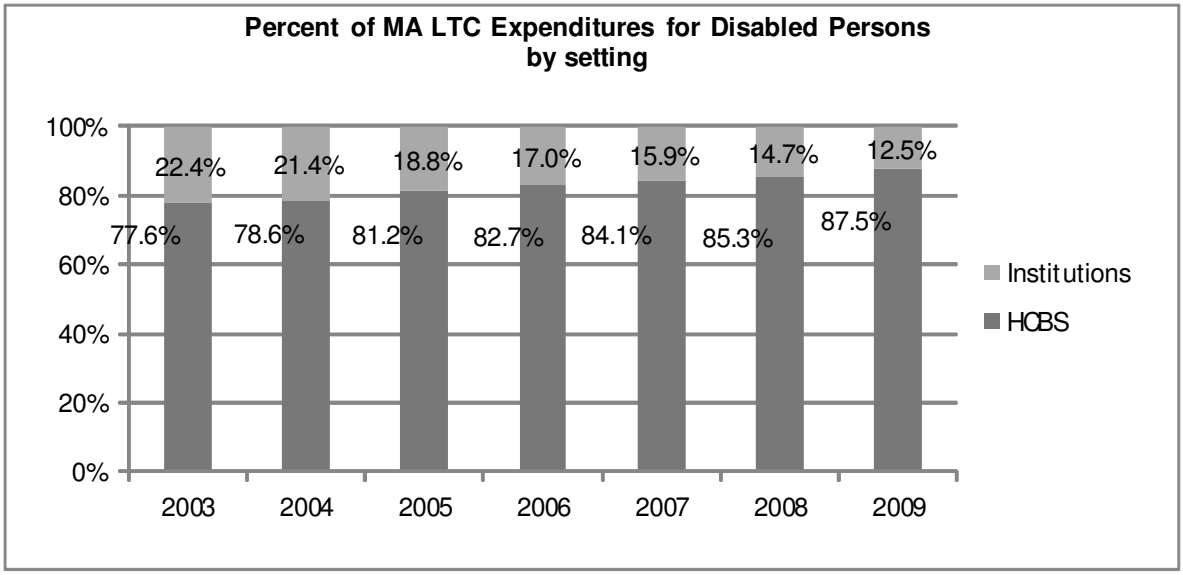
  - **Percentage of people with disabilities receiving publicly-funded long-term care who live in the community versus institutional settings.** In the following chart, "HCBS" refers to home and community based services which are designed to help people with disabilities live in their own community. LTC programs include nursing facilities under 65, ICFs/MR, HCBS Waivers, and Home Care.



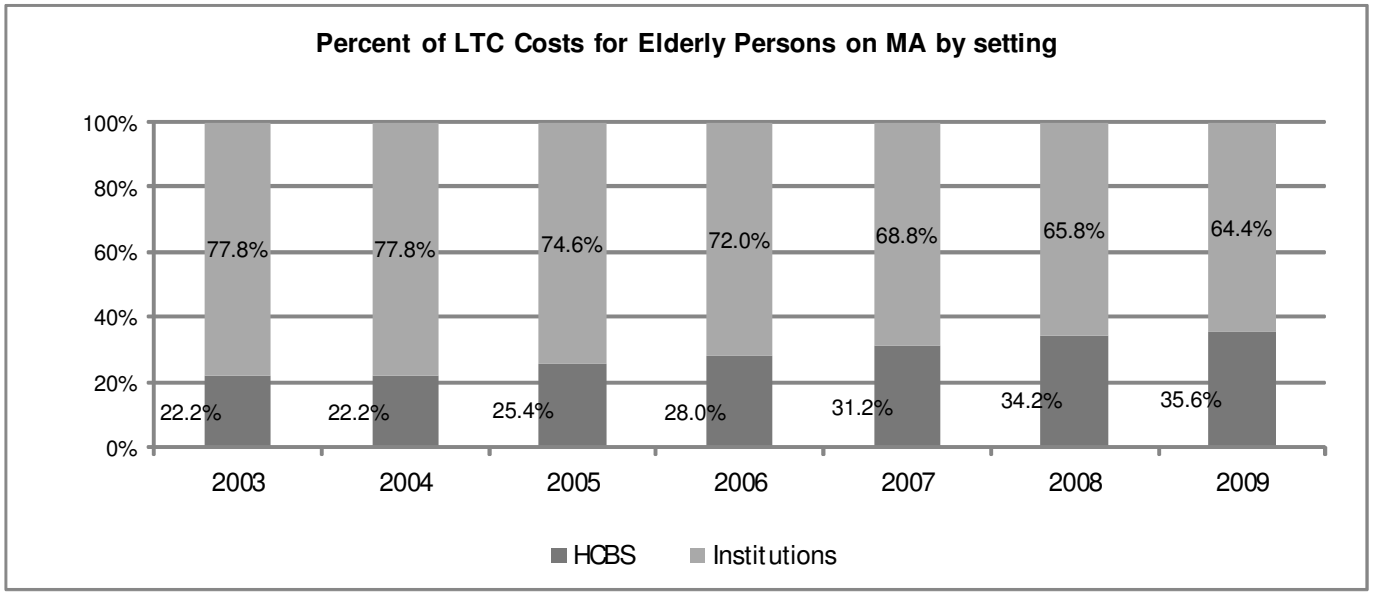
  - **Percentage of elderly receiving publicly-funded long-term care that live in the community versus an institutional setting.** In the following chart, "HCBS" refers to home and community based services which are designed to help elderly people remain in their own community. LTC for the Elderly includes the EW-Fee for Service, EW-Manage Care, FFS Homecare for 65+ and Alternative Care Program.



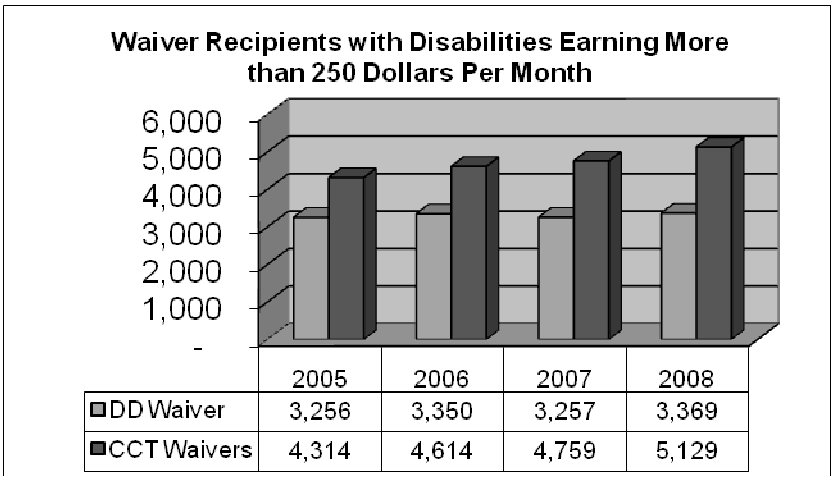
- **Percentage of public long-term care dollars expended in community versus institutional settings for people with disabilities.** In the following chart, "HCBS" refers to home and community based services which are designed to help people with disabilities live in their own community. LTC programs include nursing facilities under 65, ICFs/MR, HCBS Waivers, and Home Care.



- **Percentage of public long-term care dollars expended for elderly in community versus institutional settings**. In the following chart, "HCBS" refers to home and community based services which are designed to help elderly people remain in their own community. LTC for the Elderly includes the EW-Fee for Service, EW-Manage Care, FFS Homecare for 65+ and Alternative Care Program.



- Percentage of people with disabilities receiving CAC, CADI, TBI, and DD services who are working age and earning at least $250 per month.



	2005	2006	2007	2008
DD Waiver	3,256	3,350	3,257	3,369
CCT Waivers	4,314	4,614	4,759	5,129

Working age means 22-64 years old. "CCT recipients" are persons on the CADI, CAC, or TBI waiver programs. In 2008, there were 16,975 CCT waiver recipients, with 5,129 recipients earning more than $250 per month. "DD recipients" are persons on the DD Waiver. For 2008, there were 16,645 DD Waiver recipients with 3,369 recipients earning more than $250 per month.

Each of these measures captures the extent to which the long-term care system is able to support people with disabilities in the community and allow them to live independently.

For more information on DHS performance measures, see http://www.accountability.state.mn.us/Departments/HumanServices/index.htm.

Contact – MA LTC Waivers and Home Care

For more information on MA LTC Waivers and Home Care Grants, contact:

- Disability Services Division, (651) 431-2400
- Aging and Adult Services Division, (651) 431-2600

Information on DHS programs is on the department's Web-site: http://www.dhs.state.mn.us.

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	2,833,840	3,219,758	3,219,758	3,219,758	6,439,516
Technical Adjustments					
Current Law Base Change			1,079,343	1,321,653	2,400,996
November Forecast Adjustment		(79,533)	(92,564)	(92,789)	(185,353)
Subtotal - Forecast Base	2,833,840	3,140,225	4,206,537	4,448,622	8,655,159
Total	**2,833,840**	**3,140,225**	**4,206,537**	**4,448,622**	**8,655,159**
Health Care Access					
Current Appropriation	0	0	0	0	0
Technical Adjustments					
Current Law Base Change			3,184	6,993	10,177
November Forecast Adjustment		0	(259)	(427)	(686)
Subtotal - Forecast Base	0	0	2,925	6,566	9,491
Total	**0**	**0**	**2,925**	**6,566**	**9,491**
Expenditures by Fund					
Direct Appropriations					
General	2,738,134	3,145,192	4,224,580	4,465,168	8,689,748
Health Care Access	0	0	2,925	6,566	9,491
Statutory Appropriations					
General	6,659	0	0	0	0
Miscellaneous Special Revenue	66,698	39,531	35,107	34,772	69,879
Federal	3,729,870	3,758,745	4,261,681	4,501,192	8,762,873
Federal Stimulus	849,590	802,000	0	0	0
Total	**7,390,951**	**7,745,468**	**8,524,293**	**9,007,698**	**17,531,991**
Expenditures by Category					
Other Operating Expenses	17	0	0	0	0
Payments To Individuals	7,376,582	7,732,468	8,508,368	8,988,132	17,496,500
Local Assistance	14,352	13,000	15,925	19,566	35,491
Total	**7,390,951**	**7,745,468**	**8,524,293**	**9,007,698**	**17,531,991**

Activity at a Glance

- Pays for in-home, community-based services for low-income elderly Minnesotans.
- Helps adults 65 years and older stay in their own homes longer by providing an alternative to nursing home care.
- In FY 2009, an average of 3,321 persons per month received services.
- In FY2009, Alternative Care cost an average of $764 per person per month. This compares to $4,890 for all payer types per person in a nursing facility.

Activity Description

Alternative Care (AC) is a state-funded program. It pays for at-home care and community-based services for older adults who are at risk of becoming eligible for Medical Assistance (MA) nursing facility care within four-and-one-half months. It provides eligible older adults with in-home and community-based services and supports similar to federally-funded home and community-based programs.

Population Served

To be eligible for AC, a person must be age 65 or older, assessed as needing nursing facility level of care, and have income and assets inadequate to fund nursing facility care for more than 135 days. The person must also be capable of paying a monthly program participation fee and have needs that can be met within available resources.

In FY 2009, the AC program provided services for an average of 3,321 elderly persons per month at a cost of $764 per person. Comparatively, the average monthly cost of nursing facility care during the same time period was $4,890 per month for all payer types.

Services Provided

Alternative Care provides funding for

- respite care, both in-home and at approved facilities, to provide a break for caregivers;
- case management to ensure that program access and services planned, authorized, and provided are appropriate;
- adult day care;
- personal care services to assist with activities of daily living;
- homemaker services;
- companion service;
- caregiver training and education to provide caregivers with the knowledge and support necessary to care for an elderly person;
- chore services to provide assistance with heavy household tasks such as snow shoveling;
- home health nursing and aide services;
- transportation to AC-related services and community activities;
- nutrition services;
- AC service-related supplies and equipment;
- tele-homecare services; and
- other authorized consumer-directed services and discretionary services that are part of the person's plan of care.

Historical Perspective

The AC program was implemented in 1981. Its purpose is to provide low-income (but not yet MA eligible) older adults at risk of nursing facility placement with in-home and community-based services to help them remain at home. Funding is allocated to local lead agencies (counties and tribes) to provide services under individual service plans. The local agencies are responsible for managing their allocations to serve eligible persons by contracting out to providers.

There were three major legislative changes made to the program effective August 2005 and January 2006 resulting in a nearly 30% caseload reduction during FY 2006. The changes eliminated assisted living, adult foster care, and residential services from the AC service menu, invoked real estate liens, and reduced financial program eligibility criteria. Since 2003 the number of AC participants has steadily declined. Only recently has the participation in AC gradually begun to increase. Key Program Goals

Identify a broader goal or goals that the program supports. This should likely come from one of the following:

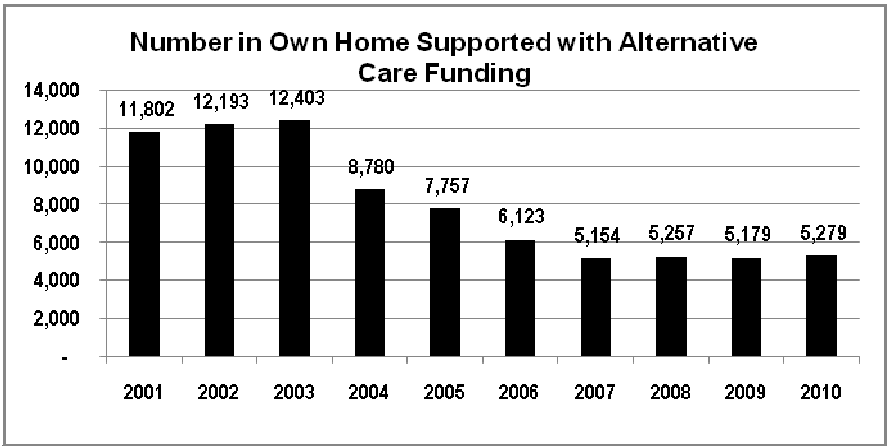
- Minnesota Milestones statewide goals – not the specific goal that the activity supports (http://server.admin.state.mn.us/mm/goal.html)
- Agency strategic goals – include reference or link to agency strategic plan if applicable
- Other statewide goals – indicate goal and include any relevant links or context for the goal

Key Activity Goals & Measures

- Older Minnesotans will receive the long-term care services they need in their homes and communities, will be able to choose how they receive services, and will have more options for using their personal resources to pay for long-term care.
- People in need will receive support that helps them live as independently as they can. This goal is from Minnesota Milestones (http://server.admin.state.mn.us/mm/goal.html).

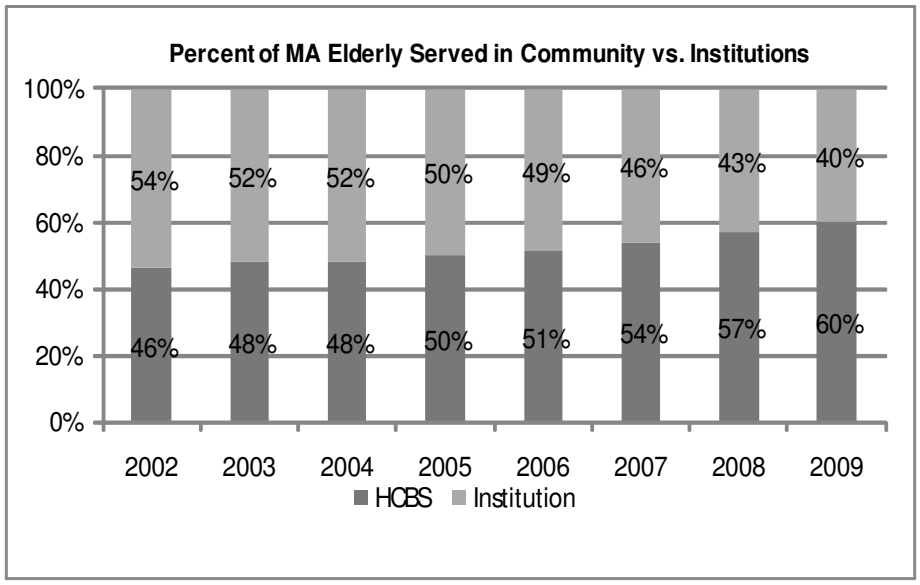
  Funds for Alternative Care grants increase the availability of non-institutional service options for very low income, older persons and their families. The recent legislative changes have ensured that these persons are supported to remain in their own homes.

- Number of low-income people (who are not eligible for Medical Assistance) supported through a state-only funding source so that they can remain in their own homes. From 2001 to 2010, the number of AC recipients declined 55%; 30% was due to instituting liens and estate recovery in 2003 and the rest was due to elimination of assisted living, adult foster care, and residential services in 2006. During this time, the number of .Elderly Waiver participants more than doubled. The number of recipients has begun to slowly increase in the past fiscal year.



Source: DHS February 2010 Forecast

Proportion of elders served in institutional vs. community settings.



"HCBS" refers to Alternative Care and other home- and community-based services. The percent in HCBS increased from 2002 to 2009, while the percent in institutions decreased.

For more information on DHS performance measures, see:
http://www.accountability.state.mn.us/Departments/HumanServices/index.htm.

Activity Funding

Alternative Care Grants is funded with appropriations from the General Fund and with enrollee premiums.

Contact

For more information on Alternative Care grants, contact the Aging and Adult Services Division at (651) 431-2600. Information on DHS programs is on the department's website: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: FORECASTED PROGRAMS
Activity: ALTERNATIVE CARE GRANTS

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	50,234	48,576	48,576	48,576	97,152
Technical Adjustments					
Current Law Base Change			(3,598)	(3,470)	(7,068)
Subtotal - Forecast Base	50,234	48,576	44,978	45,106	90,084
Total	**50,234**	**48,576**	**44,978**	**45,106**	**90,084**
Expenditures by Fund					
Direct Appropriations					
General	27,848	26,889	26,935	28,560	55,495
Statutory Appropriations					
Miscellaneous Special Revenue	2,296	2,215	2,012	2,032	4,044
Total	**30,144**	**29,104**	**28,947**	**30,592**	**59,539**
Expenditures by Category					
Payments To Individuals	30,144	29,104	28,947	30,592	59,539
Total	**30,144**	**29,104**	**28,947**	**30,592**	**59,539**

Activity at a Glance

- Provided placement in addiction treatment services for 27,100 placements in FY 2009.
- Average cost per admission is $3,800.
- 353 treatment programs participate in the CCDTF.
- Approximately 50% of all treatment admissions in the state are paid for by the CCDTF.
- The number of treatment admissions decreased by an average of 1.4% per year during CY 2007-2009 due in part to episode definition.

Activity Description

Chemical Dependency Entitlement Grants provides treatment to eligible people who have been assessed as in need of treatment for chemical abuse or dependency. This activity is administered through the Consolidated Chemical Dependency Treatment Fund (CCDTF).

Population Served

Chemical dependency (CD) treatment services are provided to anyone who is found by an assessment establishing clinical eligibility to be in need of care and is financially eligible, unless the needed services are to be provided by a managed care organization in which the person is enrolled.

CCDTF entitled eligible individuals are people who are enrolled in Medical Assistance (MA) or General Assistance Medical Care (GAMC), receive Minnesota Supplemental Assistance (MSA), or meet the MA, GAMC, or MSA income limits (100% of federal poverty guidelines).

Services Provided

For those people who meet financial and clinical eligibility, the CCDTF provides residential and outpatient addiction treatment services.

Approximately 50% of all state treatment admissions for Minnesota residents are paid for through the CCDTF. The local county social service agency or American Indian tribal entity assesses a person's need for chemical dependency treatment. A treatment authorization is made based on uniform statewide assessment and placement criteria outlined in the Department of Human Services (DHS) Rule 25 (M.R. parts 9580.6300 to 9530.7030). Almost all treatment providers in the state accept CCDTF clients.

Under the Prepaid Medical Assistance Program (PMAP), primary inpatient and outpatient chemical dependency treatment are covered services. For PMAP recipients, CCDTF payments are limited to halfway house placements and extended care treatments, which are not otherwise included in managed care contracts.

Eligible patients enrolled in prepaid health plans receive the same services as CCDTF patients.

Under a new assessment standard implemented in January 2008, individuals are assessed according to a uniform, standardized assessment tool that applies criteria derived by the American Society of Addiction Medicine. This change resulted in longer continuous treatment episodes with less discharge and readmission to other levels of care, which in turn has resulted in a decrease in overall placements.

Historical Perspective

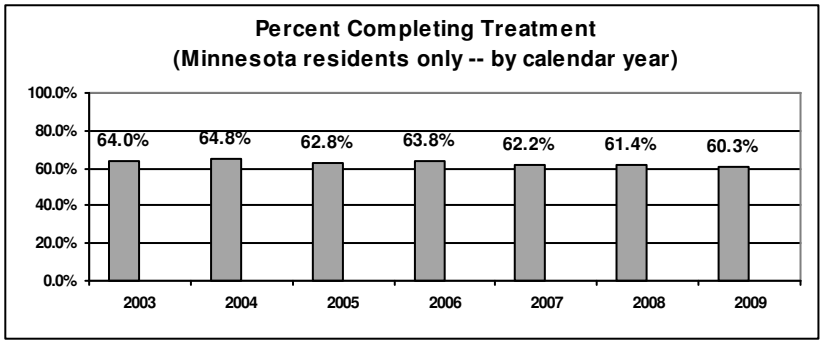
The CCDTF was implemented in 1988 to consolidate a variety of funding sources for chemical dependency treatment services for low-income, chemically-dependent Minnesota residents. The CCDTF combines previously separated funding sources – MA, GAMC, General Assistance, state appropriations, and federal block grants - into a single fund with a common set of eligibility criteria. Counties pay 16.14% of CD treatment costs.

The CCDTF has three tiers of eligibility. Tier I is funded through this CD Entitlement Grants budget activity. Tier II includes people who are not eligible for Medical Assistance (MA) or General Assistance Medical Care (GAMC), do not receive Minnesota Supplemental Assistance (MSA), but whose income does not exceed 215% of federal poverty guidelines.

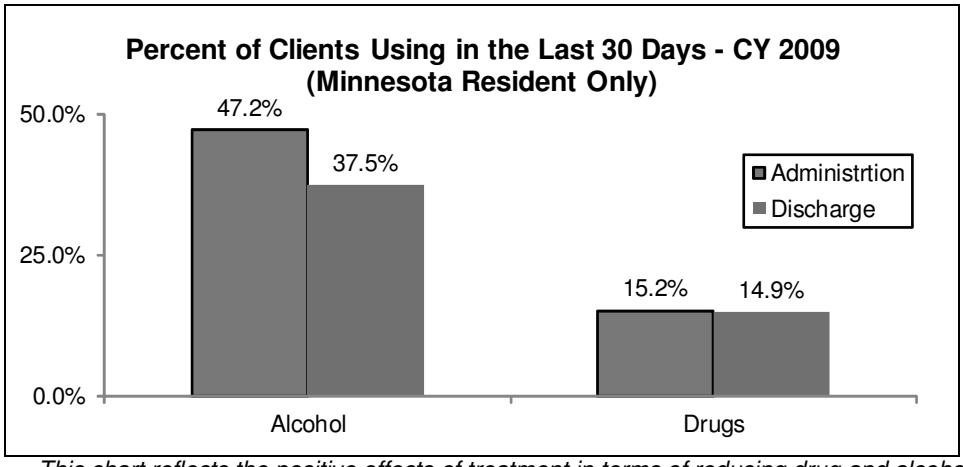
CD Non-entitlement Grants historically funded Tier II and Tier III of the Consolidated Chemical Dependency Treatment Fund (CCDTF), which provided treatment services for low-income individuals not eligible for entitlement-based treatment. Tier II was last funded in 2003. Tier III was last funded in 1990.

Key Program Goals & Measures

- ***Develop effective and accountable chemical health systems.*** The Department of Human Services (DHS) is implementing steps to support research-informed practices in chemical dependency treatment and prevention, systematically monitor outcomes, and integrate chemical, mental, and physical health services. This goal is from the Department of Human Services' *Priority Plans* (http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4694-ENG).
  - ***Percentage of clients completing chemical dependency treatment.*** Treatment completion has been found to be a strong indicator of continued sobriety after treatment. The DHS Drug and Alcohol Abuse Normative Evaluation System (DAANES) collects a number of data elements from all chemical dependency programs regardless of the admission's funding source. Below are completion results of all statewide treatment admissions for CY 2003-09.



  - **Percentage of CD clients using alcohol or illicit drugs in the previous 30 days – at admission and discharge (2007).**



This chart reflects the positive effects of treatment in terms of reducing drug and alcohol use.

For more information on DHS performance measures, see http://www.accountability.state.mn.us/Departments/HumanServices/index.htm.

Activity Funding

Chemical Dependency Entitlement Grants is funded with appropriations from the General Fund and from federal funds.

Contact

For more information on CD Entitlement Grants, contact the Chemical Health Division, (651) 431-2460

Information on DHS programs is on the department's website: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: FORECASTED PROGRAMS
Activity: CD ENTITLEMENT GRANTS

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	87,570	93,836	93,836	93,836	187,672
Technical Adjustments					
Current Law Base Change			9,563	16,754	26,317
November Forecast Adjustment		8,824	9,235	12,889	22,124
Subtotal - Forecast Base	87,570	102,660	112,634	123,479	236,113
Total	**87,570**	**102,660**	**112,634**	**123,479**	**236,113**
Expenditures by Fund					
Direct Appropriations					
General	0	0	112,634	123,479	236,113
Statutory Appropriations					
Miscellaneous Special Revenue	129,607	144,321	42,597	45,582	88,179
Total	**129,607**	**144,321**	**155,231**	**169,061**	**324,292**
Expenditures by Category					
Payments To Individuals	127,101	141,470	152,123	165,667	317,790
Local Assistance	2,506	2,851	3,108	3,394	6,502
Total	**129,607**	**144,321**	**155,231**	**169,061**	**324,292**

Program Description

The purpose of Grant Programs is to include all programs provide services but are not entitlement programs.

Grants Programs includes activities related to child care, child support, refugee services, health care, and chemical and mental health. These grants support services to children, youth, adults, people living with disabilities, mental health problems, and addictions.

Budget Activities

This program includes the following budget activities:

- Support Services Grants
- BSF Child Care Assistance Grants
- Child Care Development Grants
- Child Support Enforcement Grants
- Children's Services Grants
- Children & Community Services Grants
- Children & Economic Support Assistance Grants
- Refugee Services Grants
- Health Care Grants
- Aging & Adult Services Grants
- Deaf & Hard of Hearing Grants
- Disabilities Grants
- Adult Mental Health Grants
- Children's Mental Health Grants
- CH Non-entitlement Grants

Dollars in Thousands

	Current		Governor Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	287,524	283,573	283,273	283,273	566,546
Technical Adjustments					
Approved Transfer Between Appr			(150)	(150)	(300)
Current Law Base Change			42,755	44,110	86,865
Transfers Between Agencies			119	119	238
Subtotal - Forecast Base	287,524	283,573	325,997	327,352	653,349
Total	**287,524**	**283,573**	**325,997**	**327,352**	**653,349**
Health Care Access					
Current Appropriation	24,283	830	830	830	1,660
Technical Adjustments					
Current Law Base Change			110	110	220
Subtotal - Forecast Base	24,283	830	940	940	1,880
Total	**24,283**	**830**	**940**	**940**	**1,880**
Federal Tanf					
Current Appropriation	116,897	107,597	107,597	107,597	215,194
Technical Adjustments					
Current Law Base Change			(2,846)	(2,846)	(5,692)
Subtotal - Forecast Base	116,897	107,597	104,751	104,751	209,502
Total	**116,897**	**107,597**	**104,751**	**104,751**	**209,502**
Lottery Cash Flow					
Current Appropriation	1,428	1,429	1,429	1,429	2,858
Technical Adjustments					
Current Law Base Change			79	79	158
Subtotal - Forecast Base	1,428	1,429	1,508	1,508	3,016
Total	**1,428**	**1,429**	**1,508**	**1,508**	**3,016**

Dollars in Thousands

	Current		Governor Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Expenditures by Fund					
Direct Appropriations					
General	296,606	301,132	325,997	327,352	653,349
Health Care Access	6,940	17,746	940	940	1,880
Federal Tanf	116,832	107,597	104,751	104,751	209,502
Lottery Cash Flow	1,427	1,430	1,508	1,508	3,016
Statutory Appropriations					
Miscellaneous Special Revenue	109,782	54,457	45,451	44,628	90,079
Federal	554,736	561,067	564,195	560,449	1,124,644
Federal Stimulus	102,976	43,446	9,735	2,600	12,335
Gift	18	25	25	4	29
Total	**1,189,317**	**1,086,900**	**1,052,602**	**1,042,232**	**2,094,834**
Expenditures by Category					
Total Compensation	30	0	0	0	0
Other Operating Expenses	8,899	7,295	2,834	2,027	4,861
Payments To Individuals	694,382	538,948	502,022	503,341	1,005,363
Local Assistance	485,649	539,907	546,996	536,114	1,083,110
Other Financial Transactions	357	750	750	750	1,500
Total	**1,189,317**	**1,086,900**	**1,052,602**	**1,042,232**	**2,094,834**
Expenditures by Activity					
Support Services Grants	134,301	140,570	119,274	113,360	232,634
Bsf Child Care Assist Grants	88,638	62,560	93,074	93,074	186,148
Child Care Development Grants	13,071	12,982	10,503	10,503	21,006
Child Support Enforcement Gr	2,025	4,245	5,019	5,019	10,038
Children'S Services Grants	93,117	98,450	85,232	83,405	168,637
Children & Community Services	83,417	81,705	96,576	96,576	193,152
Children & Economic Support Gr	470,064	409,300	393,226	392,735	785,961
Refugee Services Grants	11,753	15,518	9,137	7,337	16,474
Health Care Grants	104,094	56,633	37,843	38,431	76,274
Aging & Adult Services Grants	31,715	33,303	44,417	43,602	88,019
Deaf & Hard Of Hearing Grants	2,018	1,873	2,176	2,007	4,183
Disabilities Grants	41,692	47,448	36,418	36,477	72,895
Adult Mental Health Grants	78,456	83,038	85,853	85,853	171,706
Children'S Mental Health Gr	17,761	17,504	16,682	16,682	33,364
Cd Non-Entitlement Grants	17,195	21,771	17,172	17,171	34,343
Total	**1,189,317**	**1,086,900**	**1,052,602**	**1,042,232**	**2,094,834**

Activity at a Glance

- Provides MFIP employment services to 6,400 people per month.
- Provides Food Support employment services to over 300 people per month.

Activity Description

Support Services Grants provides employment, education, training, and other support services to help low-income families and people avoid or end public assistance dependency. These grants also fund a portion of county administration for the Minnesota Family Investment Program (MFIP), Diversionary Work Program (DWP), and Work Benefit Program.

Population Served

This activity serves two core groups

- participants in MFIP, DWP, and the Work Benefit program and
- recipients of Supplemental Nutrition Assistance Program benefits (formerly "food stamps"), known in Minnesota as Food Support, through the Food Support Employment and Training (FSET) program.

Services Provided

Support Services Grants includes MFIP Consolidated Funds, which are allocated to counties and tribes, and FSET funding. This activity includes work programs provided by the Workforce Centers overseen by the Minnesota Department of Employment and Economic Development (DEED), as well as counties, tribes, and non-profit organizations. These employment service providers work with county agencies to evaluate the needs of each participant and develop individualized employment plans.

County and local employment service programs provide or, if appropriate, refer participants to services including

- job search, job counseling, job interview skills, skill development, and supported work activities;
- adult basic education, high school completion classes, and general equivalency diploma (GED)/high school equivalency coaching;
- short-term training and post-secondary education of no more than 24 months;
- English proficiency training and functional work literacy;
- county programs that help low-income families with housing, utilities, and other emergency needs; and
- assistance accessing other services, such as child care, medical benefits programs, and chemical dependency and mental health services.

Historical Perspective

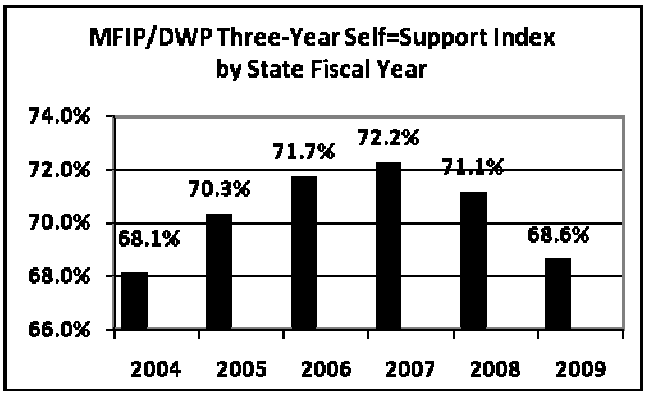
The 2003 legislature created the MFIP Consolidated Fund, combining funding for a number of support services programs for MFIP participants. The MFIP Consolidated Fund allows counties and tribes to continue successful approaches to moving MFIP families to work. A number of separate programs, including Emergency Assistance for families, were repealed. Service agreements for each county set outcomes, which include county performance measures. The 2007 and 2008 Legislatures appropriated additional funding for Integrated Services Projects (ISP) and supported work grants to counties and tribes to provide a continuum of employment assistance to MFIP participants. Funding for the ISPs was discontinued as of 12-31-09, but additional supported work funds were appropriated.

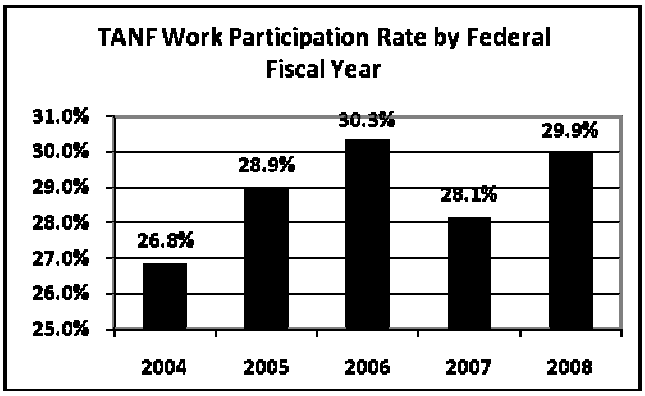
Key Activity Goals & Measures

- ***Ensure all Minnesotans will have the economic means to maintain a reasonable standard of living.*** This goal is from *Minnesota Milestones* (http://server.admin.state.mn.us/mm/goal.html).
- ***Improve outcomes for the most at-risk children.*** Support Services grants assist MFIP and DWP participants to meet their families' immediate needs and achieve long-term economic stability through work. This goal is from the Minnesota Department of Human Services' *Priority Plans.* (http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4694-ENG).
- ***Reduce disparities in service access and outcomes for racial and ethnic populations.*** Funds support projects that serve families with multiple barriers, including many African American and American Indian participants. This goal also is from DHS' *Priority Plans. (http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-5267-ENG).*

Key measures are

- **Percentage of adults working 30 or more hours or off MFIP three years after a baseline reporting period (MFIP Self-Support Index).** The MFIP Self-Support Index is a performance measure that tracks whether or not adults in MFIP are either: 1) working an average of 30 or more hours per week or 2) no longer receiving MFIP cash payments three years after a baseline measurement quarter. Participants who leave MFIP due to the 60-month time limit are not counted as meeting the criteria for success on this measure unless they are working 30 or more hours per week or qualified for Social Security disability payments before they reached the time limit.
- **Percentage of MFIP adults participating in work activities for specified hours per week. (TANF Work Participation Rate).** The TANF Work Participation Rate (WPR) is the percentage of MFIP cases in which the parent is fully engaged in employment or employment-related activities (according to federal TANF program rules, usually 130 hours per month). The TANF WPR is determined by the federal government based on monthly program data for the federal fiscal year. (Data for FFY 2009 have not yet been released.)





For more information on DHS performance measures, see
http://www.accountability.state.mn.us/Departments/HumanServices/index.htm

Activity Funding

Support Services Grants is funded with appropriations from the General Fund and from federal funds.

Contact

For more information on Support Services Grants, contact the Transition to Economic Stability Division (651) 431-4000.

Information on DHS programs is on the department's website: http://www.dhs.state.mn.

HUMAN SERVICES DEPT
Program: GRANT PROGRAMS
Activity: SUPPORT SERVICES GRANTS

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	8,715	12,498	12,498	12,498	24,996
Technical Adjustments					
Current Law Base Change			(3,783)	(3,783)	(7,566)
Subtotal - Forecast Base	8,715	12,498	8,715	8,715	17,430
Total	**8,715**	**12,498**	**8,715**	**8,715**	**17,430**
Federal Tanf					
Current Appropriation	116,557	107,457	107,457	107,457	214,914
Technical Adjustments					
Current Law Base Change			(2,846)	(2,846)	(5,692)
Subtotal - Forecast Base	116,557	107,457	104,611	104,611	209,222
Total	**116,557**	**107,457**	**104,611**	**104,611**	**209,222**
Expenditures by Fund					
Direct Appropriations					
General	8,685	12,498	8,715	8,715	17,430
Federal Tanf	116,692	107,457	104,611	104,611	209,222
Statutory Appropriations					
Federal	7	34	34	34	68
Federal Stimulus	8,917	20,581	5,914	0	5,914
Total	**134,301**	**140,570**	**119,274**	**113,360**	**232,634**
Expenditures by Category					
Other Operating Expenses	2,417	3,800	0	0	0
Payments To Individuals	33,249	47,054	30,790	30,790	61,580
Local Assistance	98,635	89,716	88,484	82,570	171,054
Total	**134,301**	**140,570**	**119,274**	**113,360**	**232,634**

Activity at a Glance

- Purchases child care for 15,900 children in 9,100 families each month.

Activity Description

Basic Sliding Fee (BSF) Child Care Assistance Grants provides financial subsidies to help low-income families pay for child care so that parents may pursue employment or education leading to employment and so that children are well-cared for and ready to learn. This program is supervised by the Minnesota Department of Human Services and administered by county social services agencies.

Population Served

Eligible low-income families who are not connected to the Minnesota Family Investment Program (MFIP) or the Diversionary Work Program (DWP) are served through the BSF child care program.

Services Provided

BSF Child Care Assistance grants help families pay child care costs on a sliding fee basis. As family income increases, so does the amount of child care expenses paid by the family. When family income reaches 67% of the state median income, family co-payments generally meet or exceed the cost of care.

BSF child care helps pay the child care costs of eligible low-income families not participating in MFIP or DWP, or in their first year after leaving MFIP or DWP. Families who have household incomes at or under 47% of the state median income when they enter the program, less than 67% of the state median income when they leave the program, and participate in authorized activities, such as employment, job search, and job training, are eligible for BSF child care.

Care must be provided by a legal child care provider over the age of 18. Providers include legal, nonlicensed family child care, license-exempt centers, licensed family child care, and licensed child care centers. Family child care and child care centers operate under separate laws and rules and exist as separate markets.

As required by state law, DHS establishes maximum payment rates for Child Care Assistance Grants by county, type of provider, age of child, and unit of time covered.

Historical Perspective

The BSF program was developed in the 1970s as a pilot program serving 24 counties, in recognition that child care was essential to the employment of low-income families. The demand for child care assistance has steadily increased over time as the number of eligible families has increased. The 2003 legislature made reforms to the Child Care Assistance Program (CCAP) to focus on the lowest income working families and control future growth. (CCAP is comprised of MFIP child care for families on MFIP or DWP and BSF child care for other low-income families.)

In 2007, the legislature appropriated $1 million for Child Care Assistance Programs for the FY2008-09 biennium to provide funding for incentives for parents and providers to promote skills and abilities that children need to succeed in school. The pilot project, School Readiness Connections, was extended in 2009-10 with an appropriation of $ 1.3 million. Child care providers selected by the department are eligible for a higher maximum payment and children are allowed to remain in care with the provider on a full-time basis as long as the family remains eligible for CCAP. The department is using the project evaluation to consider options for recommending changes to CCAP policy that could link ongoing incentives to child care programs that support school readiness.

Key Activity Goals & Measures

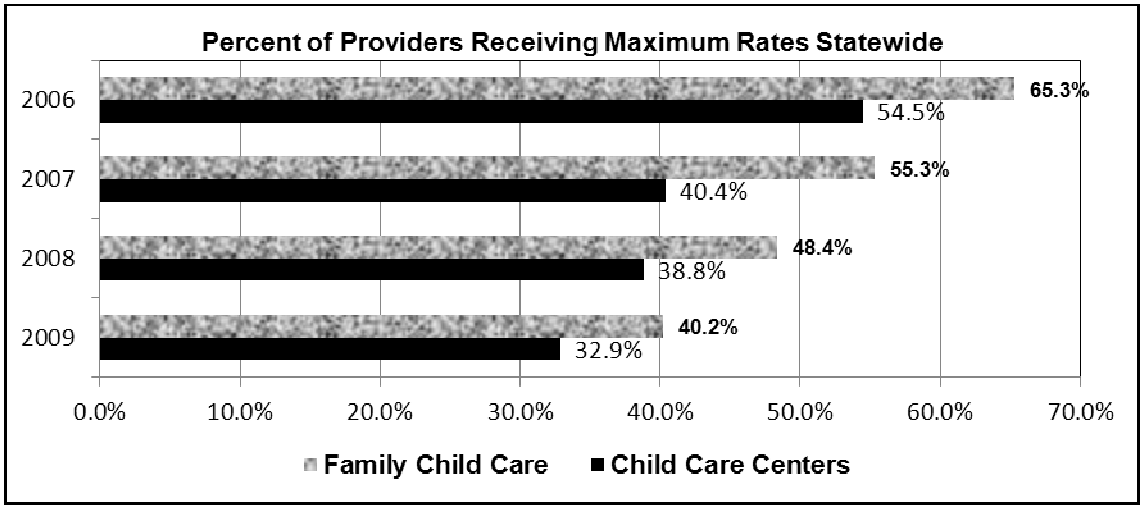
- ***Ensure all children will start school ready to learn.*** This goal is from *Minnesota Milestones* (http://server.admin.state.mn.us/mm/goal.html).
- ***Improve outcomes for the most at-risk children.*** The BSF Child Care Assistance Program improves outcomes for at-risk children by providing financial assistance to help low-income families pay for child care. Parents may pursue employment or education leading to employment while children attend child care where

they are well cared for and become better prepared to enter school ready to learn. This goal is from the Department of Human Services' *Priority Plans* (http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4694-ENG).

Key measures are

- ***Percentage of child care providers covered by maximum rates.*** As required by federal regulations, an annual child care market rate survey assesses whether or not families receiving child care assistance have access to all types of care available to the private market. Access is an important measure for two reasons. The first is that it presents the portion of rates in the child care market that can be fully paid with a CCAP subsidy. Second, access to child care providers may impact whether or not at-risk children are able to attend high-quality child care programs, which national research shows are associated with better child outcomes in low-income communities with children experiencing risk-factors. Therefore the level at which maximum rates are set may differentially affect access to high-quality child care programs.

  The following chart compares the percentage of child care center providers who receive maximum rates of payment with the percentage of family child care providers who receive maximum rates.



- **Percentage of children receiving child care assistance through the School Readiness Connections Pilot project who are ready for school.** The School Readiness Connections Pilot project targets resources to low-income families by reimbursing selected, qualified providers at higher rates for providing comprehensive services to improve the school readiness of at-risk children ages 0-5. The results of the evaluation indicate that the project goals were met and that the majority of children assessed prior to kindergarten entry were proficient in the skills and abilities necessary for school readiness. For the complete evaluation, see http://www.dhs.state.mn.us/dhs16_147885.pdf

For more information on DHS performance measures, see http://www.accountability.state.mn.us/Departments/HumanServices/index.htm.

Activity Funding

BSF Child Care Assistance Grants is funded by appropriations from the General Fund and from the federal Child Care and Development Fund (CCDF), which includes monies that the legislature transfers from the Temporary Assistance for Needy Families (TANF) block grant as well as county contributions.

Contact

For more information on BSF Child Care Assistance Programs, contact Transition to Economic Stability, (651) 431-4000.

Information on DHS programs is on the department's website: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: GRANT PROGRAMS
Activity: BSF CHILD CARE ASSIST GRANTS

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	40,100	37,592	37,592	37,592	75,184
Technical Adjustments					
Current Law Base Change			7,243	7,243	14,486
Subtotal - Forecast Base	40,100	37,592	44,835	44,835	89,670
Total	**40,100**	**37,592**	**44,835**	**44,835**	**89,670**
Expenditures by Fund					
Direct Appropriations					
General	40,100	37,592	44,835	44,835	89,670
Statutory Appropriations					
Federal	40,538	24,968	48,239	48,239	96,478
Federal Stimulus	8,000	0	0	0	0
Total	**88,638**	**62,560**	**93,074**	**93,074**	**186,148**
Expenditures by Category					
Payments To Individuals	80,959	5,500	5,500	5,500	11,000
Local Assistance	7,679	57,060	87,574	87,574	175,148
Total	**88,638**	**62,560**	**93,074**	**93,074**	**186,148**

Activity at a Glance

- Provides 27,000 child care referrals annually
- Awards 2,300 grants per year to providers to improve the quality and availability of child care
- Supports high quality training opportunities through classes offered to 35,000 participants, 575 enrollees in the new Minnesota Professional Development Registry, and 228 scholarships for provider education and training each year
- Issued over 300 Parent Aware ratings to early learning programs serving over 11,000 children in 2010

Activity Description

Child Care Development Grants promotes school readiness and improves the quality and availability of child care in Minnesota by providing consumer education to parents and the public and providing activities that increase parental choice.

Population Served

- Three out of four Minnesota families use child care for their children under age 13. These children spend an average of 24 hours a week in care.
- Over 230,000 Minnesota children under age six spend time in licensed child care arrangements.
- There are about 14,000 child care businesses and an estimated 150,000 family, friend, and neighbor caregivers in Minnesota.

Services Provided

The Minnesota Department of Human Services works with public and private agencies and individuals to promote school readiness through education and training and to provide a state infrastructure to support quality and availability of child care. These efforts include

- professional development for early childhood and school-age care providers;
  - A 2007 Minnesota law authorized development and implementation of a professional development system.
  - Statewide training, including the Minnesota Child Care Credential, is coordinated and delivered to child care providers by child care resource and referral (CCR&R) programs in partnership with other sponsoring organizations.
  - The Minnesota Center for Professional Development administers the Professional Development Registry, a career lattice, approval of training and trainers, and learning and career guidance.
  - All training aligns with the Minnesota Core Competencies: child growth and development; learning environment and curriculum; child assessment; interactions with children and youth, families, and communities; health, safety, and nutrition; caring for children with special needs; and provision of culturally responsive child care.
  - child care referrals for parents;
  - Referrals include personalized information and guidance for parents on selecting quality child care.
  - Referrals are delivered through local child care resource and referral programs at no cost to parents.
- grants and financial supports for child care providers;
  - Grants enable child care programs to improve facilities, start up or expand services, access training, and purchase equipment and materials.
  - Scholarships for credentials and higher education and bonus compensation help retain individuals working in child care and Head Start programs.
- consultation, mentoring, and coaching for child care providers; and
  - These resources provide support to individual child care providers to build their knowledge and skills to meet the needs of individual children, meet licensing standards, and improve program quality.
- the Building Quality Initiative for child care providers.
  - This is a legislatively-mandated initiative that helps child care providers prepare for a statewide quality rating and improvement system through consultation, training, grants, and professional development advising.

Other key elements include

- ongoing mechanisms for community-level input on programs and policies through advisory committees for major program components;
- research and evaluation to guide policy and program development to target resources effectively; and

- local control of grant priorities for grants administered by CCR&R sites.

Historical Perspective

The 1988 Minnesota Legislature established the Child Care Development Program to respond to increased demand for quality child care, and the need for a statewide infrastructure for parents and communities to respond to these needs. Since that time, the Child Care Development Grants program has awarded statewide and local-level grants to

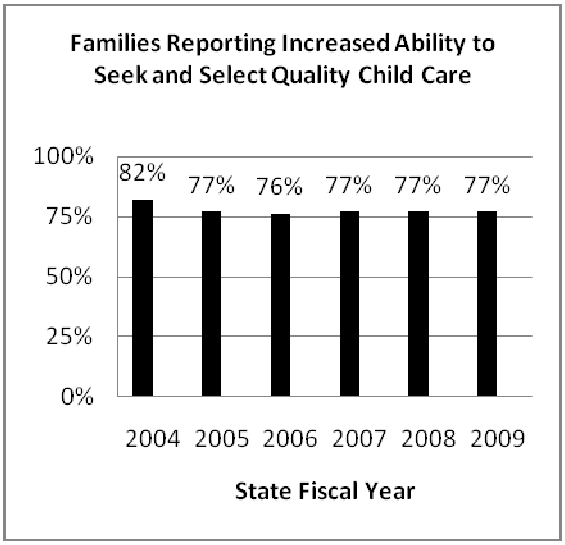
- support child care providers in improving quality;
- develop the child care infrastructure to provide referral services to parents and professional development, technical assistance, and facilities improvements to child care providers; and
- conduct research and evaluation to identify child care needs and improve program effectiveness.

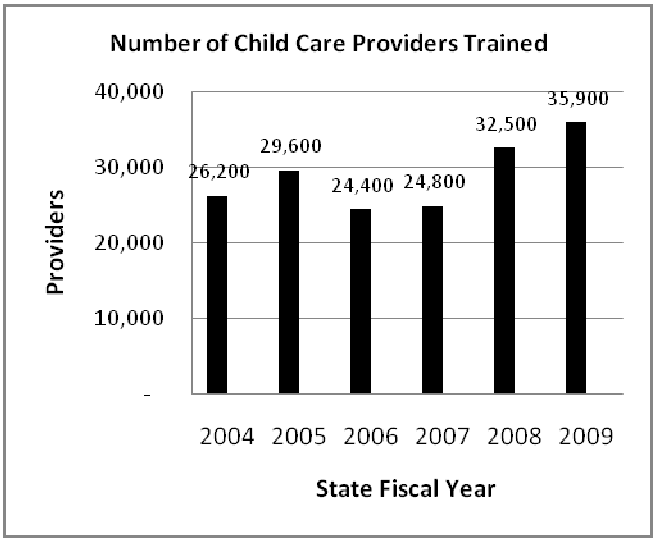
Key Activity Goals & Measures

- I***mprove the educational outcomes of children so that all children are school-ready by 2020.*** This goal is from the Governor's Early Childhood Advisory Council (http://www.education.state.mn.us/MDE/Learning_Support/Early_Learning_Services/Adv_Groups/Early_Child_Adv_Council/index.html).
- ***Improve outcomes for the most at-risk children.*** Improvement will occur by working with partners to test and evaluate approaches to improve school readiness. This goal is from the Department of Human Services' *Priority Plans* (http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4694-ENG).

Key measures are:

- ***Percentage of families using child care referral services who report increased ability to seek and select quality child care.*** The goal of child care referral services is to help families access quality child care by providing information on what constitutes a quality child care setting, how to search for quality child care, and which child care providers might meet families' needs. This measure is a self-report of families' ability to seek and select quality child care using the information gained from the child care referral experience. The results are based on a follow-up survey of parents who had used child care referral services.
- ***Number of participants attending child care resource and referral training.*** Participation in annual in-service training for more than 35,000 individuals working in Minnesota child care settings is required by licensing and, when focused on key core competencies, is also an important strategy for improving the quality of child care.

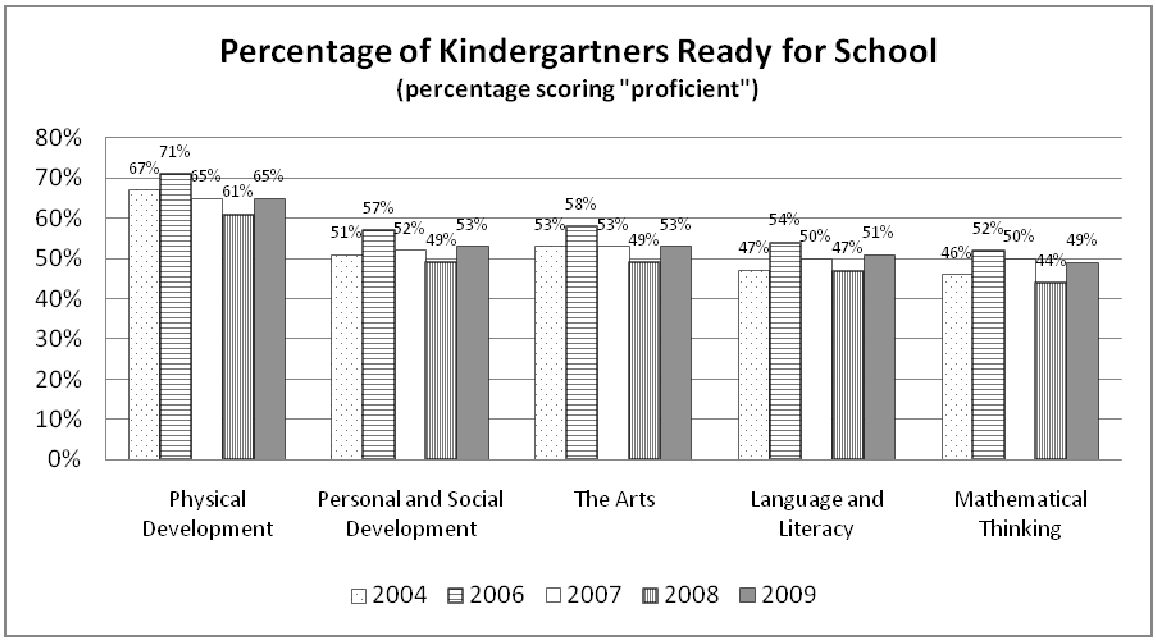




- ***Number of children who are ready for school (proficient category).*** An expected outcome of Child Care Development Grants is increased school readiness for young children in child care settings, especially

children at risk of poor outcomes. Among children ages birth to five, 75% are cared for in a child care setting on a regular basis. While research has shown that high quality early childhood programs can improve children's readiness for school, it should be noted that many other factors, such as poverty and mother's education level, are highly correlated with this outcome.

Data are collected annually by the Minnesota Department of Education through its Minnesota School Readiness Study. A geographically representative random sample of Minnesota kindergartners (about 10% of entering kindergartners) are assessed as they enter school in the fall.



Note: there was no School Readiness Study in 2005

- For more information on DHS performance measures, see http://www.accountability.state.mn.us/Departments/HumanServices/index.htm.

Activity Funding

Child Care Development Grants are funded with appropriations from the General Fund and from federal funds.

Contact

For more information on Child Care Development Grants, contact Child Development Services Division at (651) 431-3809.

Information on DHS programs is on the department's website: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: GRANT PROGRAMS
Activity: CHILD CARE DEVELOPMENT GRANTS

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	1,487	1,487	1,487	1,487	2,974
Subtotal - Forecast Base	1,487	1,487	1,487	1,487	2,974
Total	**1,487**	**1,487**	**1,487**	**1,487**	**2,974**
Expenditures by Fund					
Direct Appropriations					
General	1,437	1,487	1,487	1,487	2,974
Statutory Appropriations					
Miscellaneous Special Revenue	733	262	0	0	0
Federal	7,494	11,233	9,016	9,016	18,032
Federal Stimulus	3,407	0	0	0	0
Total	**13,071**	**12,982**	**10,503**	**10,503**	**21,006**
Expenditures by Category					
Other Operating Expenses	64	0	0	0	0
Local Assistance	13,007	12,982	10,503	10,503	21,006
Total	**13,071**	**12,982**	**10,503**	**10,503**	**21,006**

Activity at a Glance

- County agencies earned incentives for 9,093 order modifications and 6,406 paternity establishments (FY 2010).
- Access and visitation funds served 245 children and 263 adults (FY 2009).
- 117 non-custodial parents achieved increased parenting time with their children (FY 2009).

Activity Description

Child Support Enforcement Grants helps strengthen families by providing concrete supports in times of need. Child support is an important component in helping many families become self-sufficient and stay off welfare. Child support enforcement is administered at the local level by counties acting under the state's direction and supervision. These grants provide state administrative funding to counties primarily based on their performance and federal funding for access and visitation and program innovation.

Population Served

Child Support Enforcement serves both families who receive public assistance and those who are non-public assistance clients. The federal grants serve parents and children, whether they participate in the state's child support program or not.

Services Provided

Services provided by the state and counties to help families in Minnesota receive child support include

- establishing paternity;
- establishing and modifying orders for child support, medical support, and child care support;
- collecting and disbursing support; and
- enforcing support orders by using various tools to collect support, including suspension of driver's licenses and various state occupational licenses for non-payment, new hire reporting by employers, and work with financial institutions to move money directly from bank accounts.

Access and visitation federal grant funding *supports and facilitates non-custodial parents' access to and visitation of their children* and is competitively awarded by the state to qualifying community agencies.

Federal competitively awarded grant funding supports child support program innovation targeted to the agency's priorities, which may change from year to year.

Historical Perspective

The state provides incentives to county agencies for each paternity ($100), basic support ($100), and medical support ($50) order established and for each order modified ($100). Counties must reinvest the incentives money in child support program activities and cannot supplant county funds used to administer the program. With the implementation of shared income child support guidelines, the legislature also appropriated funds to counties for the administration of this program change. These funds are distributed to counties based on caseload size. Legislation passed in the 2010 session reduced both of these appropriations.

The federal Office of Child Support Enforcement allocates Access and Visitation funding to states based on their proportionate share of children nationwide living with only one biological parent. The state's annual allocation is about $130,000. The grants require a 10% non-federal match, which is supplied by the agencies in Minnesota to which the grant is awarded.

Over the years, Minnesota has successfully competed for federal Section 1115 demonstration grants. A 5% non-federal match is required. Currently, the state has a grant for a demonstration of a co-parenting court in Hennepin County to support unmarried parents in developing a healthy co-parenting relationship. The three-year demonstration will run until federal fiscal year 2013.

Key Activity Goals & Measures

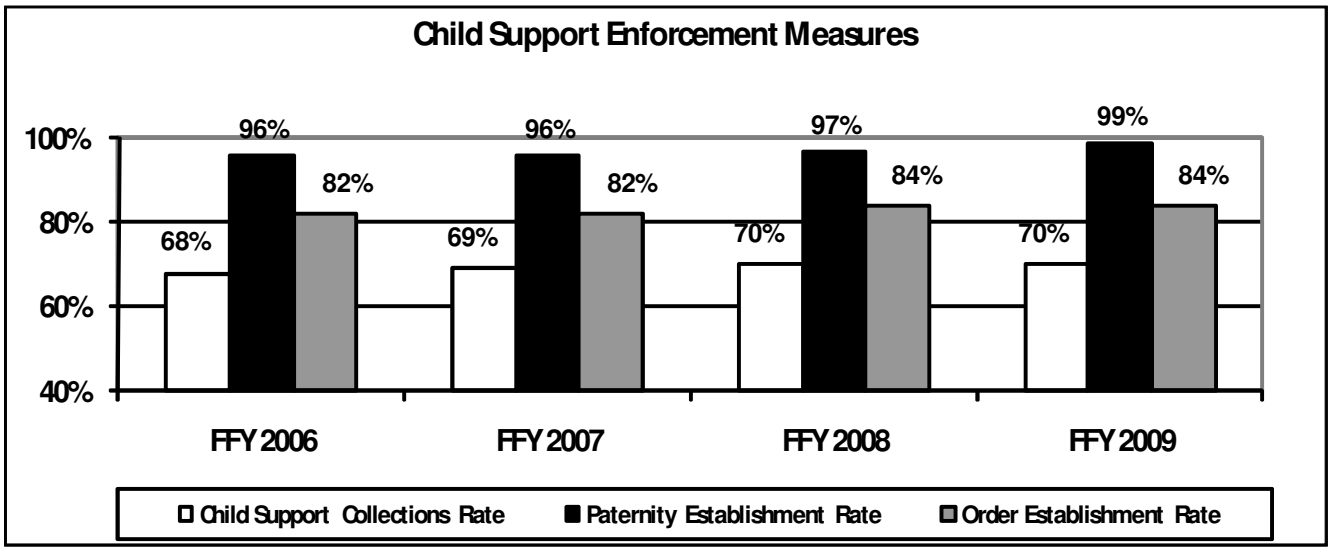
- Be effective, maximize overall performance and outcomes.
- Build and sustain collaborative relationships with those who help deliver our services.

These goals are from the *Child Support Strategic Plan 2008-2012.* More information on this plan can be found at: http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-5217B-ENG.

Key measures are

- ***Child support collection rate.*** This measure is the percentage of dollars ordered for child support that was paid by the non-custodial parent. This measure is one of five federal performance measures used to determine incentive payments to states, and subsequently to counties, by the federal government.
- ***Paternity establishment rate.*** This rate is the percentage of paternities established for children in the Title IV-D caseload who were not born in marriage. This measure is one of five federal performance measures used to determine incentive payments to states, and subsequently to counties, by the federal government.
- ***Order establishment rate***. The order establishment rate is the percentage of orders established for children in the Title IV-D caseload. This measure is one of five federal performance measures used to determine incentive payments to states, and subsequently to counties, by the federal government.

These measures are based on federal fiscal years (FFY).



For more information on Minnesota Department of Human Services (DHS) performance measures, see: http://www.accountability.state.mn.us/Departments/HumanServices/index.htm.

Activity Funding

Child Support Enforcement Grants is funded with appropriations from the General Fund and from federal funds.

Contact

For more information on Child Support Enforcement Grants, contact the Child Support Enforcement Division, (651) 431-4400.

Information on DHS programs is on the department's website: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: GRANT PROGRAMS
Activity: CHILD SUPPORT ENFORCEMENT GR

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	305	2,156	2,156	2,156	4,312
Technical Adjustments					
Current Law Base Change			1,249	1,249	2,498
Subtotal - Forecast Base	305	2,156	3,405	3,405	6,810
Total	**305**	**2,156**	**3,405**	**3,405**	**6,810**
Expenditures by Fund					
Direct Appropriations					
General	300	2,106	3,405	3,405	6,810
Statutory Appropriations					
Miscellaneous Special Revenue	1,562	1,947	1,490	1,490	2,980
Federal	163	192	124	124	248
Total	**2,025**	**4,245**	**5,019**	**5,019**	**10,038**
Expenditures by Category					
Other Operating Expenses	(380)	0	0	0	0
Payments To Individuals	380	234	50	50	100
Local Assistance	2,025	4,011	4,969	4,969	9,938
Total	**2,025**	**4,245**	**5,019**	**5,019**	**10,038**

Activity at a Glance

In 2009,
- 22,000 children were assessed for abuse or neglect;
- 4,900 children were determined to be abused or neglected;
- 11,700 children were in out-of-home placements;
- More than 650 children under state guardianship were adopted; and
- More than 9,000 children were supported in adoptive and relative homes.

Activity Description

Children's Services Grants fund a continuum of statewide child welfare services.

Population Served

Children's Services Grants fund services for children who are at risk of abuse or neglect, have been abused or neglected, are in out-of-home placements, are in need of adoption, or are under state guardianship. Children's Services grants affect the lives of
- children who are abused or neglected and need child protection services;
- children who are in out-of-home placements because they cannot live safely with their parents or need care which cannot be provided within their homes;
- children who are waiting for immediate adoption; and
- families through the strategic initiatives supported by the Minnesota Children's Trust Fund.

Services Provided

Children's Services Grants funds adoption, child protection, homeless youth services, and child abuse and neglect prevention services through counties, tribes, local service collaboratives, schools, nonprofits, and foundations.

Children's Services Grants funds the following:
- Family Assessment Response and other services to families referred to child protection;
- services to prevent child abuse and neglect;
- services to prevent homelessness for older youth leaving long-term foster care;
- recruitment of foster and adoptive families and specialized services to support the adoption of children under state guardianship;
- Adoption Assistance for children with special needs who were under state guardianship and have been adopted;
- Relative Custody Assistance for children with special needs whose custody is transferred to relatives; and
- Indian child welfare services

Historical Perspective

The focus of child welfare has evolved over the years. Most recently, Children's Services grants have been used to
- reform the child welfare system through innovative efforts such as Alternative Response (now known as Family Assessment Response), the American Indian Child Welfare Initiative, Minnesota Child Welfare Training System, and the Children's Justice Initiative (a collaboration between DHS and the Minnesota judicial branch) and
- find and support permanent families for children who cannot be safely reunited with their families through the Public/Private Adoption Initiative, Concurrent Permanency Planning, and MN Adopt.

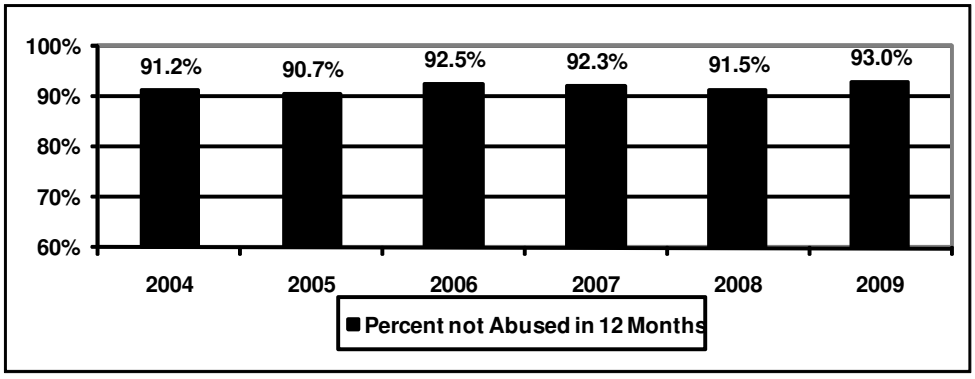
Key Activity Goals & Measures

- ***Families will provide a stable, supportive environment for children.*** This goal is from *Minnesota Milestones* (http://server.admin.state.mn.us/mm/goal.html).
- ***Improve outcomes for the most at-risk children.*** The department provides grants for early and targeted services for the children in Minnesota who are at the greatest risk for poor outcomes, including those who are in child protection, are homeless, or are teenage parents. This goal is from the Department of Human Services' *Priority Plans* (http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4694-ENG).

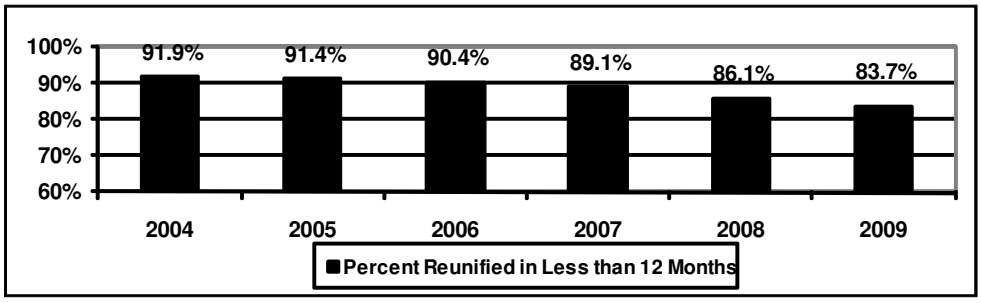
The underlying factor common to the three measures listed below is that more children will live in safe and permanent homes.

Key measures are

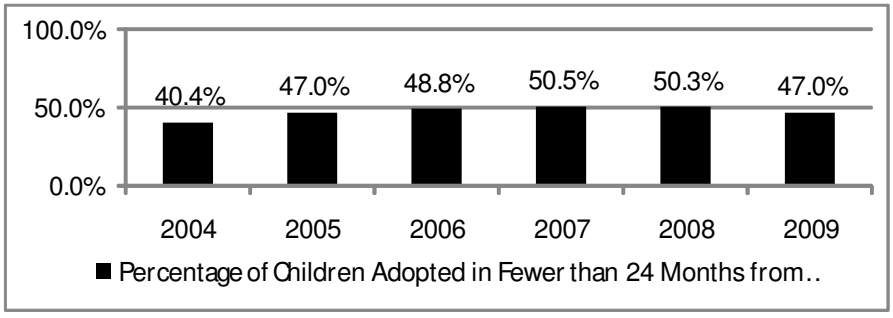
- ***Percentage of children who do not experience repeated abuse or neglect within 12 months of a prior report.*** For the period of 2004 through 2009 in Minnesota, the percentage of children who did not experience repeated abuse or neglect within 12 months of a prior report ranged from 91% (2004) to 93% (2009).



- ***Percentage of children reunified in less than 12 months from the time of the latest removal from their home.*** For the period of 2004 through 2009 in Minnesota, the percentage of children reunified in fewer than 12 months from the latest removal from their homes ranged from 84% to 92%. The national standard for this measure is 75.2%.



- ***Percentage of children who were adopted in fewer than 24 months from the time of the latest removal from their home***. The percentage of children adopted within 24 months from latest removal from home has increased from 40% in 2004 and exceeded the national standard in every year since 2002. The national standard for this measure is 36.6%.



For more information on DHS performance measures, see http://www.accountability.state.mn.us/Departments/HumanServices/index.htm.

Activity Funding

Children's Services Grants is funded primarily with appropriations from the General Fund and from federal funds. Initiatives supported by the Minnesota Children's Trust Fund are funded from a surcharge on birth certificates.

Contact

For more information about Children's Services Grants, contact the Child Safety and Permanency Division, (651) 431-4660.

Information on DHS programs is on the department's website: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: GRANT PROGRAMS
Activity: CHILDREN'S SERVICES GRANTS

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	47,433	50,498	50,498	50,498	100,996
Technical Adjustments					
Current Law Base Change			(5,371)	(5,371)	(10,742)
Subtotal - Forecast Base	47,433	50,498	45,127	45,127	90,254
Total	**47,433**	**50,498**	**45,127**	**45,127**	**90,254**
Federal Tanf					
Current Appropriation	340	140	140	140	280
Subtotal - Forecast Base	340	140	140	140	280
Total	**340**	**140**	**140**	**140**	**280**
Expenditures by Fund					
Direct Appropriations					
General	45,552	49,664	45,127	45,127	90,254
Federal Tanf	140	140	140	140	280
Statutory Appropriations					
Miscellaneous Special Revenue	5,793	7,430	3,331	2,618	5,949
Federal	37,532	37,144	35,596	35,516	71,112
Federal Stimulus	4,082	4,047	1,013	0	1,013
Gift	18	25	25	4	29
Total	**93,117**	**98,450**	**85,232**	**83,405**	**168,637**
Expenditures by Category					
Total Compensation	30	0	0	0	0
Other Operating Expenses	1,459	247	38	33	71
Payments To Individuals	44,516	48,703	42,527	42,027	84,554
Local Assistance	47,112	49,500	42,667	41,345	84,012
Total	**93,117**	**98,450**	**85,232**	**83,405**	**168,637**

Activity at a Glance

Serves 350,000 people annually who experience abuse, neglect, poverty, disability, chronic health conditions, or other factors that may result in poor outcomes or disparities.

Activity Description

Children and Community Services Grants provides funding to counties to purchase or provide social services for children and families.

Population Served

These funds provide services to clients who experience dependency, abuse, neglect, poverty, disability, chronic health conditions, mental health conditions, or other factors that may result in poor outcomes or disparities, as well as services for family members to support those individuals. Services are provided to people of all ages who are faced with a wide variety of needs. Historically, these grants have supported the following populations

- children in need of protection;
- pregnant adolescents and adolescent parents and their children;
- abused and neglected children under state guardianship;
- adults who are vulnerable and in need of protection;
- people over age 60 who need help living independently;
- children and adolescents with emotional disturbances and adults with mental illness;
- people with developmental disabilities;
- people with substance abuse issues;
- parents with incomes below 70% of state median income who need child care services for their children; and
- children and adolescents at risk of involvement with criminal activity.

Services Provided

County boards are responsible for coordinating formal and informal systems to best support and nurture children and adults within the county who meet the requirements in the state Children and Community Services Act (CCSA). This includes assisting individuals to function at the highest level of ability while maintaining family and community relationships.

Children and Community Services Grants' services focus on the following activities and outcomes

- preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests;
- preserving, rehabilitating, or reuniting families;
- achieving or maintaining self-sufficiency, including reduction or prevention of dependency;
- identifying mental health disorders early and providing treatment based on the latest scientific evidence;
- preventing or reducing inappropriate institutional care by providing for community-based care, home-based care, or other forms of less intensive care; and
- referring or admitting for institutional care people for whom other forms of care are not appropriate

Children and Community Services Grants support the following services

- adoption services;
- case management services;
- counseling services;
- foster care services for adults and children;
- protective services for adults and children;
- residential treatment services;
- special services for people with developmental, emotional, or physical disabilities;
- substance abuse services;
- transportation services; and
- public guardianship.

Historical Perspective

The Children and Community Services Act (CCSA), which was enacted by the 2003 legislature, consolidated 15 separate state and federal children and community services grants, including Title XX, into a single block grant

program. The CCSA gives counties more flexibility to ensure better outcomes for children, adolescents, and adults in need of services. The act also simplifies the planning and administrative requirements of the previous Community Social Services Act. It includes criteria for counties to limit services if CCSA funds are insufficient.

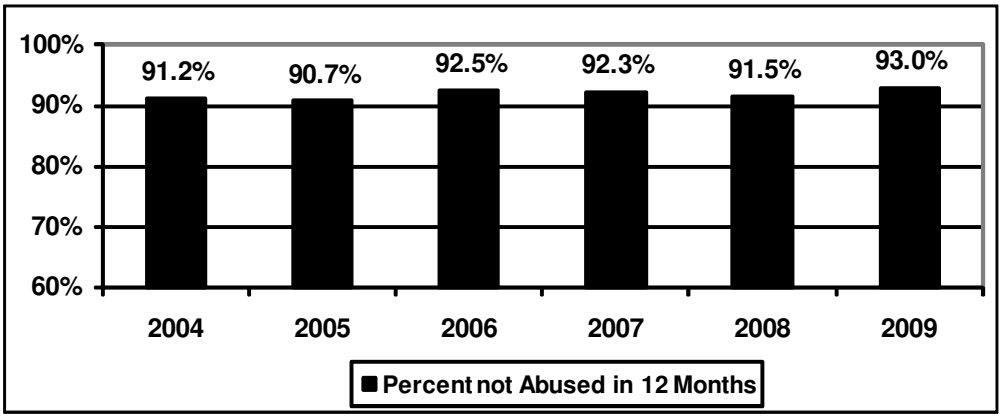
Key Activity Goals & Measures

- ***Families will provide a stable, supportive environment for their children.*** This goal is from *Minnesota Milestones* (http://server.admin.state.mn.us/mm/goal.html).
- ***Improve outcomes for the most at-risk children.*** Working with others, the department will provide early and targeted services to children in Minnesota who are at greatest risk for poor outcomes, including those who are homeless, disabled, teenage parents, in child protection, or in deep or persistent poverty. By identifying these at-risk children, building partnerships and service networks, and implementing targeted, coordinated and integrated services, children's lives will improve. They will also be better prepared for a healthy and productive adulthood.
- ***Disparities will be reduced in service access and outcomes for racial and ethnic populations.*** The department provides grants to counties to provide support at the local level based on the presenting needs of residents in that community. The program tracks several child safety and permanency outcomes by race and ethnicity at the county level. This goal is from the Minnesota Department of Human Services' *Priority Plans* (http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4694-ENG).

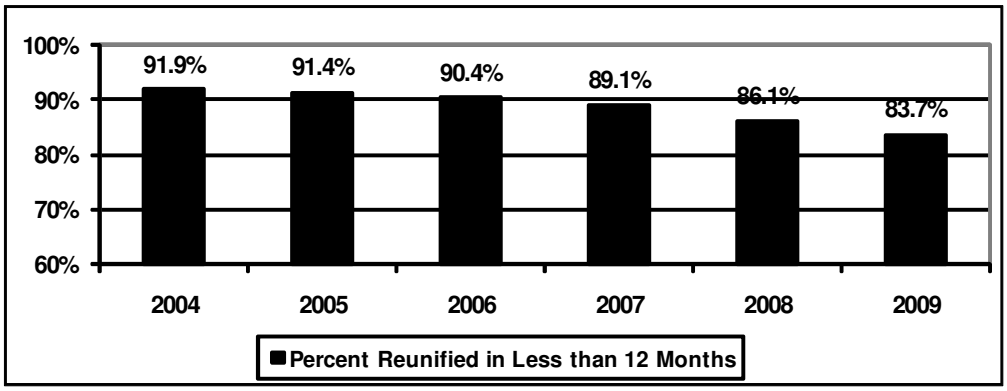
The underlying factor common to the three measures listed below is that more children will live in safe and permanent homes.

Key measures are

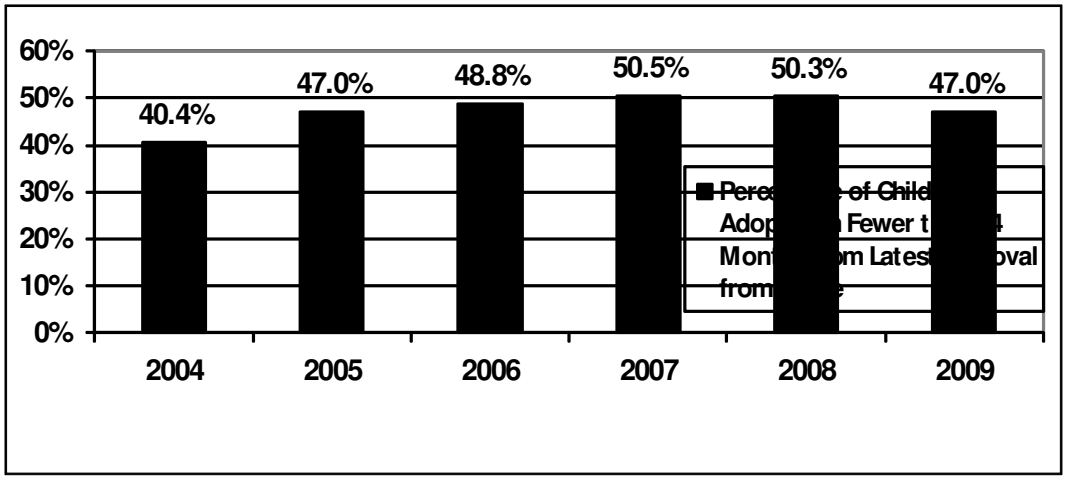
- ***Percentage of children who do not experience repeated abuse or neglect within 12 months of a prior report.*** For the period of 2004 through 2009 in Minnesota, the percentage of children who did not experience repeated abuse or neglect within 12 months of a prior report ranged from 91% (2004) to 93% (2009).



- **Percentage of children reunified in less than 12 months from the time of the latest removal from their home.** For the period of 2004 through 2009 in Minnesota, the percentage of children reunified in fewer than 12 months from the latest removal from their homes ranged from 84% to 92%. The national standard for this measure is 75.2%.



- ***Percentage of children who were adopted in fewer than 24 months from the time of the latest removal from their home***. The percentage of children adopted within 24 months from latest removal from home has increased from 40% in 2004 and exceeded the national standard in every year since 2002. The national standard for this measure is 36.6%.



For more information on DHS performance measures, see http://www.accountability.state.mn.us/Departments/HumanServices/index.htm.

Activity Funding

Children and Community Services Grants are funded with appropriations from the general fund and from federal Title XX (Social Services Block Grant) funds.

Contact

For more information on Children and Community Services Grants, contact the Child Safety and Permanency Division, (651) 431-4660.

Information on DHS programs is on the department's website: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: GRANT PROGRAMS
Activity: CHILDREN & COMMUNITY SERVICES

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	50,763	49,292	49,292	49,292	98,584
Technical Adjustments					
Current Law Base Change			15,009	15,009	30,018
Subtotal - Forecast Base	50,763	49,292	64,301	64,301	128,602
Total	**50,763**	**49,292**	**64,301**	**64,301**	**128,602**
Expenditures by Fund					
Direct Appropriations					
General	50,763	49,292	64,301	64,301	128,602
Statutory Appropriations					
Federal	32,654	32,413	32,275	32,275	64,550
Total	**83,417**	**81,705**	**96,576**	**96,576**	**193,152**
Expenditures by Category					
Local Assistance	83,417	81,705	96,576	96,576	193,152
Total	**83,417**	**81,705**	**96,576**	**96,576**	**193,152**

Activity at a Glance

- Provides transitional housing to 4,450 people annually.
- Provides food support to more than 400,000 people each month.

Activity Description

Children and Economic Assistance Grants provides funding for housing, food, and other services to low-income families and individuals in transition to economic stability.

Population Served

Eligible recipients include

- individuals and families who are at risk of homelessness and need housing and supportive services until they are able to move into stable, permanent housing;
- low-income families and individuals needing assistance to meet basic nutritional needs; and
- low-income households that need services and support to achieve long-term economic stability and maintain employment.

Services Provided

- Supportive Housing Services Grants address the needs of long-term homeless individuals and families.
- The Transitional Housing Program (THP) provides grants for programs that provide transitional housing and supportive services to homeless people for up to 24 months so that they can find stable, permanent housing.
- The Emergency Services Program funds shelters and other organizations to provide emergency shelter and essential services to homeless adults, children, and youth.
- Food shelves provide food to low-income individuals and families who have exhausted resources and are unable to meet their basic nutrition needs. Food banks, food shelves, on-site meal programs, and shelters provide food through the Minnesota Food Shelf Program and The Emergency Food Assistance Program.
- Food Support is provided through Electronic Benefit Transfer, Food Support Expedited Benefits, and Food Support Cashout Supplemental Security Income.
- The Minnesota Food Assistance Program provides state-funded grants to legal non-citizens who are no longer eligible for federal Food Support.
- Minnesota Community Action Grants provide low-income citizens with the information and skills necessary to become more self-reliant through a statewide network. Services are designed locally, based on community assessments, and aimed at ending poverty through high-impact strategies.
- Family Assets for Independence in Minnesota (FAIM) helps low-wage earners acquire financial assets and move out of poverty through matched savings accounts and financial education.
- Fraud-prevention grants are awarded to counties to fund early fraud detection and collection efforts for public assistance programs.

Historical Perspective

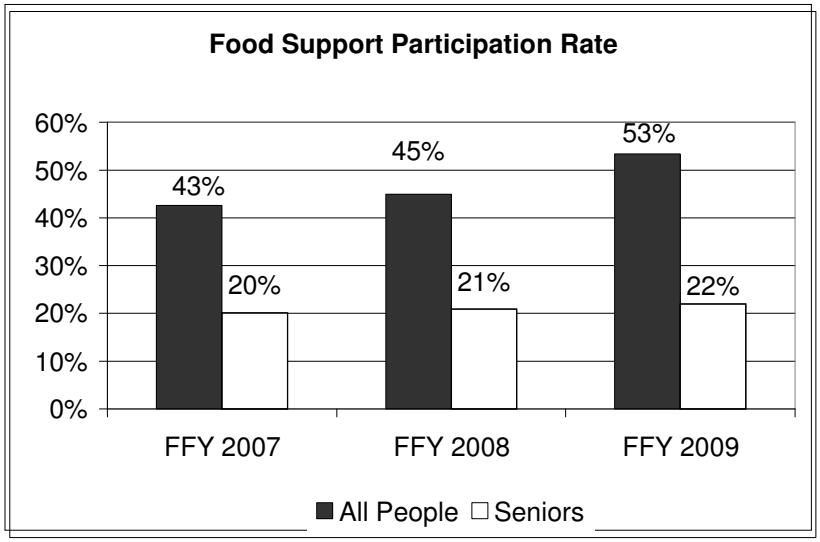
Homeless prevention programs were developed in the 1980s in response to the increasing numbers of children and families experiencing homelessness. The 2005 legislature appropriated $5 million/year for Supportive Housing Services grants to serve families and individuals experiencing long-term homelessness. Additional one-time funding was provided by the legislature in 2007 and 2008 to integrate the Supportive Housing and Managed Care Pilot into the new program. Certain legal non-citizens lost eligibility for federal Food Support in the 1990s and the state responded by creating the Minnesota Food Assistance Program. Family Assets for Independence in Minnesota is part of a national asset building initiative that also began in the 1990s. It came from the recognition that low-income families are often excluded from financial opportunities for asset development that is available to middle and upper income families.

Key Activity Goals & Measures

- ***Improve outcomes for the most at-risk children.*** DHS provides supports and services to the children in Minnesota who are at the greatest risk for poor outcomes. This goal is from the Minnesota Department of Human Services' *Priority Plans* (http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4694-ENG).
- *Provide integrated services to at-risk adults who are without children and struggling to meet their basic needs.* At-risk adults who are without children and struggling to meet their basic needs will receive a seamless

continuum of financial, employment, health care, housing, social services, and other supports from the department and its partners. This goal is also from DHS' *Priority Plans.*

Key measures are
- Food Support Participation Rate for People in Poverty
- Food Support Participation Rate for Seniors in Poverty



These measures are the average monthly number of people eligible for Food Support (including MFIP Food Portion) divided by the number of people at or below 125% of the federal poverty level, according to the 2006-2008 Three-Year Estimates of the American Community Survey. The Senior Participation Rate includes people ages 65 or older.

For more information on DHS performance measures, see http://www.accountability.state.mn.us/Departments/HumanServices/index.htm.

Activity Funding

Children and Economic Assistance Grants are funded with appropriations from the state General Fund and from federal funds.

Contact

For more information on Children and Economic Assistance Grants, contact the Community Partnerships Division, (651) 431-3809.

Information on DHS programs is on the department's website: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: GRANT PROGRAMS
Activity: CHILDREN & ECONOMIC SUPPORT GR

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	16,447	15,552	15,552	15,552	31,104
Technical Adjustments					
Current Law Base Change			753	263	1,016
Subtotal - Forecast Base	16,447	15,552	16,305	15,815	32,120
Total	**16,447**	**15,552**	**16,305**	**15,815**	**32,120**
Expenditures by Fund					
Direct Appropriations					
General	16,140	15,577	16,305	15,815	32,120
Statutory Appropriations					
Miscellaneous Special Revenue	300	140	3	3	6
Federal	376,627	375,052	374,318	374,317	748,635
Federal Stimulus	76,997	18,531	2,600	2,600	5,200
Total	**470,064**	**409,300**	**393,226**	**392,735**	**785,961**
Expenditures by Category					
Other Operating Expenses	53	5	5	5	10
Payments To Individuals	428,221	382,865	367,190	367,190	734,380
Local Assistance	41,433	25,680	25,281	24,790	50,071
Other Financial Transactions	357	750	750	750	1,500
Total	**470,064**	**409,300**	**393,226**	**392,735**	**785,961**

Activity at a Glance

Monthly average of refugees receiving resettlement services
- Refugee Cash Assistance 64
- Refugee Medical Assistance 59
- Social Services 857

Activity Description
Refugee Services Grants provides federally-funded resettlement services to help refugees rebuild their families and integrate as new Minnesotans.

Population Served
Refugees are people lawfully admitted to the United States who are unable to return to their own home country because of a fear of persecution.

Services Provided
Refugee Cash Assistance/Refugee Medical Assistance (RCA/RMA) is federal funding that provides cash assistance and pays for medical care for needy refugees who do not qualify for the Minnesota Family Investment Program (MFIP) or Medical Assistance (MA).

Social services provide refugees with culturally appropriate and bilingual employment services through contracts with nonprofit and ethnically based community organizations. Services are generally limited to refugees during their first five years in the United States, with priority given to those in their first year.

A wide range of other services is provided to help refugees adjust to life in the United States. Examples of these services are referral and information, translation and interpreter services, family literacy and English language instruction, and preparation for citizenship.

Historical Perspective
Over the last five years (Oct. 2004-Sept. 2009), Minnesota resettled 16,388 refugees from 47 ethnic nationalities or political nations. Most of the refugees came from Somalia, Laos, Ethiopia, and Burma.

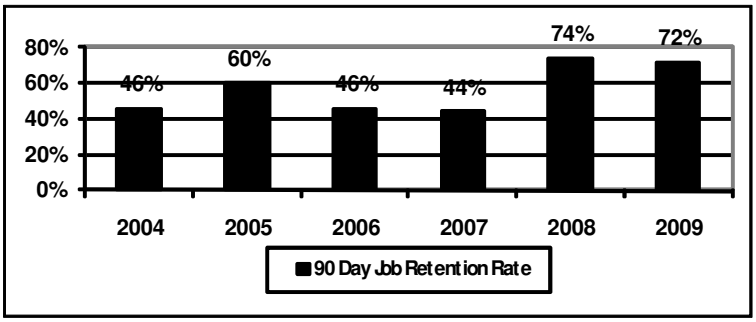
Key Activity Goals & Measures
- **All people will be welcomed, respected, and able to participate fully in Minnesota's communities and economy**. The goal of refugee services is to rebuild refugee families and integrate them as new Minnesotans. This goal is from Minnesota Milestones (http://server.admin.state.mn.us/mm/goal.html).

A specific objective of refugee services is to help families become economically self-supporting.

Key measures are:

- **Refugees' wage rate at job placement**

- **Refugees' 90-day job retention rate**



For more information on DHS performance measures, see http://www.accountability.state.mn.us/Departments/HumanServices/index.htm.

Activity Funding

Refugee Services Grants is funded with appropriations from federal funds.

Contact

For more information on Refugee Services Grants, contact Community Living Supports, (651) 431-3885.

Information on DHS programs is on the department's website: http://www.dhs.state.mn.us.

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Expenditures by Fund					
Statutory Appropriations					
Federal	11,753	15,518	9,137	7,337	16,474
Total	**11,753**	**15,518**	**9,137**	**7,337**	**16,474**
Expenditures by Category					
Other Operating Expenses	2,710	2,158	1,700	900	2,600
Payments To Individuals	1,867	3,000	3,000	3,000	6,000
Local Assistance	7,176	10,360	4,437	3,437	7,874
Total	**11,753**	**15,518**	**9,137**	**7,337**	**16,474**

Activity at a Glance

- Provides funding to private and governmental agencies for focused health care grants.
- Provides services to persons who are enrolled in or qualify for Medical Assistance (MA), General Assistance Medical Care (GAMC), and to MinnesotaCare enrollees.

Activity Description

Health Care Grants contains seven elements

- care coordination grants;
- monitor MA Prepaid Health Plan grants;
- state-wide toll-free number;
- state payment of subsidies for COBRA premiums;
- State Health Care Access Program grant; and
- outreach grants.

Population Served

This activity provides services to persons who are enrolled in or qualify for Medical Assistance (MA), General Assistance Medical Care (GAMC), and MinnesotaCare enrollees. It also provides services to people who do not qualify for Minnesota Health Care Programs but cannot afford to purchase insurance in the commercial market; these services are provided by safety net providers.

Services Provided

Care coordination grants create and fund multiple care coordination pilots for children and adults with complex health care needs in the fee-for-service delivery system.

The Monitor MA Prepaid Health Plans grants include expenditures incurred through interagency agreements with the Minnesota Department of Health (MDH). State matching funds are provided by MDH while DHS claims 50% federal financial participation.

Effective 7-1-09 through 2-28-12, a state-funded subsidy equal to 35% of the cost of COBRA health insurance is provided to persons who are eligible for both the federal subsidy of 65% of the COBRA premium and a Minnesota Health Care Program. For the purpose of MinnesotaCare eligibility, individuals who have received the COBRA subsidy are exempt from that program's four-month uninsured requirement.

DHS received a federal State Health Access Program (SHAP) grant of up to approximately $35.3 million over five years to help uninsured Minnesotans get health care through local access to care programs. DHS will distribute the SHAP funding through grants to community agencies. These agencies will develop programs that will provide affordable coverage for preventive health and primary care services to people who are:

- not eligible for Medical Assistance or GAMC;
- not enrolled onto Minnesota Care; and
- unable to afford private insurance.

Additionally, the SHAP grant provides Minnesota with the opportunity to further expand health care coverage through the development and implementation of the Minnesota Health Care Programs online application and electronic verification system.

Outreach grants assist public and private organizations in providing information and application assistance to potential Minnesota Health Care Program (MHCP) enrollees. DHS has awarded funds to two grantees to target disparate groups and refine an open enrollment process for school-aged children in collaboration with schools/school districts. One of the grantees will carry out the activities proposed under the Open Enrollment and Schools project which include:

- providing targeted outreach;
- application and enrollment assistance;
- streamlined referral processes; and
- exploration of a data share with DHS and the Department of Education.

The other grantee will evaluate its current strategies and existing data sources to identify efficiencies and develop new and innovative strategies to reach school-aged children without coverage and their families.

Historical Perspective

Prior to the 2005 legislative session, Minnesota Health Care Program Outreach grants and County Prepaid Medical Assistance Program (PMAP) grants also operated out of this budget activity. The Health Care Program Outreach grants were eliminated in the 2005 legislative session. Additional outreach grant funds were appropriated in the 2008 legislative session. County PMAP grants were phased out in the 2003 legislative session, with grants to counties ending in FY 2004.

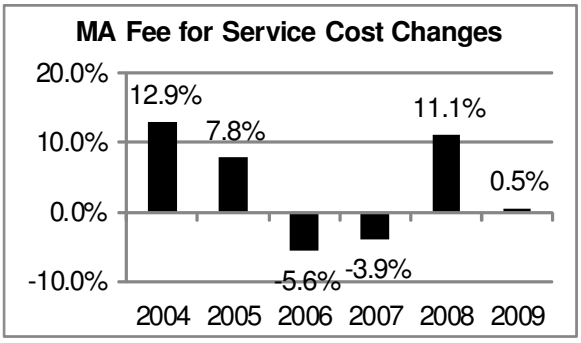
Funds to pay COBRA premium subsidies were appropriated in 2009. During the 2010 session, the period for which subsidies could be paid was extended from 12-31-10, to 8-31-11, to match the extension of federal COBRA premium subsidy.

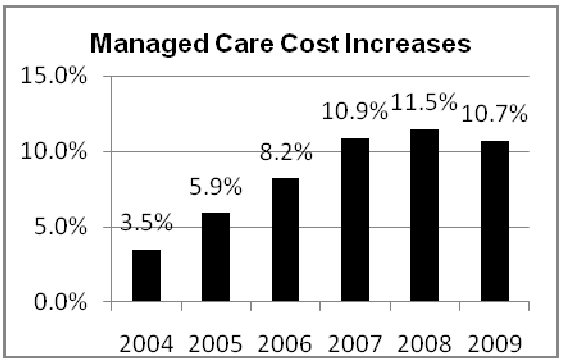
Key Activity Goals & Measures

- **Use the state's participation in the health care market to improve health care quality, access, outcomes, and affordability for all Minnesotans.** For the health care and nursing home services that it purchases, the department will improve price and quality transparency, encourage the use of evidence-based care, and use the payment system to encourage quality and efficiency. This goal is from the Department of Human Services' Priority Plans (http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4694-ENG).

- **Improve public health care program value. Basic health care costs account for approximately half of the Department of Human Services' (DHS') state funding.** At a time of lean budgets, it is critical that DHS look at all possible measures to reduce costs. In addition, it is important that the department improve price and quality transparency, encourage the use of evidence-based care, and use the payment system to encourage quality and efficiency. These strategies will improve quality, access, outcomes and affordability for all Minnesotans. http://www.accountability.state.mn.us/Departments/HumanServices/Goals.htm.

- **Cost increases in Minnesota health care programs.**





For more information on DHS performance measures, see
http://www.accountability.state.mn.us/Departments/HumanServices/index.htm

Activity Funding

Health Care Grants is funded from appropriations from the General Fund and health care access fund, from private grants, and from federal funds.

Contact

For more information on Health Care Grants, contact the Health Care Programs office at (651) 431-2478.

Information on DHS programs is available on the department's website: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: GRANT PROGRAMS
Activity: HEALTH CARE GRANTS

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	295	295	295	295	590
Subtotal - Forecast Base	295	295	295	295	590
Total	**295**	**295**	**295**	**295**	**590**
Health Care Access					
Current Appropriation	23,533	80	80	80	160
Technical Adjustments					
Current Law Base Change			110	110	220
Subtotal - Forecast Base	23,533	80	190	190	380
Total	**23,533**	**80**	**190**	**190**	**380**
Expenditures by Fund					
Direct Appropriations					
General	287	295	295	295	590
Health Care Access	6,190	16,996	190	190	380
Statutory Appropriations					
Miscellaneous Special Revenue	95,619	35,000	32,000	32,000	64,000
Federal	1,998	4,342	5,358	5,946	11,304
Total	**104,094**	**56,633**	**37,843**	**38,431**	**76,274**
Expenditures by Category					
Payments To Individuals	95,619	35,000	32,000	32,000	64,000
Local Assistance	8,475	21,633	5,843	6,431	12,274
Total	**104,094**	**56,633**	**37,843**	**38,431**	**76,274**

Activity at a Glance

- Provides congregate dining to 57,000 people and home-delivered meals to 14,000 people annuallyProvides social service support to 258,000 people, health promotion to 6,000 people, and caregiver supports to 10,000 people annually.
- Supports nearly 18,000 volunteers per year who provide services through the Retired and Senior Volunteer Program (RSVP), Foster Grandparents, and Senior Companions.
- Provides, through the Senior LinkAge Line, comprehensive assistance and individualized help to more than 65,000 individuals through 103,000 unduplicated contacts in 2009.
- Through www.MinnesotaHelp.info, a web-based database of over 11,000 providers available to the public, provides 397.000 visitors with community-based resources and customized long-term care planning tools.
- Funds home and community-based service options for more than 18,000 people and increased capacity by 6,000 volunteers in FY 2009 through the Community Service/Service Development grant program.

Activity Description

Aging and Adult Services Grants provides non-medical social services and supports for older Minnesotans and their families to enable them to stay in their own homes and avoid institutionalization.

Population Served

To be eligible for most of the services paid through these grants, people must be age 60 or older. Although not means-tested, services are targeted to people with the greatest social and economic needs. This conforms to eligibility criteria under the federal Older Americans Act (OAA), which also provides federal funding for a number of these services.

State Community Service/Services Development (CS/SD) and Caregiver Respite and Support (Caregiver) programs increase service availability and service choice for older Minnesotans in both urban and rural communities, providing greater opportunity for Minnesotans to age in place. From FY 2002 through FY 2009, state CS/SD and Caregiver funds have been awarded to 281 projects that have increased the supply of in-home supports, served more than 226,000 people in 87 counties and involved more than 55,000 volunteers.

Services Provided

Aging and Adult Services grants provide:

- nutritional services including meals and grocery delivery;
- transportation, chore services, and other services that help people stay in their own homes;
- evidence-based health promotion, chronic disease management, and falls prevention services;
- mentoring of families and children through older adult volunteer community services projects;
- care and one-on-one attention for special needs children (through the Foster Grandparents Program);
- assistance with daily activities for frail older adults;
- information and assistance through Senior LinkAge Line,® the online database www.MinnesotaHelp.info, and web-based long-term care planning tools including comprehensive, objective long-term care options counseling;
- counseling about Medicare, supplemental insurance, and other health and long-term care insurance options;
- comprehensive prescription drug expense assistance, including Medicare Part D, to Minnesotans of all ages;
- assistance and community based follow-up provided to nursing facility residents who want to return to the community;
- respite and other supportive services to family caregivers, including the option for consumer-directed supports; and
- expansion and development of more home and community services and housing options.

Historical Perspective

In 2001, the Minnesota Long-Term Care Task Force issued a report[1] that identified a number of critical issues facing the state, including: the increasing need for long-term care as a result of the aging population; the needs of family caregivers; the over-reliance on institutional models of care, such as nursing facilities; and the need for more community-based options. As a result, the legislature enacted a number of policies to rebalance the long-

[1] Reshaping Long-Term Care in Minnesota: State of Minnesota Long-Term Care Task Force Final Report, January 2001. http://archive.leg.state.mn.us/docs/pre2003/other/010126.pdf.

term care system. This included new and increased state funding to expand the capacity of the community-based system and support the informal network of families, friends, and neighbors.

The state grant programs are aligned and coordinated with the services provided under the federal OAA. The OAA was passed by Congress in 1965 at the same time the Medicaid program, which began federal funding for nursing facility care, was established. The OAA's purpose was to assist elderly people to live as independently as possible and avoid premature institutionalization. Federal OAA funds in Minnesota are administered through the Minnesota Board on Aging to provide less formal, community-based services, including volunteer-based services. Federal funding for these programs and services has remained relatively static since 2002. During this same time period, the population of older persons in Minnesota has increased about 7%.

In 2003 state funding for most of these grants was reduced by 15%. However $125,000 per year was restored during the 2007 legislative session for the senior nutrition and volunteer grant programs. Since 2009, Aging and Adult Services grants have been impacted by reductions, unallotment, and/or one-month delays each year.

Key Activity Goals & Measures

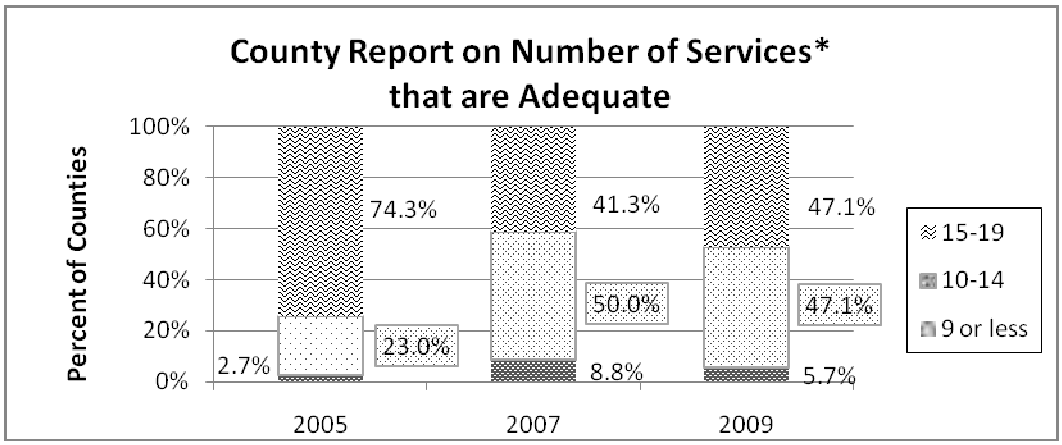
- Older Minnesotans will receive the long-term care services they need in their homes and communities, choose how they receive services, and have more options for using their personal resources to pay for long-term care. Funds in this grant area increase the availability of non-institutional service options for older persons and their families. Competitive grants promote evidence-based models that leverage local private funds and in-kind contributions to promote affordable services that are both dependable and sustainable. This goal is from Departmental Results (http://www.departmentresults.state.mn.us/hs/index.html).

Key activity measures include

- ***Percentage of Minnesota counties reporting adequate home and community-based services for rebalancing long-term care.*** "Rebalancing" refers to shifting services to home and community-based services from institutional care. In 2009, less than half of counties (47.1%) report that they have adequate capacity across 15 or more of their services. This is a slight improvement from 2007 (41.3%) but notably different from 2005, when nearly three-quarters of counties (74.3%) reported having adequate capacity across 15 or more of their services.

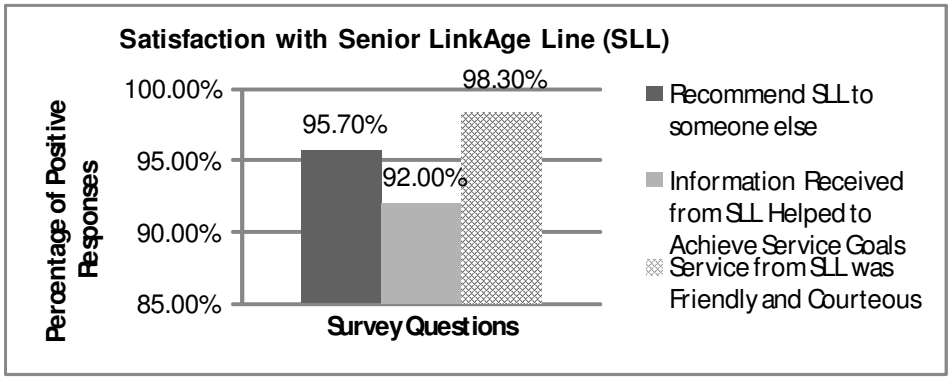
Year	Average Number of Services* with Adequate Capacity by County (out of 19 services)
2005	16
2007	14
2009	14

Data Source: 2005-2009 LTC Gaps Analysis Surveys of counties. Counties are surveyed every two years on any changes in capacity and current capacity across a variety of home and community-based services and housing options.

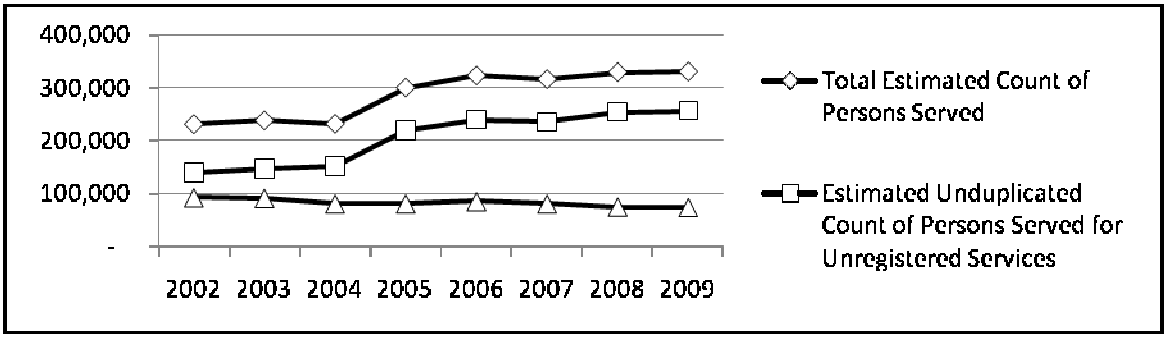


* Due to changes in the services included in each survey year, this analysis includes only the 19 services common across each service year: Adult Day Care, Adult Protection, Chore Service, Companion Service, End-of-life, Hospice, Palliative Care, Fiscal Support Entities (CDCS), Guardianship/Conservatorship, Home Delivered Meals, Home Health Aide, Home Modifications and Adaptations, Homemaker Service, Insurance Counseling/Forms Assistance, Long Term Care Consultation/Community Assessment, Non-County Case Management, Non-County Information/Referral and Assistance, Relocation Service Coordination, Respite Care, In Home, Skilled Home Nursing Care, and Transportation.

- **Level of consumer satisfaction with the Senior LinkAge® Line**



- **Number of people served by the Older American's Act Title III services (non-entitlement)**



A "registered service" requires a detailed client profile and is for more specified needs, such as personal care, homemaker, chore, home-delivered meals, adult day care, case management, assisted transportation (need an escort), congregate meals, and nutrition counseling. An "un-registered service" does not require a client profile and includes such services as transportation, information and referral, outreach, nutrition education, and legal assistance.

For more information on DHS performance measures, see http://www.accountability.state.mn.us/Departments/HumanServices/index.htm.

Activity Funding

Aging and Adult Services Grants is funded with appropriations from the General Fund and from federal funds.

Contact

For more information on these grants, contact Aging and Adult Services Division at (651) 431-2600.

Information on DHS programs is on the department's website: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: GRANT PROGRAMS
Activity: AGING & ADULT SERVICES GRANTS

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	9,899	10,175	10,175	10,175	20,350
Technical Adjustments					
Current Law Base Change			12,159	12,335	24,494
Subtotal - Forecast Base	9,899	10,175	22,334	22,510	44,844
Total	**9,899**	**10,175**	**22,334**	**22,510**	**44,844**
Expenditures by Fund					
Direct Appropriations					
General	10,518	10,795	22,334	22,510	44,844
Statutory Appropriations					
Miscellaneous Special Revenue	200	187	187	187	374
Federal	19,424	22,034	21,688	20,905	42,593
Federal Stimulus	1,573	287	208	0	208
Total	**31,715**	**33,303**	**44,417**	**43,602**	**88,019**
Expenditures by Category					
Other Operating Expenses	(3)	0	0	0	0
Payments To Individuals	0	377	482	168	650
Local Assistance	31,718	32,926	43,935	43,434	87,369
Total	**31,715**	**33,303**	**44,417**	**43,602**	**88,019**

Activity at a Glance

- 22,000 people receive services in FY 2009.
- 20 programs funded in FY 2009.
- Specialized services that allow some of the most vulnerable Minnesotans, including those who are deafblind and those who have hearing loss and are seriously mentally ill, to live in their communities.

Activity Description

Deaf and Hard of Hearing Grants provides statewide services that enable at-risk Minnesotans who are deaf, deafblind, or hard of hearing to gain and maintain the ability to live independently and participate in their families and communities.

Population Served

Deaf and Hard of Hearing Grants serves

- children and adults who are deafblind;
- children who are deaf, deafblind, or hard of hearing and have emotional/behavioral disorders;
- adults who are deaf, deafblind, or hard of hearing and have mental illness;
- families with children who are deaf and learning American Sign Language;
- individuals with hearing loss who rely on captioning to access live news programming; and
- individuals with hearing loss who use sign language interpreting services.

Services Provided

Sign language interpreter referral and interpreter-related services allow deaf, hard of hearing, and deafblind Minnesotans to access core services such as courts, medical care, mental health services, law enforcement, and educational programs. Services include coordination and placement of qualified sign language, oral, cued-speech, and emergency on-call interpreters; interpreting services for chemical health support groups; and advocacy for communication access in emergency situations.

Deafblind grants support adults who are both deaf and blind so they can live independently and stay in their own homes. These grants also provide services to deafblind children and their families that result in enhanced communication skills and community integration and that teach siblings and parents the skills needed to support the deafblind child within the family. Supports include one-to-one services and assistive technology.

Specialized mental health services assist children, youth, and adults who are deaf, hard of hearing, or deafblind and who have emotional and behavioral disorders or mental illness. Grants provide linguistically and culturally appropriate services including home-based outreach supports, a drop-in center, inpatient therapy, outpatient therapy, family counseling, and educational opportunities for families, schools, and mental health providers.

Mentor services are provided to families that have children with hearing loss who choose to use American Sign Language (ASL) for family communication. Mentors teach ASL to parents and family members, help parents learn about deaf culture, introduce families to local deaf community members, and serve as role models for the child who is deaf.

Real-time television captioning grants allow deaf, deafblind, and hard of hearing consumers in greater Minnesota access to live local news programming from some public and commercial television stations. Access to information is a key factor in reducing isolation and promoting community involvement for individuals with hearing loss.

Historical Perspective

Minnesota has long recognized that the ability to meet one's basic needs and be safe can easily be put at risk when a person has a hearing loss. Hearing loss is isolating because it impacts a person's ability to communicate with others – family, neighbors, friends, and service providers. It also has a detrimental effect on the 'information storehouse' each of us develops over our lifetime because it impedes the ability for direct learning such as participating in a classroom, listening to the radio or television, taking online courses, etc. More importantly, it impedes indirect learning. A compounding factor is the age at which an individual loses their hearing. If a person is born with a significant hearing loss or develops a hearing loss prior to the development of spoken language, the natural process for developing language (listening and imitating sounds) is compromised. This means that English must be intentionally taught because it can no longer be acquired simply by being exposed to it.

Since the early 1980s, Minnesota has had a system of supports for individuals who are deaf, deafblind, and hard of hearing. Services have evolved over time and now focus on the segment of the population that continues to be vulnerable because of the compounding effects of hearing loss, especially when coupled with other disabilities.

The Deaf and Hard of Hearing grants support a network of services for the most vulnerable Minnesotans with hearing loss. Some of these are adults who are at risk for institutionalization because their hearing loss complicates the treatment and service options for their other disabilities (mental health issues, blindness). Some of these are children who are at risk for delayed language and social/emotional development. Others are individuals who live in more remote areas of the state where local services that are designed to accommodate hearing loss are sparse or non-existent.

These grants are administered within DHS by the Deaf and Hard of Hearing Services (DHHS) Division. The division offers a network of services, including regional offices throughout Minnesota, to assist vulnerable individuals who are deaf, deafblind, or hard of hearing as they try to gain access to services and to provide resources and information to families and service providers. The DHHS regional offices now also house the DHHS mental health program, which evolved following the closing of the Deaf Services unit at St. Peter Regional Treatment Center. The Telephone Equipment Distribution (TED) program, funded by the Telecommunications Access Fund in the Department of Commerce, also operates out of the DHHS regional offices. TED provides adaptive telephone equipment to people with a hearing loss or speech or mobility disabilities who meet eligibility criteria and need such equipment to access telecommunications services.

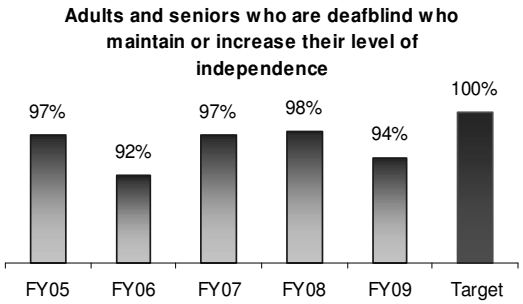
In 1985 the Minnesota Legislature created the Minnesota Commission Serving Deaf and Hard of Hearing (MCDHH), now called the Commission of Deaf, Deafblind and Hard of Hearing Minnesotans. The primary focus of this commission is to advocate for equal opportunity for Minnesotans who are deaf, hard of hearing, and deafblind. Unlike the Deaf and Hard of Hearing Services regional offices and grant programs that offer direct services to consumers, the MCDHH's purpose is to convene stakeholders; identify barriers that prevent success and access to services; propose policy and program solutions; and make recommendations to the governor, legislature, and state departments. MCDHH is a fifteen-member, governor-appointed board supported by department staff.

Key Activity Goals & Measures

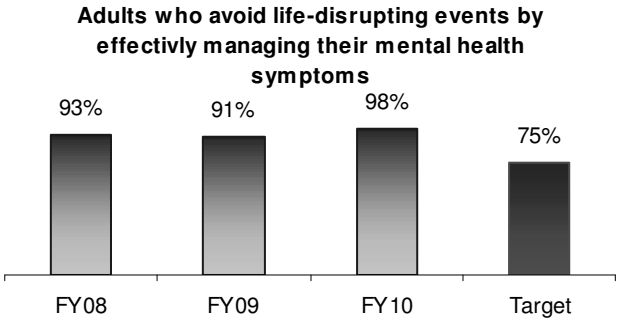
- ***People in need will receive support that helps them live as independently as they can.*** This goal is from *Minnesota Milestones* (http://server.admin.state.mn.us/mm/goal.html).
- ***Improve outcomes for the most at-risk children.*** This goal is from *DHS Priorities 2010* (http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-5267-ENG).
- ***To support and enhance quality of life for older people and people with disabilities.*** This goal is from the *DHS Continuing Care Strategic Plan.*

Key measures are

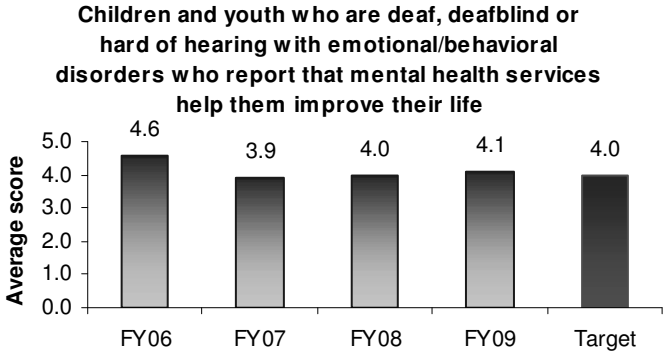
- ***Adults and senior citizens who are deafblind maintain or increase their level of independence;*** Adults and older individuals who have hearing loss and an additional disability of vision loss need supports in order to conduct routine daily activities, access information, and communicate with others; with the right supports at the right time, individuals who are deafblind are able to live independently and integrate into their communities.



- ***Adults who are deaf, deafblind, or hard of hearing and have a psychiatric disorder who avoid life-disrupting events by effectively managing their mental health symptoms -*** Individuals with psychiatric conditions and disorders that disrupt their thinking, emotions, mood, ability to relate to others, and overall daily functioning are at-risk for experiencing life-disrupting events. These are events that result in serious injury, loss of housing or employment, commitment, hospitalization, and/or encounters with law enforcement. When an individual with a psychiatric condition also has a significant hearing loss, his or her ability to avoid these life-disrupting events may be diminished even more unless the person has access to the right supports at the right time. Research has shown that, for individuals who are deaf and use American Sign Language (ASL), the delivery of direct mental health services requires clinicians to be fluent in ASL and trained in the delivery of culturally and linguistically affirmative services in addition to mental health expertise.



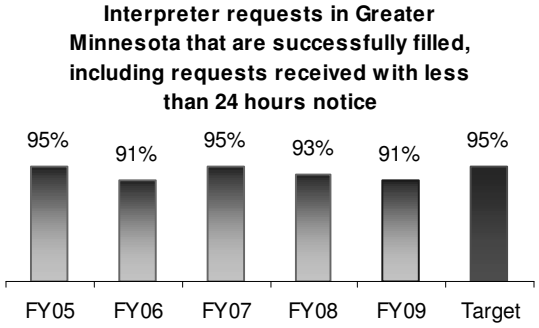
- **Children and youth who are deaf or hard of hearing and have emotional or behavioral disorders report that specialized mental health services help them improve their lives -** Young people with significant hearing loss face barriers in communication, in gaining access to information, and in learning social norms. Emotional and behavioral issues compound the individual's ability to function successfully in society. Appropriate therapy requires therapists who are fluent in American Sign Language and trained in the delivery of mental health services to people who are deaf or hard of hearing.



Average of responses to the statement: "My therapist helps me improve my life"
5 = Strongly agree, 4 = Agree, 3 = Neutral, 2 = Disagree, 1 = Strongly disagree

- **Requests for sign language interpreter services in greater Minnesota that are successfully filled, including emergency requests received with less than 24 hours notice** - Interpreting services are critical for people who are deaf to be able to live independently, be self-sufficient, and access core services. Because of the vast geographic area of greater Minnesota and the relatively short supply of qualified interpreters, state grant funding supplements a referral service to ensure that interpreting services are available. The challenge

in meeting the target percentage is related to finding interpreters for last minute emergency requests. Historically, the target has been consistently met for non-emergency requests.



For more information on DHS performance measures, see http://www.accountability.state.mn.us/Departments/HumanServices/index.htm.

Activity Funding

Deaf & Hard of Hearing Grants for sign language interpreter referral and development, deafblind, specialized mental health services, and mentor services are 100% state funded with appropriations from the general fund.

Television captioning grants are 100% state funded by special revenue through the Telecommunications Access Minnesota (TAM) fund. TAM is administered by the Department of Commerce; grant dollars come to DHS through an interagency agreement.

Contact

For more information on these grants, contact the Deaf and Hard of Hearing Services Division at (651) 431-2355. Information on DHS programs is on the department's website: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: GRANT PROGRAMS
Activity: DEAF & HARD OF HEARING GRANTS

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	1,930	1,748	1,748	1,748	3,496
Technical Adjustments					
Approved Transfer Between Appr			(150)	(150)	(300)
Current Law Base Change			338	169	507
Subtotal - Forecast Base	1,930	1,748	1,936	1,767	3,703
Total	**1,930**	**1,748**	**1,936**	**1,767**	**3,703**
Expenditures by Fund					
Direct Appropriations					
General	1,821	1,609	1,936	1,767	3,703
Statutory Appropriations					
Miscellaneous Special Revenue	197	264	240	240	480
Total	**2,018**	**1,873**	**2,176**	**2,007**	**4,183**
Expenditures by Category					
Other Operating Expenses	0	24	0	0	0
Local Assistance	2,018	1,849	2,176	2,007	4,183
Total	**2,018**	**1,873**	**2,176**	**2,007**	**4,183**

Activity at a Glance

- The FSG program serves 1,800 children at an annual average cost of $2,300 per child (CY 2008 data).
- The CSG program serves 1,200 individuals at a monthly average cost of $1,100 per recipient.
- SILS serves 1,500 adults with disabilities at an annual average cost of $5,600 per recipient (CY 2008 data).
- HIV/AIDS programs help 1,700 people living with HIV/AIDS pay for HIV-related prescription drugs, insurance costs, dental, nutritional, mental health, case management, and other support services. The program serves over 25% of the people with known HIV infection in Minnesota.
- DLL had 32,200 contacts, served 15,700 people, and participated in 200 outreach and education events in FY 2010.
- Region 10QA provides alternative quality-based licensing of DD waiver programs in two SE Minnesota counties and offers person-centered service quality assessments throughout the region.
- Housing Access Services helped 70 people relocate in FY 2010.
- Advocating Change Together received $127,000 in FY 2010 to develop a self-advocacy network.

Activity Description

Disabilities Grants includes a variety of programs to provide community service options for individuals with disabilities, to provide support to lead agencies, and to develop and maintain a system-wide infrastructure.

Population Served

The target population for each of the programs varies:

- Family Support Grant (FSG) serves families whose annual adjusted gross income is less than $88,170 and who have a child with a certified disability.
- Consumer Support Grant (CSG) is available for people who are eligible for MA as an alternative to home care.
- Semi-Independent Living Services (SILS) serves people who are at least 18 years old, have a developmental disability, require a level of support that is not at a level that would put them at risk of institutionalization, and require systematic instruction or assistance to manage activities of daily living.
- HIV/AIDS programs serve people living with HIV/AIDS who have incomes under 300% of the federal poverty guideline (FPG) and cash assets under $25,000.
- Housing Access Services provides assistance to people who qualify for waiver or home care services and want to move out of a licensed setting or family home into their own home.
- Advocating Change Together works to establish a statewide self-advocacy network for adults with disabilities.
- Alternatives to corporate foster care grants are available to provide options to support individuals with disabilities in their own homes through the use of technology.
- Technology grants for the support of the comprehensive assessment will be made available to lead agencies, including counties, tribes, and health plans.
- Minnesota Disability Health Options (MnDHO) transition grants will be available to counties to assist individuals transitioning from MnDHO to Medicaid fee-for-service
- Disability Linkage Line (DLL) serves people with disabilities and chronic illnesses and their families, caregivers, or service providers. No caller is turned away from receiving information from DLL.
- Region 10 Quality Assurance alternative licensing serves people who live in Fillmore and Olmsted counties and receive services through the state's Developmental Disabilities (DD) Medicaid waiver program. Region 10 QA also makes its person-centered assessments of service quality available to individuals with all disabilities throughout southeastern Minnesota.

Services Provided

- FSG provides cash to families to offset the higher-than-average cost of raising a child with a certified disability. The maximum grant per family is $3,060 per year per eligible child. Allowable expenses include computers, day care, educational services, medical services, respite care, specialized clothing, special dietary needs, special equipment, and transportation.
- CSG helps families purchase home care, adaptive aids, home modifications, respite care, and other assistance with the tasks of daily living. Recipients receive a grant amount less than or equal to the state share of the amount of certain home care services they would receive under Medical Assistance (MA).

- SILS is used by adults with developmental disabilities to purchase instruction or assistance with nutrition education, meal planning and preparation, shopping, first aid, money management, personal care and hygiene, self-administration of medications, use of emergency resources, social skill development, home maintenance and upkeep, and transportation skills.
- HIV/AIDS programs assist enrollees with premiums to maintain private insurance, co-payments for HIV-related medications, mental health services, dental services, nutritional supplements, and case management.
- Housing Access Services provides a grant to a non-profit organization to help individuals move out of licensed settings or family homes into their own homes.
- DLL provides one-to-one assistance to help people learn about their options and connect with the supports and services they choose. Inquiries include requests for information and referrals on disability benefits programs, employment, home modifications, assistive technology, personal assistance services, transitional services, accessible housing, social activities, and disability rights.
- Region 10 QA combines traditional compliance-based provider reviews with VOICE, an innovative, person-centered assessment of the value and quality of services received and experienced by individuals with disabilities. Through active inclusion in this process, people with disabilities and their communities benefit by participating in local guidance and oversight of quality improvement efforts undertaken by service providers and participating counties.

Historical Perspective

Beginning in 1983 with SILS and FSG, Minnesota established programs that emphasize self reliance, personal responsibility, and consumer direction for people with disabilities. In 1995, Minnesota took another step by offering the CSG program, which lets people choose to access the state share of MA funds through a cash and counseling model. These programs have laid the ground work for the consumer-directed options now available across all Minnesota long-term care waivers.

The HIV/AIDS program began in 1987 with the desire to keep private insurance policies in place for people living with HIV/AIDS and at the same time provide access to a limited scope of additionally needed services and products. Need for the program continues to climb as the number of people living with HIV in Minnesota increases.

To make access to services more streamlined at the state level, responsibility for case management of services to people with HIV was consolidated at the Department of Human Services (DHS) in 2001. In 2004, in response to increasing budget pressures, the HIV/AIDS program implemented a cost-sharing requirement for individuals enrolled in the program. By May 2006, more than 450 individuals were assessed a cost share, with only eight people being deemed programmatically ineligible due to failure to pay. A tightening of policies, staff commitment, and client follow-through have supported the cost-sharing strategies in bringing fiscal balance to the program through FY 2008. On 12-1-07, cost share was suspended due to a funding increase from the federal Ryan White HIV/AIDS Treatment Modernization Act of 2006. The suspension is temporary and cost sharing may be resumed when necessary.

In 2001 DHS' Disability Services Division conducted a planning initiative to assess what changes were needed in Minnesota to better support community living for people with disabilities. Feedback from all participant groups was that a major redesign of the information system for people with disabilities was needed. Because the information system was fragmented, consumers were not aware of their options, could not make informed decisions, and were at greater risk of ending up in institutional settings. In response, Disability Linkage Line was created to build a statewide network and call center for all disability-related questions. Pilot services were launched in the summer of 2004. DLL services were expanded statewide in the spring of 2005.

In 1995, stakeholders from the 11 counties in southeastern Minnesota (Region 10) held a meeting to discuss the service system for persons with disabilities. A priority for the stakeholders was to assure the quality of services to persons with disabilities despite whatever changes were made at the state or federal level. The stakeholders worked with state lawmakers to develop and pass legislation that allows counties to participate in an alternative QA licensing system that focuses on quality and value-based outcomes of service providers versus minimal

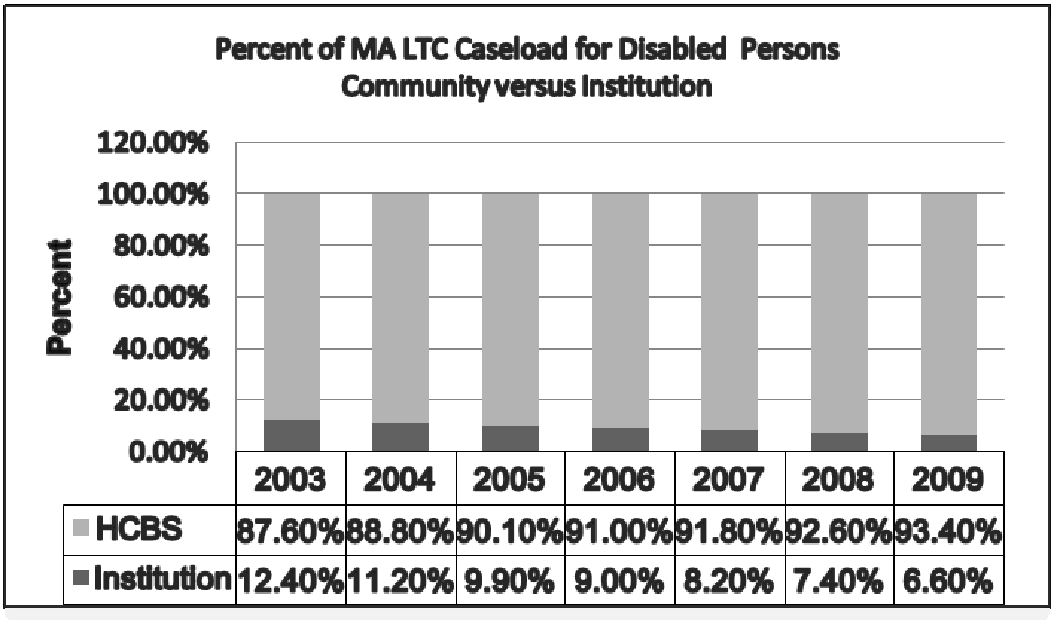
licensing requirements. A Region 10 QA Commission, composed of members drawn from the community of stakeholders, was established to oversee the development and ongoing implementation of this QA system. In 1997, Region 10 QA received approval from DHS to implement an alternative set of quality assurance standards and related licensing procedures that replaced current compliance-based rules and regulations for licensed providers supporting people with developmental disabilities. Funding for the Region 10 QA Commission was eliminated by the 2009 legislature and a portion of the funding was reinstated by the 2010 legislature. Currently, two of the eleven Region 10 counties are participating in the formal alternative licensing process.

During the 2008 session, the Minnesota legislature provided funding and directed the commissioner of human services to create housing access services to support eligible people with disabilities who seek to live in their own homes using state plan home care services or long term care waiver services.

Key Activity Goals & Measures

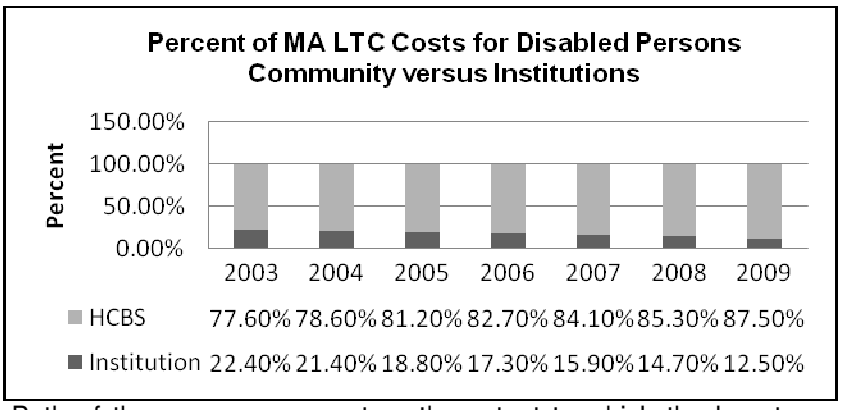
- ***The Continuing Care Administration strives to improve the dignity, health, and independence of the people it serves.*** By doing so, Minnesotans will live as independently as possible; enjoy health, with access to quality health care; have safe, affordable places to live; be contributing and valued members of their communities; and participate in rewarding daily activities, including gainful employment. This goal is derived from the DHS Continuing Care Administration's mission and vision.
- ***Support and enhance the quality of life for people with disabilities.*** Minnesota's long-term care service programs support people with disabilities who do not have the resources to meet their own needs. These supports keep people safe and healthy so they can have a good quality of life and live with dignity. This goal is from the DHS Continuing Care Administration Strategic Plan.

- *Percentage of people with disabilities receiving publicly-funded long-term care who live in the community versus institutional settings.*



	2003	2004	2005	2006	2007	2008	2009
HCBS	87.60%	88.80%	90.10%	91.00%	91.80%	92.60%	93.40%
Institution	12.40%	11.20%	9.90%	9.00%	8.20%	7.40%	6.60%

- Percentage of public long-term care dollars expended in community versus institutional settings for people with disabilities.



Both of these measures capture the extent to which the long-term care system is able to support people with disabilities in the community and allow them to live independently.

For more information on DHS performance measures, see http://www.accountability.state.mn.us/Departments/HumanServices/index.htm.

Activity Funding

Disabilities Grants is funded with appropriations from the General Fund and from federal funds.

Contact

For more information on Disabilities Grants, contact the Disabilities Services Division, (651) 431-2400.

Information on DHS programs is on the department's website: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: GRANT PROGRAMS
Activity: DISABILITIES GRANTS

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	19,201	14,427	14,427	14,427	28,854
Technical Adjustments					
Current Law Base Change			7,154	8,992	16,146
Transfers Between Agencies			119	119	238
Subtotal - Forecast Base	19,201	14,427	21,700	23,538	45,238
Total	**19,201**	**14,427**	**21,700**	**23,538**	**45,238**
Expenditures by Fund					
Direct Appropriations					
General	30,704	29,734	21,700	23,538	45,238
Statutory Appropriations					
Miscellaneous Special Revenue	3,343	7,564	6,460	6,350	12,810
Federal	7,645	10,150	8,258	6,589	14,847
Total	**41,692**	**47,448**	**36,418**	**36,477**	**72,895**
Expenditures by Category					
Other Operating Expenses	663	372	560	559	1,119
Payments To Individuals	7,928	14,815	19,083	21,216	40,299
Local Assistance	33,101	32,261	16,775	14,702	31,477
Total	**41,692**	**47,448**	**36,418**	**36,477**	**72,895**

Activity at a Glance

- Provides mental health case management to 22,600 adults annually.
- Provides community support services to 21,300 people annually.
- Provides residential treatment to 2,200 people annually.
- Provides Assertive Community Treatment (ACT) to 2,300 people annually.
- Provides crisis services to 5,900 people and crisis housing to 2,300 people annually.
- Provides compulsive gambling treatment to 1,000 people annually.

Activity Description

Adult Mental Health Grants serves Minnesotans with mental illness, spurs development of non-institutional treatment options, and pays for mental health services for people when they cannot afford to pay. This activity supports the overall objective of promoting assistance for people to live independently, when possible, and, when not, to live in treatment settings that are clean, safe, caring, and effective. These grants are used in conjunction with other funding, particularly Medical Assistance (MA) and Group Residential Housing (GRH).

Population Served

Approximately 211,000 Minnesota adults have a serious mental illness (SMI) such as schizophrenia, major depression, and bipolar disorder. Of that total, 75% (158,000) are estimated to be in the public mental health system. This compares to about 55,000 people who actually received these services in FY 2009 (based on county reports to the Community Mental Health Reporting System).

These grants primarily serve adults with serious mental illness. (This definition does not include people with developmental disabilities or chemical dependency unless these conditions co-exist with mental illness.) This grant area includes a few grants that serve both adults and children. (Grants that only serve children are in the Children's Mental Health Grants budget activity.)

Services Provided

Mental Health Grants support a variety of services.

- *Adult Mental Health Initiative/Integrated Fund* supports the continued availability of community-based services and alternative service delivery models to reduce reliance on facility-based care. Integration of grants at the county level allows administration to be more effective and efficient. During the past year, all Adult Mental Health Initiatives (serving 87 counties) have received additional *Crisis Services Grants* to continue to build capacity for mobile crisis teams and crisis stabilization services and to provide ongoing funding for crisis services for individuals who are underinsured or uninsured.
- *Grants for Community Support Services for Adults with Serious and Persistent Mental Illness (Adult Rule 78)* are distributed to counties for client outreach, medication monitoring, independent living skills development, employability skills development, psychosocial rehabilitation, day treatment, and case management if Medicaid is inadequate or not available. These funds are allocated by formula, primarily based on a county's population and are used primarily to provide these services to eligible individuals who are uninsured or underinsured.
- *Adult Residential Grants (Rule 12)* pay the non-federal share of the program component of intensive residential treatment facilities for people with mental illness. These grants are now fully integrated into the adult mental health initiative/integrated fund.
- *Crisis Housing* provides financial help when people are hospitalized and need help to maintain their current housing. Eligible people need to be in inpatient care for up to 90 days and have no other source of income to pay housing costs.
- *Regional Treatment Center (RTC) Alternatives* pays for extended inpatient psychiatric services ("contract beds") in community hospitals for people who are committed or who would be committed if these community services were not available. This is part of a package of expanded community mental health services for the area formerly served by non-metro RTCs.
- *Federal Mental Health Block Grant* funds are used to demonstrate innovative approaches based on best practices that, based on evaluation results, could be implemented statewide. Minnesota has allocated about half of the federal block grant for children's mental health. At least 25% is used for Indian mental health services, not more than 15% for planning and evaluation, and not more than 5% for statewide administration.

Grants provided for Indian mental health services fund nine projects on reservations and two in the metro area. In addition, the federal block grant has been used to provide education and information to both families who have a relative with mental illness and to the general public to reduce stigma, to promote the establishment and operation of a state-wide mental health consumer organization, and to increase the effectiveness of Local Advisory Councils who provide input to county boards across the state.

- *Projects for Assistance with Transition for the Homeless (PATH)* funds, from the federal McKinney Act, are provided to counties to address mental illness among the homeless. Grants to counties are made in combination with Rule 78 Community Support Program funds.
- *Mental Health Infrastructure Grants* are provided to counties and non-profit providers to develop housing with support services, culturally-competent services, provider skills, implementation and capacity to use evidence-based and research-informed practices in direct service, and capacity building for individuals with serious mental illness who have served in jails or who interface with law enforcement.
- *Compulsive Gambling Treatment and Education* funds inpatient and outpatient treatment programs on an individual client, fee-for-service basis. The program also pays for research, public education and awareness efforts, in-service training for treatment providers, and a statewide toll-free, 24-hour helpline.

Historical Perspective

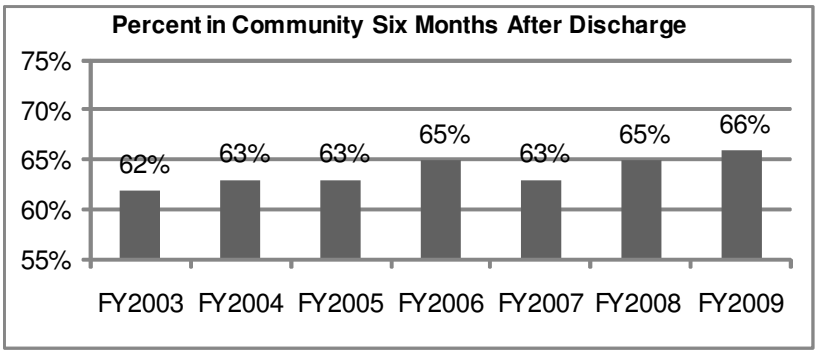
Federal restrictions that prohibit the use of Medicaid for adults in Institutions for Mental Diseases (IMDs)1 have required the state to rely on state General Fund grant programs to a much larger degree than programs serving other populations, such as the elderly or developmentally disabled. During the past several years, Minnesota has made progress in expanding the range of non-residential community mental health services and maximizing federal reimbursement for these services. Intensive Residential Treatment, Crisis Response Services, Adult Rehabilitative Mental Health Services, Assertive Community Treatment, Certified Peer Specialists, and Intensive Outpatient for Dialectical Behavior Therapy have been added as benefits under the Medicaid program. These services are intended to assist with reducing reliance on more costly institutional care.

Over 80% of the funds in this activity are used by counties to pay for staff providing direct services to adults with serious mental illness.

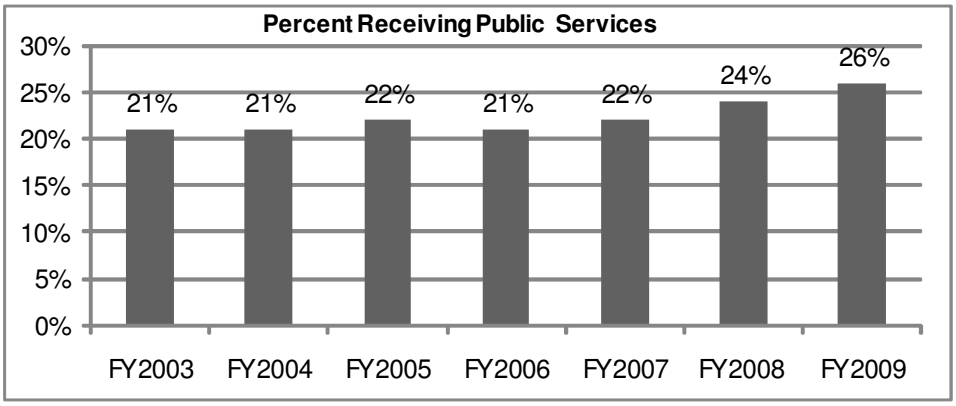
Key Activity Goals & Measures

- ***Develop effective and accountable mental health and chemical health systems.*** The Department of Human Services (DHS) is implementing steps to support research-informed practices in chemical and mental health services, systematically monitor outcomes, and integrate chemical, mental, and physical health systems. This goal is from the Department of Human Services' *Priority Plans* (http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4694-ENG).
  - Percent of adults with serious mental illness who remained in the community six months after discharge from an inpatient psychiatric setting. This measure gives an indication of the effectiveness of the community-based system to provide the range of services that allow individuals to be as independent as possible in the community.

[1] Institution for Mental Diseases (IMD) is a classification under Medicaid that denotes a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases.



- ***Percent of adults with serious mental illness who are receiving public mental health services.*** This indicator, which is often referred to as the "penetration rate," measures access to needed services.



For more information on DHS performance measures, see http://www.accountability.state.mn.us/Departments/HumanServices/index.htm.

Activity Funding

Adult Mental Health Grants is funded with appropriations from the General Fund, lottery fund, and special revenue fund, as well as from federal funds.

Contact

For further information about Mental Health Grants, please contact Chemical and Mental Health Services, (651) 431-2240.

Information on DHS programs is on the department's website: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: GRANT PROGRAMS
Activity: ADULT MENTAL HEALTH GRANTS

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	72,539	69,835	69,535	69,535	139,070
Technical Adjustments					
Current Law Base Change			8,004	8,004	16,008
Subtotal - Forecast Base	72,539	69,835	77,539	77,539	155,078
Total	**72,539**	**69,835**	**77,539**	**77,539**	**155,078**
Health Care Access					
Current Appropriation	750	750	750	750	1,500
Subtotal - Forecast Base	750	750	750	750	1,500
Total	**750**	**750**	**750**	**750**	**1,500**
Lottery Cash Flow					
Current Appropriation	1,428	1,429	1,429	1,429	2,858
Technical Adjustments					
Current Law Base Change			79	79	158
Subtotal - Forecast Base	1,428	1,429	1,508	1,508	3,016
Total	**1,428**	**1,429**	**1,508**	**1,508**	**3,016**
Expenditures by Fund					
Direct Appropriations					
General	71,160	71,643	77,539	77,539	155,078
Health Care Access	750	750	750	750	1,500
Lottery Cash Flow	1,427	1,430	1,508	1,508	3,016
Statutory Appropriations					
Miscellaneous Special Revenue	231	251	340	340	680
Federal	4,888	8,964	5,716	5,716	11,432
Total	**78,456**	**83,038**	**85,853**	**85,853**	**171,706**
Expenditures by Category					
Other Operating Expenses	1,422	568	400	400	800
Local Assistance	77,034	82,470	85,453	85,453	170,906
Total	**78,456**	**83,038**	**85,853**	**85,853**	**171,706**

Activity at a Glance

In FY 2008:
- 10,000 children in the child welfare and juvenile justice systems received mental health screenings
- 10,000 children received case management services

Activity Description

Children's Mental Health Grants funds statewide community-based mental health services.

Population Served

Children's Mental Health Grants funds treatment services for children, from birth to age 21, who have psychiatric diagnoses and need mental health services.

Services Provided

Children's Mental Health Grants fund development of local service delivery capacity, specifically targeting Minnesota children with diagnosed mental illness and young children showing problems with healthy mental development. Resources are targeted strategically to enhance statewide capacity to identify mental health problems at the earliest possible stage, expand access to scientifically-supported treatment in normal childhood environments, measure the success of treatment, and support families through the extraordinary stresses of raising challenging children.

Children's Mental Health Grants funds community, school, and home-based children's mental health services provided by non-profit agencies, schools, Medicaid-enrolled mental health clinics, tribes, counties, and culturally-specific agencies. While the public mental health system is responsible for the full continuum of children's mental health treatment interventions and ancillary services, grants cover treatment services for children who are un-insured or whose family insurance does not cover necessary mental health services. Additionally, grants fund coordination of physical healthcare and developmental disabilities services and build community alternatives to inpatient hospitalization and residential treatment.

Children's Mental Health Grants funds the following activities
- school-based and school-linked mental health infrastructure development statewide;
- early childhood mental illness identification and intervention in multiple settings, including primary care, pre-school, child care/Head Start, and homes;
- evidence-based practices development, implementation, and measurement;
- crisis intervention infrastructure statewide;
- respite care service capacity statewide;
- culturally-specific provider growth and cultural minority families' access enhancement;
- mental health screening for children and adolescents in the child welfare and juvenile justice systems; and
- children's mental health case management statewide.

Historical Perspective

Medical science has evolved rapidly in understanding the causes and treatment of mental illness. This has changed the focus of the state's children's mental health care system in recent years. Focus has evolved from reducing aberrant behavior and offering a life-time of social and functional supports intended to help children and families merely cope with mental illness. It has moved, instead, to ameliorate mental illness: to improving access to the most effective treatments, to finding and intervening earlier when treatment is most effective, and to improving quality by measuring results so as to determine the most effective treatment for each combination of diagnosis and demographic characteristics. Effectiveness can be improved by insisting that mental health care is based on a thorough diagnosis of the illness and the preparation of an individualized treatment plan. Payment for mental health treatment requires qualification as a licensed mental health professional and more clinical training opportunities are being provided to these professionals.

State appropriations for children's mental health grants started with the passage of the Comprehensive Children's Mental Health Act in 1989, with a $3 million annual appropriation to support the development of family community support mental health case management services for children with severe emotional disturbance. This was augmented over the course of the 1990s with funds to expand on the availability of community-based children's mental health services as well as some more targeted grants:

- to support the development of regional children's mental health collaboratives;
- to continue services for children with severe emotional disturbance who had lost access to personal care services due to a tightening of eligibility criteria under the Medical Assistance program's TEFRA option, and;
- for services to children with severe emotional disturbance with histories of violent behavior.

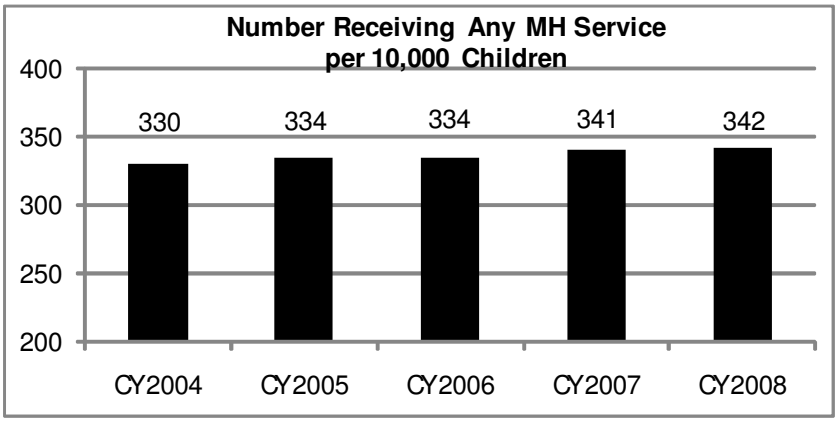
By 2002, dedicated state children's mental grants had grown to over $20 million annually. Beginning in state fiscal year 2004 dedicated state children's mental health grants were largely eliminated and the funding transferred into the Children and Community Services Block Grant, giving counties more discretion on the services provided and the populations served with the funds. Almost immediately, the need for dedicated children's mental health grant funds became apparent and was addressed through appropriations for the grant programs listed above in the previous section.

In the larger context, state children's mental health grants amount to about 12% of $198 million in annual public spending for children's mental health services, while county discretionary spending (27%) and Minnesota Health Care Programs (56%) are the two largest funding sources.

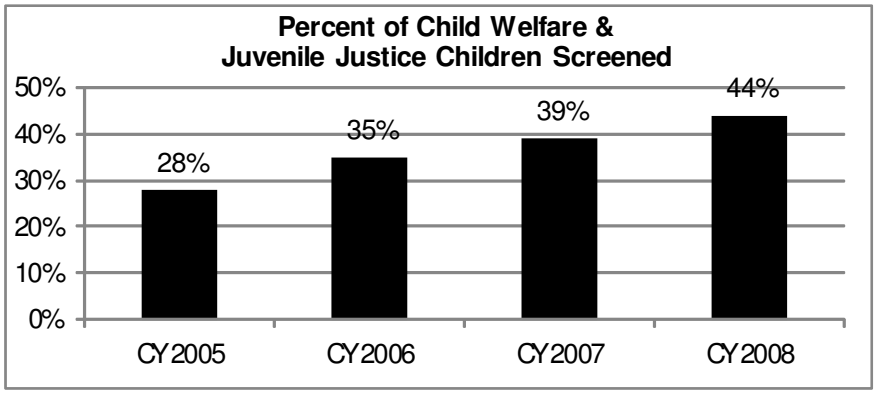
Key Activity Goals & Measures

- ***Develop effective and accountable mental health and chemical health systems***. The Department of Human Services is implementing steps to support research-informed practices in children's mental health service delivery, systematically monitor outcomes, and integrate chemical, mental, and physical health services. This goal is from the Department of Human Services' *Priority Plans* (http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4694-ENG).

  - ***Service Penetration Rate.*** One indicator of service utilization is to measure how deeply into the general population of Minnesota's children does the utilization of publicly-financed mental health services reach. By comparing this measure over a number of years, some indication is given as to whether use of mental health services is changing over time. By measuring service utilization per 10,000 children in the general population, year-to-year population shifts are taken out of consideration and use of services can be compared across years. This is not an indicator of need for services.



  - ***Percentage of children involved in the child welfare system who received a mental health screening.*** Since July 1, 2004, counties have been required to conduct mental health screenings for children in the child welfare and juvenile justice systems. With recent research showing that 70% of adolescents in juvenile justice placements have a diagnosable psychiatric illness, the juvenile corrections system has moved to identify those who need treatment. Children identified as being at risk of needing child protection services often have treatable psychiatric disorders that can be identified and treated through the state's screening grants.



For more information on DHS performance measures, see http://www.accountability.state.mn.us/Departments/HumanServices/index.htm.

Activity Funding

Children's Mental Health Grants is funded by appropriations from the General Fund.

Contact

For more information about this activity, contact Children's Mental Health, (651) 431-2321.
Information on DHS programs is on the department's website: http://www.dhs.state.mn.us

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	16,685	16,682	16,682	16,682	33,364
Subtotal - Forecast Base	16,685	16,682	16,682	16,682	33,364
Total	**16,685**	**16,682**	**16,682**	**16,682**	**33,364**
Expenditures by Fund					
Direct Appropriations					
General	17,761	17,504	16,682	16,682	33,364
Total	**17,761**	**17,504**	**16,682**	**16,682**	**33,364**
Expenditures by Category					
Other Operating Expenses	71	0	0	0	0
Local Assistance	17,690	17,504	16,682	16,682	33,364
Total	**17,761**	**17,504**	**16,682**	**16,682**	**33,364**

Activity at a Glance

- Provides prevention services to more than 29,500 youth each year.
- Provides intervention and case management services to 1,800 pregnant women and women with children annually.
- Provides intervention and case management services, including treatment supports and recovery maintenance, to an additional 7,000 individuals in special populations each year.
- Provides training for 2,700 chemical dependency professionals annually.

Activity Description

Chemical Dependency (CD) Non-Entitlement Grants pays for statewide prevention, intervention, treatment support, recovery maintenance, and case management services, including culturally appropriate services and support. A combination of state and federal dollars supports this activity.

Population Served

CD Non-Entitlement Grants serve

- people who receive prevention services with a focus on youth and families;
- individuals who receive intervention and case management services, including pregnant women, women with dependent children, and other special populations who receive intervention and case management services, and;
- chemical dependency treatment professionals and prevention specialists who receive training on best practices.

Services Provided

State-funded non-entitlement grants support

- community drug and alcohol abuse prevention for American Indians and
- treatment support and recovery maintenance services for American Indians.

Federally-funded non-entitlement grants support

- community drug and alcohol abuse prevention for communities of color;
- women's treatment supports including subsidized housing, transportation, child care, parenting education, and case management;
- intervention and case management services, including treatment supports and recovery maintenance services for the following special populations: elderly, disabled, individuals with dual diagnoses of mental illness and chemical dependency, individuals experiencing chronic homelessness, and people involved in the criminal justice system;
- a statewide prevention resource center that provides alcohol and other drug abuse education, information, and training to Minnesota counties, tribes, local communities, and organizations, and;
- annual inspection of tobacco retailers and law enforcement agency survey to measure the degree of compliance with state laws prohibiting the sale of tobacco products to youth.

Beginning in 2006, statewide prevention activities are delivered through a seven-region prevention system. Regional prevention coordinators in each region are responsible for assessing community needs and readiness for prevention activities. They are assisting the state in planning and implementing evidence-based prevention programs to reduce substance abuse and related problems through training, technical assistance, and coalition building.

Non-entitlement funds also support the dissemination of approximately 550,000 pieces of prevention material, over 300,000 Web hits to a contracted site on alcohol, tobacco, and other drug abuse prevention, 31,500 requests for information handled by prevention resource centers, over 1,200 pieces of alcohol, tobacco, and other drug prevention material translated into Spanish, Hmong, Lao, and Somali, and over 200 public service announcements developed and disseminated to over 2,000 outlets.

Historical Perspective

Over the last decade, as research studies indicated that the prevalence of substance abuse was higher for certain populations or that some groups did not succeed in chemical dependency treatment at the same rate as the general population, specific improvement efforts were established. These efforts were designed to build

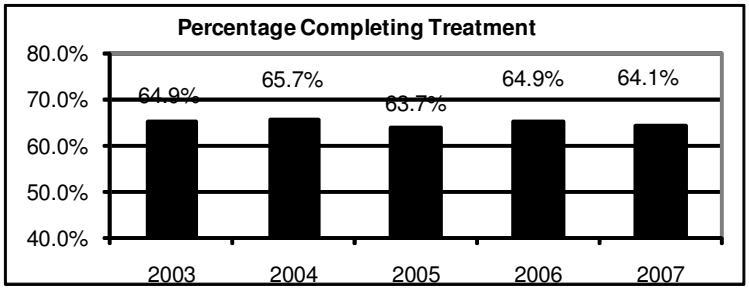
prevention strategies and treatment support services that focus on the unique strengths and needs of these various populations. The need for these specialized models of prevention and treatment has grown as counties and tribes recognize the role substance abuse plays in difficult Temporary Assistance to Needy Families and Child Welfare cases.

The CD Non-Entitlement Grants budget activity had historically funded Tier II and Tier III of the Consolidated Chemical Dependency Treatment Fund (CCDTF), providing treatment services for low-income individuals not eligible for entitlement-based treatment. Both Tier II and Tier III had operated on a sliding fee scale. The statutory authority for these tiers remains, but Tier II was last funded in 2003, and Tier III was last funded in 1990.

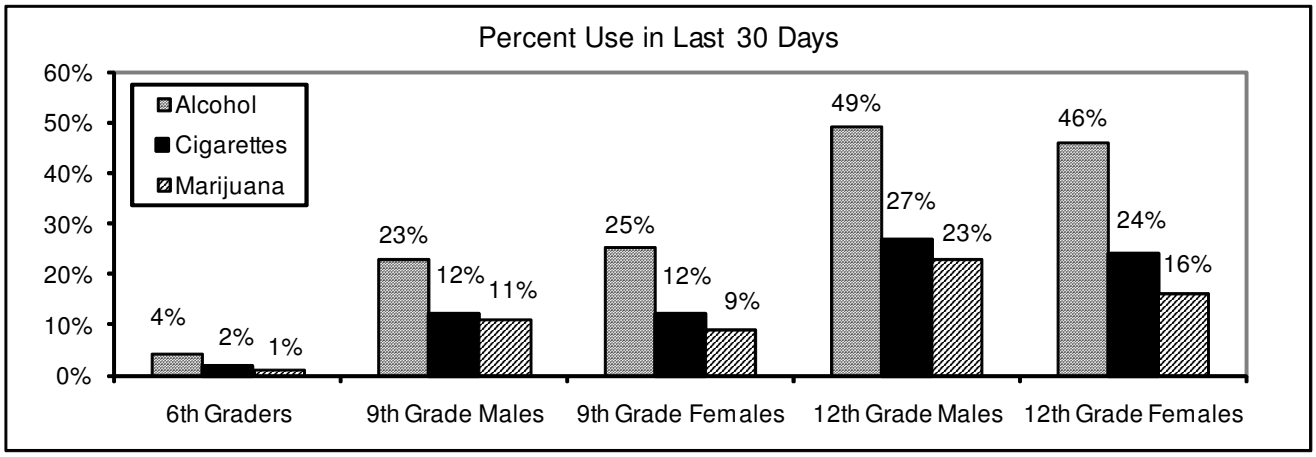
Key Program Goals and Measures

- ***Develop effective and accountable chemical health systems.*** The Department of Human Services (DHS) is implementing steps to support research-informed practices in chemical dependency treatment and prevention, systematically monitor outcomes, and integrate chemical, mental, and physical health services. This goal is from the Department of Human Services' *Priority Plans*, which is available on the web: http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4694-ENG.

  - ***Percentage of clients completing chemical dependency treatment.*** Treatment completion has been found to be a strong indicator of continued sobriety after treatment. The Minnesota Department of Human Services Drug and Alcohol Abuse Normative Evaluation System (DAANES) collects a number of data elements from all chemical dependency programs regardless of the admission's funding source. Below are completion results of all statewide treatment admissions in CY 2003-09:



  - ***Percentage of youth using alcohol, marijuana, and tobacco in the past 30 days.*** The Minnesota Student Survey is conducted every three years and was last administered in the spring of 2007 to public school students in Grades 6, 9, and 12. Of the 338 public operating districts, 309 (91%) agreed to participate. Student participation was voluntary and the survey was administered anonymously. Across the state, approximately 81% of public school sixth graders, 76% of public school ninth graders, and 58% of public school twelfth graders participated in the 2007 Minnesota Student Survey. Overall participation across the three grades was approximately 72%. Below are the results of the survey:



For more information on DHS performance measures, see http://www.accountability.state.mn.us/Departments/HumanServices/index.htm.

Activity Funding

Chemical Dependency Non-Entitlement Grants is funded with appropriations from the General Fund and from federal funds.

Contact

For more information on Chemical Dependency Non-Entitlement Grants, contact the Chemical Health Division, (651) 431-2460.

Information on DHS programs is available on the department's website: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: GRANT PROGRAMS
Activity: CD NON-ENTITLEMENT GRANTS

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	1,725	1,336	1,336	1,336	2,672
Subtotal - Forecast Base	1,725	1,336	1,336	1,336	2,672
Total	**1,725**	**1,336**	**1,336**	**1,336**	**2,672**
Expenditures by Fund					
Direct Appropriations					
General	1,378	1,336	1,336	1,336	2,672
Statutory Appropriations					
Miscellaneous Special Revenue	1,804	1,412	1,400	1,400	2,800
Federal	14,013	19,023	14,436	14,435	28,871
Total	**17,195**	**21,771**	**17,172**	**17,171**	**34,343**
Expenditures by Category					
Other Operating Expenses	423	121	131	130	261
Payments To Individuals	1,643	1,400	1,400	1,400	2,800
Local Assistance	15,129	20,250	15,641	15,641	31,282
Total	**17,195**	**21,771**	**17,172**	**17,171**	**34,343**

Program Description

The purpose of the State Operated Services (SOS) program is to provide direct care treatment and support services to persons with mental illness, chemical addiction, and neurocognitive disabilities. Services for these individuals are provided by the department at a variety of community and campus-based programs and residences located throughout Minnesota.

State Operated Services also provides treatment services to persons committed by the courts as mentally ill and dangerous as a set of forensic services based in St. Peter.

Laws of Minnesota 2010, First Special Session, Chapter 1, Article 19, Section 4, directs the Chemical and Mental Health Services (CMHS) Transformation Advisory Task Force to make recommendations to the commissioner of human services and the legislature on the continuum of services needed to provide individuals with complex conditions including mental illness, chemical dependency, traumatic brain injury, and developmental disabilities access to quality care and the appropriate level of care across the state to promote wellness, reduce cost, and improve efficiency. The work of this task force is to be completed by 12-15-10.

Budget Activities

- SOS Mental Health
- Enterprise Services
- Minnesota Security Hospital

HUMAN SERVICES DEPT

Program: STATE OPERATED SERVICES

Program Summary

Dollars in Thousands

	Current		Governor Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	106,510	193,236	193,236	193,236	386,472
Technical Adjustments					
Approved Transfer Between Appr			2,500	2,500	5,000
Current Law Base Change			(8,198)	(8,306)	(16,504)
Subtotal - Forecast Base	106,510	193,236	187,538	187,430	374,968
Total	**106,510**	**193,236**	**187,538**	**187,430**	**374,968**
Federal Stimulus					
Current Appropriation	83,515	0	0	0	0
Subtotal - Forecast Base	83,515	0	0	0	0
Total	**83,515**	**0**	**0**	**0**	**0**
Expenditures by Fund					
Direct Appropriations					
General	96,799	198,026	187,538	187,430	374,968
Federal Stimulus	83,504	1	0	0	0
Statutory Appropriations					
Miscellaneous Special Revenue	15,689	15,818	15,461	15,212	30,673
Miscellaneous Agency	1,705	1,650	1,650	1,650	3,300
Gift	4	13	10	8	18
Revenue Based State Oper Serv	79,804	79,826	79,826	79,826	159,652
Mn Neurorehab Hospital Brainer	7,267	2,073	2,073	2,073	4,146
Dhs Chemical Dependency Servs	20,379	20,256	20,256	20,256	40,512
Total	**305,151**	**317,663**	**306,814**	**306,455**	**613,269**
Expenditures by Category					
Total Compensation	253,758	254,130	248,090	247,846	495,936
Other Operating Expenses	47,365	60,061	50,545	50,430	100,975
Capital Outlay & Real Property	111	8	8	8	16
Payments To Individuals	3,492	3,464	3,360	3,360	6,720
Other Financial Transactions	425	0	0	0	0
Transfers	0	0	4,811	4,811	9,622
Total	**305,151**	**317,663**	**306,814**	**306,455**	**613,269**
Expenditures by Activity					
Sos Mental Health	112,096	143,908	133,206	132,847	266,053
Enterprise Services	107,453	102,172	102,163	102,163	204,326
Minnesota Security Hospital	85,602	71,583	71,445	71,445	142,890
Total	**305,151**	**317,663**	**306,814**	**306,455**	**613,269**
Full-Time Equivalents (FTE)	**3,491.6**	**3,413.8**	**3,362.6**	**3,311.3**	

Activity at a Glance

- State Operated Services Mental Health provided inpatient and residential services to approximately 2,900 people in FY 2010.
- Approximately 3,700 episodes of service were provided to persons in these programs.
- The service sites ended FY 2010 with an average daily population of 261.

Activity Description

State Operated Services' (SOS) Mental Health services provide specialized treatment and related supports for persons with serious mental illness (SMI), emotional disturbances, and co-occurring neurocognitive disabilities. These services are provided in an array of facilities including psychiatric hospitals, intensive residential treatment services (IRTS), and a variety of other service settings.

Population Served

SOS Mental Health provides treatment to youth and adults with emotional disturbances, serious mental illness, and co-occurring neurocognitive disabilities.

Services Provided

SOS Mental Health includes services delivered at psychiatric hospitals, intensive residential treatment services (IRTS), and a variety of other service settings. Each client receives: an assessment of their mental, social, and physical health by a variety of medical professionals; an individual treatment plan, including medication management and 24-hour nursing care; and individualized discharge planning for transitioning back to an appropriate setting in the community. Service sites are located throughout the state. Existing settings include hospitals in Alexandria, Annandale, Anoka, Baxter, Bemidji, Fergus Falls, Rochester, St. Peter, and Willmar. Other service settings are located in Brainerd, Cambridge, St. Paul, Wadena, and Willmar.

Additional services are also provided in partnership with county social service agencies and mental health providers. These include:

- *Adult Rehabilitative Mental Health Services (ARMHS)*
  - These services instruct, assist, and support individuals in such areas as relapse prevention, transportation, illness management, and life skills.
- *Assertive Community Treatment (ACT) Teams*
  - These teams which provide intensive, around-the-clock supports to persons with serious mental illness in their homes, at work, and elsewhere in the community. Multidisciplinary treatment teams help stabilize an individual, allowing the individual to avoid entering a treatment facility.
- *Crisis Response*
  - This service provides mobile crisis teams to short-term crisis stabilization beds to assist those individuals experiencing a crisis and requiring specialized treatment.

Historical Perspective

Minnesota's policy for serving people with disabilities has emphasized a broad array of community-based treatment and support options enabling people to access the most appropriate care as close to their home community and natural support system as possible. This policy direction has resulted in the reduction in the care provided in large institutions and creation of community-based services. Services developed in the community include ARMHS, ACT, and Crisis Response services.

Key Activity Goals & Measures

- ***Develop effective and accountable mental health and chemical health systems.*** SOS Mental Health services operated by DHS help to ensure the health of Minnesotans and to ensure that our communities will be safe. Providing services through community-based alternatives, such as ARMHS, ACT, Crisis Response, and residential and hospital-level of care, ensures that services are focused on clients. These services are part of an effective and accountable mental health system. This goal is from the Department of Human Services' *Priority Plans* (http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4694-ENG)

- ***Percentage of patients readmitted to a state-operated psychiatric hospital compared with the national average.*** This measure is under development. It will provide an indication of the community-based service system's ability to support youth and adults with emotional disturbances, serious mental illness, and neurocognitive disabilities in independent community settings.
- ***Average length of stay for adults with serious mental illness (SMI) in an acute care or intensive residential treatment setting.*** This measure is under development. The average length of stay will provide an indication of the community-based service system's ability to support adults with SMI in independent community living.

For more information on DHS performance measures, see http://www.accountability.state.mn.us/Departments/HumanServices/index.htm.

Activity Funding

This activity is funded by appropriations from the General Fund.

Contact

For more information on State Operated Services, contact State Operated Services Support, (651) 431-3676. Information on DHS programs is on the department's website: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: STATE OPERATED SERVICES
Activity: SOS MENTAL HEALTH

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	106,280	109,501	109,501	109,501	219,002
Technical Adjustments					
Approved Transfer Between Appr			16,653	16,653	33,306
Current Law Base Change			(8,198)	(8,306)	(16,504)
Subtotal - Forecast Base	106,280	109,501	117,956	117,848	235,804
Total	**106,280**	**109,501**	**117,956**	**117,848**	**235,804**
Federal Stimulus					
Current Appropriation	6,850	0	0	0	0
Subtotal - Forecast Base	6,850	0	0	0	0
Total	**6,850**	**0**	**0**	**0**	**0**
Expenditures by Fund					
Direct Appropriations					
General	89,855	128,308	117,956	117,848	235,804
Federal Stimulus	6,850	0	0	0	0
Statutory Appropriations					
Miscellaneous Special Revenue	15,000	15,145	14,798	14,549	29,347
Miscellaneous Agency	390	450	450	450	900
Gift	1	5	2	0	2
Total	**112,096**	**143,908**	**133,206**	**132,847**	**266,053**
Expenditures by Category					
Total Compensation	96,430	113,734	107,695	107,451	215,146
Other Operating Expenses	15,214	29,586	20,216	20,101	40,317
Capital Outlay & Real Property	17	0	0	0	0
Payments To Individuals	424	588	484	484	968
Other Financial Transactions	11	0	0	0	0
Transfers	0	0	4,811	4,811	9,622
Total	**112,096**	**143,908**	**133,206**	**132,847**	**266,053**
Full-Time Equivalents (FTE)	**1,154.8**	**1,279.0**	**1,259.8**	**1,240.6**	

Activity at a Glance

In FY 2010
- Provided treatment to 2,250 persons with chemical dependency;
- Provided foster care services to 40 children and adolescents with emotional disturbances and serious acting out behaviors;
- Provided services to 780 people in community residential sites; and
- Provided day treatment and habilitation to 890 people with developmental disabilities.

Activity Description

State Operated Services' (SOS) Enterprise Services operates in the marketplace with other providers, funded solely through revenues collected from third-party payment sources. As such, these services do not rely on a state appropriation for funding. Enterprise Services are delivered by state employees and focus on providing treatment and residential care for adults and children with chemical dependency, behavioral health issues, and developmental disabilities.

Population Served

Enterprise Services programs serve
- people with chemical abuse or dependency problems;
- children and adolescents with severe emotional disturbances and serious acting out behaviors; and
- people who are developmentally disabled (DD).

Services Provided

Enterprise Services includes a variety of programs:
- Chemical Addiction Recovery Enterprise (C.A.R.E.) programs provide inpatient and outpatient treatment to persons with chemical dependency and substance abuse problems. Programs are operated in Anoka, Brainerd, Carlton, Fergus Falls, St. Peter, and Willmar.
- Child and Adolescent Behavioral Health Services (CABHS) provides an array of foster care services to children or adolescents who have severe emotional disturbances and serious acting out behaviors. Child and Adolescent Behavioral Health Services provides these services at sites statewide and the treatment structure of the foster care home is based on a combination of evidence-based models, including the multidimensional treatment foster care model, wrap-around services model, and, where appropriate, dialectical behavioral therapy.
- State Operated Services community-based residential services for people with disabilities typically are provided in four-bed group homes. Individual service agreements are negotiated with the counties for each client based on his/her needs. Clients take advantage of and are integrated into the daily flow of their community.
- Day Training and Habilitation (DT&H) programs provide vocational support services to people with disabilities and include evaluation, training, and supported employment. Individual service agreements are negotiated for each client.

Historical Perspective

Changes in the funding structure for chemical dependency treatment moved State Operated Services chemical dependency programs into enterprise services in 1988. In 1999, the legislature adopted statutory language that allowed State Operated Services to establish other enterprise services. These services are defined as the range of services, which are delivered by state employees, needed by people with disabilities. These services are fully funded by public or private third-party health insurance or other revenue sources. State Operated Services specializes in providing these services to vulnerable people for whom no other providers are available or for whom State Operated Services may be the provider selected by the payer. As such, these services fill a need in the continuum of services for vulnerable people with disabilities by providing services not otherwise available.

Key Activity Goals & Measures

- ***Our communities will be safe, friendly, and caring.*** This goal is from *Minnesota Milestones* (http://server.admin.state.mn.us/mm/goal.html).
- ***Develop effective and accountable mental health and chemical health systems.*** This goal is from the Department of Human Services' *Priority Plans (*http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4694-ENG).

Enterprise Services, operated by the Department of Human Services, help to ensure the health of Minnesotans and to ensure that our communities will be safe. These services are focused on providing high quality client care.

- ***Percent of people civilly committed to enterprise programs versus those who voluntarily received services in these programs.*** Enterprise services were developed to meet the needs of underserved areas of the state and/or populations that other community providers have refused to serve. This measure will indicate the number of individuals who could have been served by community providers if there were willing providers available.

For more information on DHS performance measures, see http://www.accountability.state.mn.us/Departments/HumanServices/index.htm.

Activity Funding

Enterprise Services operates without a state appropriation and is supported solely through collections from third party payment sources including

- commercial and private insurance;
- publicly funded payers (such as counties, Medical Assistance, Medicare, or the Consolidated Chemical Dependency Treatment Fund); and
- individual or self-pay.

Contact

For more information on Enterprise Services contact State Operated Services Support, (651) 431-3676.

Information on Department of Human Services programs is on the department's website: http://www.dhs.state.mn.us.

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Expenditures by Fund					
Statutory Appropriations					
Miscellaneous Special Revenue	0	9	0	0	0
Gift	3	8	8	8	16
Revenue Based State Oper Serv	79,804	79,826	79,826	79,826	159,652
Mn Neurorehab Hospital Brainer	7,267	2,073	2,073	2,073	4,146
Dhs Chemical Dependency Servs	20,379	20,256	20,256	20,256	40,512
Total	**107,453**	**102,172**	**102,163**	**102,163**	**204,326**
Expenditures by Category					
Total Compensation	86,781	82,211	82,211	82,211	164,422
Other Operating Expenses	19,329	19,021	19,012	19,012	38,024
Capital Outlay & Real Property	8	8	8	8	16
Payments To Individuals	921	932	932	932	1,864
Other Financial Transactions	414	0	0	0	0
Total	**107,453**	**102,172**	**102,163**	**102,163**	**204,326**
Full-Time Equivalents (FTE)	**1,427.6**	**1,354.6**	**1,334.3**	**1,313.9**	

Activity at a Glance

In 2010
- Minnesota Security Hospital programs provided services to 238 individuals in the secure setting.
- The Forensics Treat to Competency programs provided services to 141 individuals.
- Transition Programs provided services to an additional 159 individuals.
- The Forensics Nursing Home served 20 individuals.

Activity Description

The Minnesota Security Hospital (MSH) and the Forensics Nursing Home are operated by State Operated Services (SOS). These programs provide specialized treatment and related supports for persons committed by the courts.

Population Served

This budget activity serves
- persons who are committed as mentally ill and dangerous (MI&D);
- persons who have received a court-ordered evaluation of their competency, or court-ordered treatment to restore competency prior to standing trial for an offense; and
- people in need of nursing home level of care who have been committed as mentally ill and dangerous, sexual psychopathic personality (SPP), a sexually dangerous person (SDP), or those who are on medical release from the Minnesota Department of Corrections (DOC).

Services Provided

Services for those committed by the courts as mentally ill and dangerous are provided at the Minnesota Security Hospital (MSH) in St. Peter. The Minnesota Security Hospital is a secure treatment facility that provides multi-disciplinary treatment serving adults and adolescents from throughout the state, who are admitted pursuant to judicial or other lawful orders, for assessment and/or treatment of acute and chronic major mental disorders. The Minnesota Security Hospital also provides comprehensive, court-ordered forensic evaluations; including competency to stand trial and pre-sentence mental health evaluations. The Minnesota Security Hospital operates a transition program that provides a supervised residential setting offering social rehabilitation treatment to increase self-sufficiency and build the skills necessary for a safe return to the community.

In addition, the Minnesota Security Hospital operates a forensic nursing home which provides services to those individuals who are in need of nursing home level of care and are committed as mentally ill and dangerous, sexual psychopathic personality (SPP), a sexually dangerous person (SDP), or those on medical release from the DOC.

Historical Perspective

For several years, the services provided by the MSH saw significant population growth. Efforts continue to enhance treatment methods and security, to create operational efficiencies, and to ensure that cost effective services are provided.

Key Activity Goals & Measures

- ***Develop effective and accountable mental health and chemical health systems.*** The services provided by MSH help ensure the health of Minnesotans and that our communities will be safe. These services are part of an effective and accountable mental health system. This goal is from the Department of Human Services' *Priority Plans* (http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4694-ENG).
  - Percent of patients who are qualified for community-based treatment and supervision and are receiving community-based treatment and supervision. SOS continues to develop community-based treatment options for patients who no longer need the level of security and supervision in the Minnesota Security Hospital programs. This measure is under development.

For more information on DHS performance measures, see http://www.accountability.state.mn.us/Departments/HumanServices/index.htm.

Activity Funding

The MSH programs are funded by appropriations from the General Fund. For FY 2010 only, the legislature appropriated federal American Recovery and Reinvestment Act (ARRA) funds in place of general fund dollars for a portion of the programs' funding.

Contact

For more information on State Operated Services, contact (651) 431-3676.

Information on Department of Human Services programs is on the department's website: http://www.dhs.state.mn.us.

HUMAN SERVICES DEPT
Program: STATE OPERATED SERVICES
Activity: MINNESOTA SECURITY HOSPITAL

Budget Activity Summary

Dollars in Thousands

	Current		Governor's Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	230	83,735	83,735	83,735	167,470
Technical Adjustments					
Approved Transfer Between Appr			(14,153)	(14,153)	(28,306)
Subtotal - Forecast Base	230	83,735	69,582	69,582	139,164
Total	**230**	**83,735**	**69,582**	**69,582**	**139,164**
Federal Stimulus					
Current Appropriation	76,665	0	0	0	0
Subtotal - Forecast Base	76,665	0	0	0	0
Total	**76,665**	**0**	**0**	**0**	**0**
Expenditures by Fund					
Direct Appropriations					
General	6,944	69,718	69,582	69,582	139,164
Federal Stimulus	76,654	1	0	0	0
Statutory Appropriations					
Miscellaneous Special Revenue	689	664	663	663	1,326
Miscellaneous Agency	1,315	1,200	1,200	1,200	2,400
Total	**85,602**	**71,583**	**71,445**	**71,445**	**142,890**
Expenditures by Category					
Total Compensation	70,547	58,185	58,184	58,184	116,368
Other Operating Expenses	12,822	11,454	11,317	11,317	22,634
Capital Outlay & Real Property	86	0	0	0	0
Payments To Individuals	2,147	1,944	1,944	1,944	3,888
Total	**85,602**	**71,583**	**71,445**	**71,445**	**142,890**
Full-Time Equivalents (FTE)	**909.2**	**780.2**	**768.5**	**756.8**	

Program at a Glance

- The Minnesota Sex Offender Program (MSOP) provides services to individuals who have completed their prison sentences and are civilly committed by the courts and have been placed in sex offender treatment.
- MSOP is one program with two locations, St. Peter and Moose Lake.
- At the end of FY 2010, the Minnesota Sex Offender Program had a census of 575 clients in MSOP programming.
- MSOP has a biennial budget of $135 million.

Program Description

DHS operates the Minnesota Sex Offender Program (MSOP) to provide services to individuals who have been court-ordered to receive sex offender treatment. MSOP clients have completed their prison sentences and are civilly committed by the courts and placed in sex offender treatment for an indeterminate period of time. A civil court may commit a person for sex offender treatment if a judge determines that the individual is a "sexual psychopathic personality" (SPP), a "sexually dangerous person" (SDP), or both.

Within DHS, the Minnesota Sex Offender Program was separated from the administration of State Operated Services in 2008. MSOP operates independently from State Operated Services and provides specialized treatment in a secure treatment setting for those individuals committed as a sexual psychopathic personality or as a sexually dangerous person.

MSOP is one program with two locations, Moose Lake and St. Peter. As of 7-1-10, MSOP was providing treatment for 575 clients across both sites. Seventeen of the 575 clients are on judicial holds pending civil commitment. Fifty-six others are residing in the Department of Corrections (those individuals are dually committed to MSOP and are serving a criminal sentence). Most clients begin treatment at the MSOP Moose Lake facility and, after successfully completing the first two phases of treatment, are transferred to the St. Peter facility to complete treatment and begin working toward provisional discharge.

Population Served

The MSOP serves persons who have been committed as "sexual psychopathic personality" (SPP), a "sexually dangerous person" (SDP), or both. The majority of persons committed to this program have been referred by the Department of Corrections, upon completion of their criminal sentences, to individual counties for consideration of civil commitment.

Services Provided

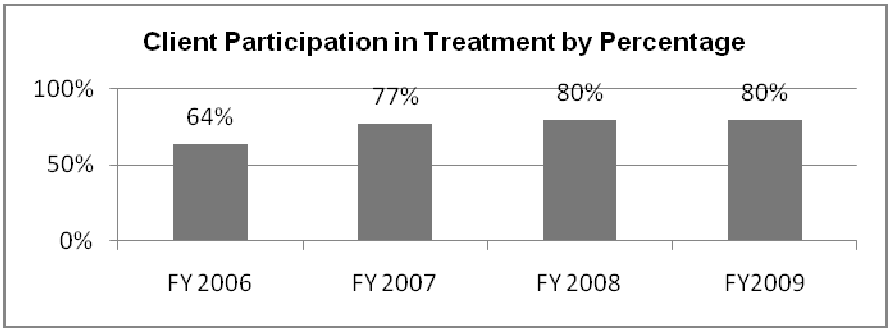
Once individuals are civilly committed, they are provided an opportunity to participate in residential sex offender treatment. The treatment is based on cognitive-behavioral techniques and includes strategies to prevent individual sex offenders from relapsing. Consistent with the Risk/Needs/Responsivity model of treatment, clients are individually assessed and placed in programming based upon clinical needs and willingness to participate in treatment. Clients acquire skills through active participation in group therapy and are provided opportunities to demonstrate meaningful change through participation in rehabilitative services, including education classes, therapeutic recreational activities, and vocational work program assignments. MSOP staff observes and monitors clients not only in treatment groups, but also in all aspects of daily living.

Historical Perspective

Over the past several years, MSOP has experienced significant population growth, undergone extensive modifications in the treatment program, implemented efficiencies in administration and fiscal practices, and enhanced security procedures. Efforts continue to enhance treatment methods, increase safely/security, and create operational efficiencies to assure that cost effective services are provided.

Key Program Goals & Measures

- ***MSOP will provide a therapeutic environment.*** This goal is from the Minnesota Sex Offender Program. Sex offender treatment involves vocational work opportunities, education, therapeutic recreation, and treatment.
- To assess this goal, 80% of population involved in sex offender treatment.



Assessment measures and targets are currently being developed to asses similar participation trends in vocational, educational, and therapeutic recreational programming. These tools will be used to report on these data in the Annual Performance Report to the legislature, completed on the previous calendar in January of each year.

Program Funding

The MSOP has been historically funded by appropriations from the General Fund. For FY 2010 only, the legislature appropriated federal American Recovery and Reinvestment Act (ARRA) funds in place of General Fund dollars for a portion of the program's funding.

Contact

For more information on the Minnesota Sex Offender Program, contact the program at (651) 431-5877.
Information on this DHS program is also on the department's website: http://www.dhs.state.mn.us/msop.

Dollars in Thousands

	Current		Governor Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
General					
Current Appropriation	38,348	67,358	67,358	67,358	134,716
Technical Adjustments					
Approved Transfer Between Appr			67	67	134
Current Law Base Change			(273)	(274)	(547)
Transfers Between Agencies			418	419	837
Subtotal - Forecast Base	38,348	67,358	67,570	67,570	135,140
Total	**38,348**	**67,358**	**67,570**	**67,570**	**135,140**
Federal Stimulus					
Current Appropriation	26,495	0	0	0	0
Subtotal - Forecast Base	26,495	0	0	0	0
Total	**26,495**	**0**	**0**	**0**	**0**
Expenditures by Fund					
Direct Appropriations					
General	31,952	70,165	67,570	67,570	135,140
Federal Stimulus	26,495	0	0	0	0
Statutory Appropriations					
Miscellaneous Agency	1,793	1,500	1,500	1,500	3,000
Materials Distribution	651	750	750	750	1,500
Total	**60,891**	**72,415**	**69,820**	**69,820**	**139,640**
Expenditures by Category					
Total Compensation	48,546	52,587	52,587	52,587	105,174
Other Operating Expenses	10,277	18,072	13,723	13,723	27,446
Capital Outlay & Real Property	44	0	0	0	0
Payments To Individuals	2,024	1,756	1,756	1,756	3,512
Transfers	0	0	1,754	1,754	3,508
Total	**60,891**	**72,415**	**69,820**	**69,820**	**139,640**
Expenditures by Activity					
Sex Offender Program	60,891	72,415	69,820	69,820	139,640
Total	**60,891**	**72,415**	**69,820**	**69,820**	**139,640**
Full-Time Equivalents (FTE)	**754.3**	**754.3**	**743.0**	**731.7**	

Program at a Glance

The Fiduciary Activities program includes expenditures accounted for in the State's fiduciary fund group. For DHS, the bulk of these expenditures are attributable to the payment of child support collections to custodial parents.

Program Description

The Fiduciary Activities program includes expenditures accounted for in the state's fiduciary fund group. By definition, the fiduciary fund group is used to account for assets held in trust by the government for the benefit of individuals or other. Accordingly, the fiduciary fund group is excluded from the state's budgetary fund balance presentation.

For DHS, the bulk of these expenditures are attributable to the payment of child support collections to custodial parents.

Listed below are the specific types of expenditures included in DHS' Fiduciary Activities budget program:

- Child Support Payments: Payments made to custodial parents from funds collected by the state from the non-custodial parent.
- MAXIS Off-Line Recoveries: Funds recovered by the state and money received from counties that cannot be receipted in MAXIS. The funds are held here until DHS can determine what program is to be credited and to whom payment should be made. Payments are made to: U.S. Treasury for federal shares, counties for incentives, clients for returned money or their balance of interim assistance recoveries, providers for Supplemental Security Income (SSI) services, or the state for any state share.
- Long Term Care Civil Penalties: Monies collected by the federal Centers for Medicare and Medicaid Services (CMS) from nursing homes that are assessed penalties for non-compliance. The portion given to states is to be utilized solely for approved projects that specifically address nursing home deficiencies.

By isolating these expenditures in this budget program, the other DHS budget activities are not distorted. The expenditures and the associated accounting processes reflected by this budget program are supported administratively by the budget activities within the Central Office Operations budget program.

Contact

For more information about the Fiduciary Activities program, please contact the DHS Financial Operations Division at 651-431-3725.

Information about the Department of Human Services programs is on the department's Web site: http://www.dhs.state.mn.us

Dollars in Thousands

	Current		Governor Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Expenditures by Fund					
Statutory Appropriations					
Miscellaneous Agency	641,288	659,989	660,494	661,129	1,321,623
Total	**641,288**	**659,989**	**660,494**	**661,129**	**1,321,623**
Expenditures by Category					
Total Compensation	16	0	0	0	0
Other Operating Expenses	1,581	6,369	4,427	4,427	8,854
Payments To Individuals	53	75	75	75	150
Local Assistance	193	839	839	839	1,678
Other Financial Transactions	639,445	652,706	655,153	655,788	1,310,941
Total	**641,288**	**659,989**	**660,494**	**661,129**	**1,321,623**
Expenditures by Activity					
Fiduciary Activities	641,288	659,989	660,494	661,129	1,321,623
Total	**641,288**	**659,989**	**660,494**	**661,129**	**1,321,623**

Program at a Glance

The **Technical Activities budget program** includes inter-fund and pass-through expenditures. These expenditures are the result of accounting technicalities.

Program Description

The Technical Activities budget program includes inter-fund and pass-through expenditures that occur as the result of accounting technicalities.

Listed below are the specific types of the inter-fund and pass-through expenditures included in the Technical Activities budget program.

- Federal administrative reimbursement earned by and paid to counties, tribes and other local agencies.
- Federal administrative reimbursement earned by and paid to other state agencies.
- Administrative reimbursement (primarily federal funds) earned on statewide indirect costs and paid to the General Fund.
- Administrative reimbursement (primarily federal funds) earned on DHS central office administrative costs and paid to either the General Fund or Special Revenue Fund, as prescribed by state law and policy.
- Federal reimbursement earned on program expenditures and paid to the General Fund as prescribed by state policy and law.
- Transfers between federal grants, programs and state agencies that are accounted for as expenditures in the state's accounting system.
- Other technical accounting transactions.

By isolating these expenditures in this budget program, the other budget activities are not distorted. The expenditures and the associated accounting processes reflected by the Technical Activities budget program are supported administratively by the Finance & Management budget activity within the Central Office Operations budget program.

Contact

For more information about the Technical Activities budget program, please contact the DHS Financial Operations Division at 651-431-3725.

Information about the Department of Human Services programs is on the department's Web site: http://www.dhs.state.mn.us.

Dollars in Thousands

	Current		Governor Recomm.		Biennium
	FY2010	FY2011	FY2012	FY2013	2012-13
Direct Appropriations by Fund					
Federal Tanf					
Current Appropriation	76,727	88,590	88,590	88,590	177,180
Technical Adjustments					
Current Law Base Change			(21,375)	(21,080)	(42,455)
November Forecast Adjustment		(478)	(410)	(373)	(783)
Subtotal - Forecast Base	76,727	88,112	66,805	67,137	133,942
Total	**76,727**	**88,112**	**66,805**	**67,137**	**133,942**
Expenditures by Fund					
Direct Appropriations					
Federal Tanf	58,403	88,112	66,805	67,137	133,942
Statutory Appropriations					
Miscellaneous Special Revenue	6,325	6,394	6,306	6,298	12,604
Federal	376,847	387,960	382,198	381,705	763,903
Federal Stimulus	29,469	4,896	2,834	2,834	5,668
Total	**471,044**	**487,362**	**458,143**	**457,974**	**916,117**
Expenditures by Category					
Total Compensation	17	17	17	17	34
Other Operating Expenses	120,237	131,769	130,400	130,399	260,799
Payments To Individuals	56	56	56	56	112
Local Assistance	346,234	350,920	323,970	323,802	647,772
Other Financial Transactions	4,500	4,600	3,700	3,700	7,400
Total	**471,044**	**487,362**	**458,143**	**457,974**	**916,117**
Expenditures by Activity					
Technical Activities	471,044	487,362	458,143	457,974	916,117
Total	**471,044**	**487,362**	**458,143**	**457,974**	**916,117**

Dollars in Thousands

	Actual FY2010	Budgeted FY2011	Governor's Recomm. FY2012	Governor's Recomm. FY2013	Biennium 2012-13
Non Dedicated Revenue:					
Departmental Earnings:					
General	51,072	49,700	47,630	47,630	95,260
Grants:					
General	2,098	39	39	0	39
Other Revenues:					
General	133,734	146,166	139,522	145,149	284,671
Health Care Access	7,121	7,121	7,121	7,121	14,242
Taxes:					
General	231,443	240,350	239,537	241,999	481,536
Total Non-Dedicated Receipts	**425,468**	**443,376**	**433,849**	**441,899**	**875,748**
Dedicated Receipts:					
Departmental Earnings (Inter-Agency):					
Miscellaneous Special Revenue	6,087	100	100	100	200
Departmental Earnings:					
General	-18	0	0	0	0
Health Care Access	-132	0	0	0	0
Miscellaneous Special Revenue	47,722	57,882	63,231	64,488	127,719
Federal	14,180	0	0	0	0
Federal Stimulus	1,745	0	0	0	0
Revenue Based State Oper Serv	82,066	81,012	81,012	81,012	162,024
Mn Neurorehab Hospital Brainer	6,773	2,128	2,128	2,128	4,256
Dhs Chemical Dependency Servs	20,264	20,933	20,933	20,933	41,866
Materials Distribution	937	898	898	898	1,796
Grants:					
Miscellaneous Special Revenue	154,930	98,764	99,902	101,192	201,094
Federal	5,006,625	5,177,835	5,666,136	5,964,276	11,630,412
Federal Stimulus	1,138,571	871,284	12,571	5,434	18,005
Other Revenues:					
General	801	0	0	0	0
Health Care Access	47	0	0	0	0
Miscellaneous Special Revenue	137,030	122,089	109,893	111,848	221,741
Federal	35,104	14	14	14	28
Federal Stimulus	4,626	0	0	0	0
Miscellaneous Agency	643,181	648,584	658,998	659,633	1,318,631
Gift	28	47	18	17	35
Endowment	1	1	1	1	2
Revenue Based State Oper Serv	184	171	171	171	342
Mn Neurorehab Hospital Brainer	7	4	4	4	8
Dhs Chemical Dependency Servs	7	0	0	0	0
Materials Distribution	1	2	2	2	4
Other Sources:					
Miscellaneous Special Revenue	0	1,401	1,400	1,400	2,800
Federal	0	2	0	0	0
Miscellaneous Agency	3,285	4,499	4,499	4,499	8,998
Total Dedicated Receipts	**7,304,052**	**7,087,650**	**6,721,911**	**7,018,050**	**13,739,961**
Agency Total Revenue	**7,729,520**	**7,531,026**	**7,155,760**	**7,459,949**	**14,615,709**