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Human Services (REVISED)

www.mn.gov/dhs

AT A GLANCE

- Health care programs (Medical Assistance, Minnesota-Care) — 1,140,924 people on average enrolled per month in 2015
- Supplemental Nutrition Assistance Program (SNAP) — over 466,000 people received help each month in 2015
- Minnesota Family Investment Program and Diversionary Work Program — 34,300 families with low incomes assisted per month in 2015
- Child support — more than 360,000 custodial and noncustodial parents and their 250,000 children receive services
- Child care assistance — more than 30,000 children assisted in a month in 2015
- Adults receiving publicly funded mental health services — 69,324 people per month in 2015
- Children and youth receiving publicly funded mental health services — 28,898 per month in 2015
- DHS Direct Care and Treatment provided services to more than 12,000 individuals in fiscal year 2015
- In FY2015 DHS all funds spending was $15.2 billion.[i]

PURPOSE

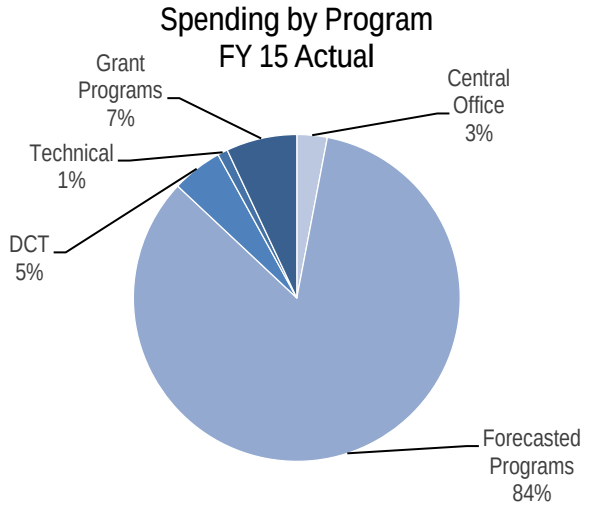
The Minnesota Department of Human Services (DHS), working in partnership with many others, helps people meet their basic needs so they can live in dignity and achieve their highest potential.

- We focus on people, not programs.
- We provide ladders up and safety nets for the people we serve.
- We work in partnership with others; we cannot do it alone.
- We are accountable for results, first to the people we serve and, ultimately, to all Minnesotans.

DHS contributes to the following statewide outcomes:

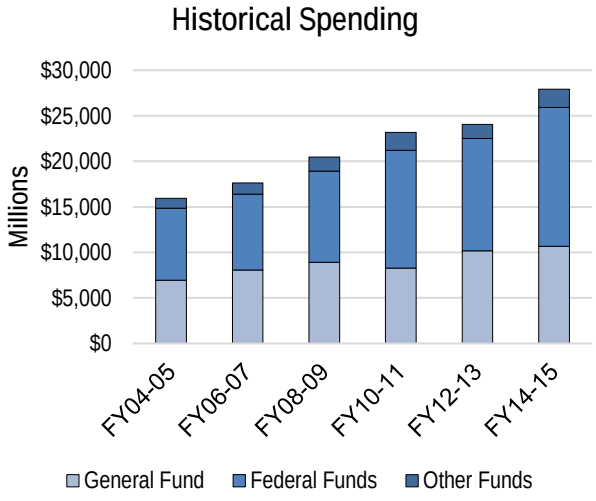
- All Minnesotans have optimal health.
- Strong and stable families and communities.
- People in Minnesota are safe.

BUDGET



Represents all funds spending. Forecasted Programs includes: Medical Assistance 72%, MinnesotaCare 2%, Economic support programs 8%, and other health care programs 2%.
Direct Care and Treatment (DCT) includes Minnesota Sex Offender Program and State-Operated Services

Source: SWIFT



Source: Consolidated Fund Statement

Minnesota has a strong tradition of providing human services for people in need so they can live as independently as possible, and of working to ensure that Minnesotans with disabilities are able to live, work and enjoy life in the most integrated setting desired. DHS provides oversight and direction for most health and human services programs, making sure providers meet service expectations. Most services are delivered directly to people by counties, tribes, health care providers or other community partners. Some DHS employees provide direct care and treatment to people with mental illness, chemical dependency and developmental disabilities as well as to individuals civilly committed for sex offender treatment.Examples of our work include:

- Health care programs which purchase medical care and related home- and community-based services for children, seniors, people with disabilities and people with low incomes.
- Economic assistance programs which provide assistance to low-income Minnesotans to help them move toward greater independence.
- Services to children who have suffered abuse or neglect, to assure their safety and well-being, and early intervention services to children at-risk of abuse or neglect.
- Grant programs to support local delivery of human services for populations in need, including recent refugee immigrant populations, adults and children with mental illness or substance abuse problems, people who are deaf or hard of hearing, seniors and vulnerable adults.
- Direct care provided through a statewide array of institutional and community-based services. Services are targeted to people experiencing mental illness, chemical dependency, developmental disabilities and/or an acquired brain injury, some of whom are civilly committed by the court because they may pose a risk to themselves or others.
- Residential services and treatment to people who are committed by the court as a sexual psychopathic personality or a sexually dangerous person.

STRATEGIES

We emphasize several strategies across our budget activity and program areas to realize our mission and support the statewide outcomes listed above. We organize the strategies currently emphasized within DHS in seven categories:

- Better and Equitable Outcomes
  - *Adults and children are safe and secure*
    - Better protect children and vulnerable adults in families
    - Streamline the adult protection system
    - Develop more accurate and efficient background study process
    - Increase fraud investigations of Child Care Assistance providers
    - Implement new regulatory oversight to support people living safely in homes and communities
    - Expand provider investigations through Recovery Act contracts
    - Implement onsite enrollment screening requirements for medium- and high-risk providers
  - *Adults and children have stability in their living situation*
    - Increase access to prevention, outreach, shelter, and housing for at-risk and homeless youth
    - Lower the disproportionate number of children of color in out-of-home placements
    - Decrease the number of children in foster care waiting for adoption
  - *Children have the ability to develop to their fullest potential*
    - Reduce the rate of prenatal exposure to alcohol or drugs
    - Increase the number of children in underserved communities enrolled in quality child care settings
  - *Adults and children under the care of the Commissioner live with dignity and achieve their highest potential*
    - Better protect children and vulnerable adults in facilities, especially those directly in our care
  - *Adults live with dignity, autonomy, and choice*
    - Serve more people in their own homes, communities and integrated workplaces
    - Enhance long-term care planning
    - Evaluate quality of life and care for people receiving services by using online report cards for home and community-based services and nursing facilities
    - Decrease the amount of time it takes to determine disability status and eligibility for assistance
    - Launch new Community First Services and Supports to support people in their communities

- *People have access to health care and experience good health*
  - Improve access to affordable health care
  - Integrate primary care, behavioral health and long-term care
  - Implement a new autism benefit for children
  - Expand the number of providers and enrollees participating in Integrated Health Partnerships (Medicaid Accountable Care Organizations)
  - Reduce the gap in access and outcomes for health care in cultural and ethnic communities
  - Hold managed care plans accountable for health equity outcomes related to depression, diabetes and well child visits
- *People are economically secure*
  - Keep more people fed and healthy by increasing nutrition assistance participation, especially for seniors
  - Reduce Supplemental Nutrition Assistance Program error rate

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The Department of Human Services' overall legal authority comes from Minnesota Statutes chapters 245 (https://www.revisor.mn.gov/statutes?id=245) and 256. (https://www.revisor.mn.gov/statutes/?id=256) We list additional program-specific legal authority at the end of each budget activity narrative.

[i] Excludes Fiduciary and Technical Activities

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecasted Base FY18	Forecasted Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
1000 - General	5,215,240	5,450,031	5,344,071	5,877,238	6,739,426	7,034,927	6,480,886	6,819,420
1200 - State Government Special Rev	4,011	4,557	4,450	4,339	4,274	4,274	7,409	7,409
2000 - Restrict Misc Special Revenue	265,511	289,199	331,886	303,384	292,712	295,144	318,155	318,913
2001 - Other Misc Special Revenue	221,363	258,379	301,553	391,466	254,899	253,732	265,397	259,747
2360 - Health Care Access	473,298	495,569	763,823	334,914	300,480	315,163	669,459	674,926
2403 - Gift	32	25	20	130	80	73	80	73
3000 - Federal	6,795,902	7,932,920	8,421,760	8,489,616	9,220,383	9,482,051	9,220,533	9,482,201
3001 - Federal TANF	239,973	235,040	237,044	272,566	276,250	266,905	276,250	266,905
4100 - Sos Tbi & Adol Ent Svcs	1,636	1,772	1,621	2,051	2,051	2,051	2,051	2,051
4101 - Dhs Chemical Dependency Servs	20,466	19,372	18,173	19,304	19,304	19,304	19,699	20,101
4350 - Mn State Operated Comm Svcs	95,418	99,902	103,496	104,626	91,626	91,626	101,703	98,743
4503 - Minnesota State Industries	1,767	2,680	1,170	1,685	1,900	1,900	100	100
4800 - Lottery	1,496	1,577	1,514	1,942	1,896	1,896	1,896	1,896
6000 - Miscellaneous Agency	34,939	34,269	34,913	215,764	214,348	214,348	214,348	214,348
6003 - Child Support Enforcement	624,394	624,544	615,740	640,336	640,336	640,336	640,336	640,336
Total	**13,995,444**	**15,449,836**	**16,181,232**	**16,659,360**	**18,059,964**	**18,623,730**	**18,218,301**	**18,807,169**
Biennial Change				3,395,312		3,843,102		4,184,878
Biennial % Change				12		12		13
Governor's Change from Base								341,776
Governor's % Change from Base								1

Expenditures by Program

Program: Central Office Operations	370,710	424,494	488,075	603,727	446,844	440,424	504,739	487,795
Program: Forecasted Programs	10,782,132	12,203,888	12,815,828	12,748,184	14,329,044	14,916,446	14,355,252	14,956,981
Program: Grant Programs	1,171,975	1,136,061	1,124,786	1,267,037	1,254,957	1,238,867	1,290,357	1,285,242
Program: Direct Care and Treatment	403,989	418,064	416,083	478,013	461,360	461,231	500,194	510,389
Program: Fiduciary Activities	657,709	656,891	647,531	853,394	851,958	851,958	851,958	851,958
Program: Technical Activities	608,928	610,437	688,928	709,005	715,801	714,805	715,801	714,805
Total	**13,995,444**	**15,449,836**	**16,181,232**	**16,659,360**	**18,059,964**	**18,623,730**	**18,218,301**	**18,807,169**

Expenditures by Category

Compensation	535,184	569,644	511,804	576,891	561,389	558,585	630,735	630,598
Operating Expenses	611,295	646,266	825,665	752,799	603,408	599,063	630,791	623,579
Other Financial Transactions	666,627	666,146	656,654	666,511	665,692	665,690	666,992	666,190
Grants, Aids and Subsidies	12,182,171	13,565,720	14,185,697	14,663,146	16,229,462	16,800,378	16,289,770	16,886,788
Capital Outlay-Real Property	166	2,060	1,412	13	13	13	13	13

(Dollars in Thousands)

Expenditures by Category

Total	**13,995,444**	**15,449,836**	**16,181,232**	**16,659,360**	**18,059,964**	**18,623,730**	**18,218,301**	**18,807,169**
Full-Time Equivalents	**6,669.4**	**6,865.9**	**6,098.4**	**7,107.9**	**6,666.3**	**6,543.2**	**7,301.1**	**7,204.6**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	4,444	153,789	7,716	23,972	0	0	0	0
Direct Appropriation	5,530,458	6,092,808	5,616,984	6,064,533	6,939,726	7,253,964	6,699,257	7,050,853
Receipts	435	490	563	0	0	0	0	0
Net Transfers	(159,430)	(623,743)	(196,358)	(211,267)	(200,300)	(219,038)	(218,371)	(231,434)
Cancellations	147,684	167,909	60,862	0	0	0	0	0
Expenditures	**5,215,240**	**5,450,031**	**5,344,071**	**5,877,238**	**6,739,426**	**7,034,927**	**6,480,886**	**6,819,420**
Balance Forward Out	12,981	5,403	23,972	0	0	0	0	0
Biennial Change in Expenditures				556,038		2,553,043		2,078,996
Biennial % Change in Expenditures				5		23		19
Gov's Exp Change from Base								(474,047)
Gov's Exp % Change from Base								(3)
Full-Time Equivalents	3,428.4	3,473.9	3,389.6	4,135.6	3,940.4	3,863.4	4,338.5	4,412.5

1200 - State Government Special Rev

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	108	0	64	0	0	0	0
Direct Appropriation	4,099	4,510	4,514	4,274	4,274	4,274	7,409	7,409
Net Transfers	0	0	0	0	0	0	0	0
Cancellations	0	61	0	0	0	0	0	0
Expenditures	**4,011**	**4,557**	**4,450**	**4,339**	**4,274**	**4,274**	**7,409**	**7,409**
Balance Forward Out	88	0	64	0	0	0	0	0
Biennial Change in Expenditures				221		(241)		6,029
Biennial % Change in Expenditures				3		(3)		69
Gov's Exp Change from Base								6,270
Gov's Exp % Change from Base								73
Full-Time Equivalents	41.6	37.2	36.3	43.8	43.8	43.8	43.8	43.8

2000 - Restrict Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	54,471	48,101	42,159	51,273	40,092	39,804	40,092	39,528
Direct Appropriation	2,713	2,713	2,713	3,713	3,713	3,713	3,713	3,713
Receipts	191,134	187,832	243,169	172,913	169,102	151,936	173,269	155,923

(Dollars in Thousands)

2000 - Restrict Misc Special Revenue

Net Transfers	63,967	90,280	95,118	115,573	119,610	139,530	119,610	138,099
Cancellations	0	42	0	0	0	0	0	0
Expenditures	**265,511**	**289,199**	**331,886**	**303,384**	**292,712**	**295,144**	**318,155**	**318,913**
Balance Forward Out	46,774	39,684	51,273	40,092	39,804	39,838	39,528	39,349
Biennial Change in Expenditures				80,560		(47,414)		1,798
Biennial % Change in Expenditures				15		(7)		0
Gov's Exp Change from Base								49,212
Gov's Exp % Change from Base								8
Full-Time Equivalents	208.9	206.6	164.0	173.1	173.1	173.1	191.1	192.1

2001 - Other Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	28,419	33,552	18,969	15,636	15,519	21,960	15,519	21,960
Receipts	140,622	191,594	206,870	301,942	172,831	172,698	172,831	172,698
Net Transfers	80,938	72,430	91,350	89,407	88,508	87,829	99,006	93,844
Expenditures	**221,363**	**258,379**	**301,553**	**391,466**	**254,899**	**253,732**	**265,397**	**259,747**
Balance Forward Out	28,616	39,196	15,636	15,519	21,960	28,756	21,960	28,756
Biennial Change in Expenditures				213,277		(184,388)		(167,875)
Biennial % Change in Expenditures				44		(27)		(24)
Gov's Exp Change from Base								16,513
Gov's Exp % Change from Base								3
Full-Time Equivalents	900.7	957.5	413.1	473.5	468.2	462.3	473.5	473.5

2360 - Health Care Access

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	12,544	68	323	0	0	0	0
Direct Appropriation	483,283	486,627	769,377	302,372	270,337	285,890	642,151	645,682
Receipts	15,680	15,634	29,994	44,964	43,410	43,043	43,410	43,043
Net Transfers	(11,727)	451,903	(14,219)	(12,745)	(13,267)	(13,770)	(16,102)	(13,799)
Cancellations	10,933	471,138	21,073	0	0	0	0	0
Expenditures	**473,298**	**495,569**	**763,823**	**334,914**	**300,480**	**315,163**	**669,459**	**674,926**
Balance Forward Out	3,003	0	323	0	0	0	0	0
Biennial Change in Expenditures				129,870		(483,093)		245,649
Biennial % Change in Expenditures				13		(44)		22
Gov's Exp Change from Base								728,742

(Dollars in Thousands)

2360 - Health Care Access

Gov's Exp % Change from Base								118
Full-Time Equivalents	344.3	357.6	332.3	398.5	393.6	388.2	493.9	405.9

2400 - Endowment

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	60	60	60	61	61	61	61	61
Receipts	0	0	0	0	0	0	0	0
Balance Forward Out	60	60	61	61	61	61	61	61

2403 - Gift

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	122	103	101	96	33	18	33	18
Receipts	12	23	15	67	66	66	66	66
Expenditures	**32**	**25**	**20**	**130**	**80**	**73**	**80**	**73**
Balance Forward Out	103	101	96	33	18	10	18	10
Biennial Change in Expenditures				94		3		3
Biennial % Change in Expenditures				166		2		2
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

3000 - Federal

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	42,846	8,832	46,340	18,383	55,475	192,259	55,475	192,259
Receipts	6,756,138	8,032,993	8,393,802	8,526,710	9,357,168	9,631,759	9,357,318	9,631,909
Net Transfers	0	0	0	0	0	0	0	0
Expenditures	**6,795,902**	**7,932,920**	**8,421,760**	**8,489,616**	**9,220,383**	**9,482,051**	**9,220,533**	**9,482,201**
Balance Forward Out	3,082	108,908	18,383	55,475	192,259	341,966	192,259	341,966
Biennial Change in Expenditures				2,182,554		1,791,059		1,791,359
Biennial % Change in Expenditures				15		11		11
Gov's Exp Change from Base								300
Gov's Exp % Change from Base								0
Full-Time Equivalents	179.2	175.1	196.9	242.4	242.4	234.4	242.4	234.4

(Dollars in Thousands)

3001 - Federal TANF

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	12,062	25,403	44,875	63,858	40,016	15,336	40,016	15,336
Receipts	253,313	254,512	256,027	248,723	251,569	251,568	251,569	251,568
Expenditures	**239,973**	**235,040**	**237,044**	**272,566**	**276,250**	**266,905**	**276,250**	**266,905**
Balance Forward Out	25,403	44,875	63,858	40,016	15,336	0	15,336	0
Biennial Change in Expenditures				34,597		33,544		33,544
Biennial % Change in Expenditures				7		7		7
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0
Full-Time Equivalents	14.7	13.0	12.0	14.7	14.7	14.7	14.7	14.7

4100 - Sos Tbi & Adol Ent Svcs

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	516	552	532	342	342	342	342	342
Receipts	1,740	1,977	1,431	2,052	2,052	2,052	2,052	2,052
Net Transfers	(75)	(225)	0	0	0	0	0	0
Expenditures	**1,636**	**1,772**	**1,621**	**2,051**	**2,051**	**2,051**	**2,051**	**2,051**
Balance Forward Out	546	532	342	342	342	342	342	342
Biennial Change in Expenditures				264		430		430
Biennial % Change in Expenditures				8		12		12
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0
Full-Time Equivalents	29.4	30.8	24.0	28.0	28.0	28.0	28.0	28.0

4101 - Dhs Chemical Dependency Servs

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	3	95	41	38	38	38	38	38
Receipts	15,464	11,715	8,544	13,191	13,313	13,313	13,313	13,313
Net Transfers	5,000	7,600	9,626	6,113	5,991	5,991	6,386	6,788
Expenditures	**20,466**	**19,372**	**18,173**	**19,304**	**19,304**	**19,304**	**19,699**	**20,101**
Balance Forward Out	0	38	38	38	38	38	38	38
Biennial Change in Expenditures				(2,361)		1,131		2,323
Biennial % Change in Expenditures				(6)		3		6

(Dollars in Thousands)

4101 - Dhs Chemical Dependency Servs

Gov's Exp Change from Base								1,192
Gov's Exp % Change from Base								3
Full-Time Equivalents	209.5	207.5	158.1	167.1	164.2	161.0	167.7	167.8

4350 - Mn State Operated Comm Svcs

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	5,372	188	173	2,909	0	0	0	0
Receipts	90,387	96,028	93,061	87,717	91,626	91,626	91,626	91,626
Net Transfers	(340)	3,707	13,170	14,000	0	0	10,077	7,117
Expenditures	**95,418**	**99,902**	**103,496**	**104,626**	**91,626**	**91,626**	**101,703**	**98,743**
Balance Forward Out	0	22	2,909	0	0	0	0	0
Biennial Change in Expenditures				12,802		(24,870)		(7,676)
Biennial % Change in Expenditures				7		(12)		(4)
Gov's Exp Change from Base								17,194
Gov's Exp % Change from Base								9
Full-Time Equivalents	1,309.0	1,394.2	1,369.0	1,427.9	1,194.6	1,171.0	1,304.1	1,228.7

4503 - Minnesota State Industries

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	1,674	1,740	971	965	1,090	1,000	1,090	1,000
Receipts	1,735	1,457	1,164	1,810	1,810	1,810	10	10
Expenditures	**1,767**	**2,680**	**1,170**	**1,685**	**1,900**	**1,900**	**100**	**100**
Balance Forward Out	1,642	517	965	1,090	1,000	910	1,000	910
Biennial Change in Expenditures				(1,592)		946		(2,654)
Biennial % Change in Expenditures				(36)		33		(93)
Gov's Exp Change from Base								(3,600)
Gov's Exp % Change from Base								(95)
Full-Time Equivalents	2.0	11.3	1.8	1.8	1.8	1.8	1.8	1.8

4800 - Lottery

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	0	0	46	0	0	0	0
Direct Appropriation	1,890	1,890	1,893	1,896	1,896	1,896	1,896	1,896

(Dollars in Thousands)

4800 - Lottery

Cancellations	393	313	333	0	0	0	0	0
Expenditures	**1,496**	**1,577**	**1,514**	**1,942**	**1,896**	**1,896**	**1,896**	**1,896**
Balance Forward Out	0	0	46	0	0	0	0	0
Biennial Change in Expenditures				382		336		336
Biennial % Change in Expenditures				12		10		10
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0
Full-Time Equivalents	1.5	1.1	1.3	1.5	1.5	1.5	1.5	1.5

6000 - Miscellaneous Agency

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	2,783	2,813	5,586	4,394	576	559	576	559
Receipts	35,096	35,576	33,721	211,945	214,329	214,329	214,329	214,329
Net Transfers	(142)	(5)	0	0	0	0	0	0
Expenditures	**34,939**	**34,269**	**34,913**	**215,764**	**214,348**	**214,348**	**214,348**	**214,348**
Balance Forward Out	2,798	4,115	4,394	576	559	541	559	541
Biennial Change in Expenditures				181,468		178,019		178,019
Biennial % Change in Expenditures				262		71		71
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0
Full-Time Equivalents	0.2							

6003 - Child Support Enforcement

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	9,709	9,811	9,904	9,380	0	0	0	0
Receipts	624,495	624,637	615,216	630,956	640,336	640,336	640,336	640,336
Expenditures	**624,394**	**624,544**	**615,740**	**640,336**	**640,336**	**640,336**	**640,336**	**640,336**
Balance Forward Out	9,811	9,904	9,380	0	0	0	0	0
Biennial Change in Expenditures				7,138		24,596		24,596
Biennial % Change in Expenditures				1		2		2
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

Change Item Title: HCBS Reform: Federal Compliance & Service Access for Disability Waivers (CS57)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	(2,197)	(7,285)	(9,506)	(19,041)
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	(2,197)	(7,285)	(9,506)	(19,041)
FTEs	**1**	**3**	**2**	**2**

Recommendation:

Effective July 1, 2017, the Governor recommends modifying elements of the rate setting for home and community based services under the Medicaid disability waivers in order to maintain federal compliance with federal requirements and ensure service access to disability waiver recipients. This proposal makes changes to the Disability Waiver Rate Setting (DWRS) System by modifying cost components and inflationary adjustments in rate formulas and establishing a provider cost audit function to ensure that the rate setting methodology accurately reflects provider costs over time. This proposal also provides adjustments to rate frameworks for unit-based and employment services in order to help support Minnesotans with disabilities to have access to needed services in their home or in the community. This proposal will ensure that Minnesota maintains compliance with federal requirements to implement a statewide rate methodology, complies with requirements to ensure access to disability waiver services, and helps meet the goals of the CMS Home and Community Based Services Rule and Minnesota's Olmstead Plan.

The HCBS Reform proposals continue the redesign of home and community based services to align with changing expectations of those receiving services, provisions in the Americans with Disabilities Act, and long term sustainability of services. These proposals support better outcomes, administrative efficiencies, and increase functionality of waiver management tools. Together, these proposals enable people to receive flexible, individualized services where they live and work.

Rationale/Background:

In 2013, the Minnesota legislature authorized the Department of Human Services to implement a statewide rate setting methodology for disability waiver services. The new system (Disability Waiver Rate Setting or DWRS) established a consistent formula for setting rates for disability waiver programs (Brain Injury, Community Alternative Care, Community Access for Disability Inclusion, and Developmental Disability waivers) in statute. Minnesota was under a Corrective Action Plan with the federal Centers for Medicare and Medicaid Services (CMS) due to inconsistent rate setting methods throughout the state. Failure to comply with the Corrective Action Plan jeopardized all federal funding of the disability waivers. Implementation of the DWRS, as well as other changes required by the Corrective Action Plan, brought Minnesota's four disability waivers into federal compliance.

Under the direction of CMS, DWRS established rate formulas (called frameworks) that are based on the statewide average costs required for Home and Community Based Services (HCBS). This ensures that the state pays the appropriate value for the service and that people have access to needed services throughout the whole state. State statute details the rate setting frameworks, including the value of each cost component used to calculate rates. Cost components vary by service and include factors such as staff wages, employee benefits, employer-paid taxes, paid time off, indirect staff time, and program expenses.

After implementation of this system in 2014, the state was required by statute to conduct in-depth analysis in order to determine the long-term fiscal impacts of this system and to ensure that costs are accurately reflected in the rates. The changes in this proposal are the results of that requirement. Additionally, removal of budget neutrality factors from rate setting frameworks by the end of 2018 are a requirement of the federal corrective action plan approved by CMS.

The implementation of DWRS is a requirement of CMS. In order to maintain ongoing compliance in federal waiver plans going forward, cost components used to calculate rates will be required to be outlined and justified. The items in this proposal will ensure ongoing federal compliance with CMS by appropriately setting cost components for rate frameworks over time and maintaining continued access to disability waiver services.

In addition to maintaining federal compliance with rate setting requirements, this proposal also ensures that individuals have access to services that assist them in attaining and maintaining integrated competitive employment, a goal outlined in Minnesota's Olmstead Plan and in the Home and Community Based Services (HCBS) rule requirements released by CMS in January 2014. The new rule requires person centered planning and regulates the settings of residential and non-residential services to assure that they are not isolating for people with disabilities nor promoting characteristics of an institutional setting. Under the rule, residential and non-residential service settings must allow people to have greater personal autonomy and community integration, and greater choice for community employment opportunities and other home and community-based services funded through Medicaid. CMS requires states to develop transition plans for bringing current programs and services into compliance with these new regulations.

According to the National Report on Employment Services and Outcomes (2013), of the $255,163,000 spent in day and employment services for people with disabilities in Minnesota, only $19,129,000 supported people in integrated employment. Minnesota has one of the highest rates of segregated work outcomes for day and employment programs in the nation. When people with disabilities have the opportunity to access community based employment services, they are more likely to have greater choice, wealth, integration and equity in employment. With this proposal, it is estimated that 9,490 people monthly will receive the new employment services by SFY 2020.

Proposal:

This proposal modifies existing language in the rate setting for Minnesota's disability waivers in order to bring the State of Minnesota into compliance with CMS requirements for a uniform, statewide rate setting methodology for HCBS services. The proposal will result in appropriate rate setting formulas that accurately reflect the average cost of providing services and ensure that individuals have access to needed services throughout the state. This proposal will also ensure that Minnesota complies with federal guidance requiring rate frameworks to be re-based over time.

This proposal makes the following changes to DWRS:

- Removes after-model budget neutrality factors from rate calculations, as required by CMS;
- Adjusts component values for unit-based with programming services and unit based without programming services;
- Adjusts rate-setting methodologies for Respite Care Services;
- Adjusts rate-setting methodologies for Independent Living Skills Training services;
- Modifies language which authorized automatic inflationary adjustments to component values in the rate setting formulas;
- Adds a provider cost audit and analysis function to rate setting statute;
- Adds a required rate study related to transportation services;
- Establishes new employment service rate methodologies and modifies the billing units for day services;
- Includes technical language to modify research requirements in rate setting statute;
- Makes a change to banding language in M.S. §256B.4913 to mirror language passed in 2013. Currently, statute does not include authority to establish historic county weighted averages for day services. This is likely an oversight which was made during the plain language conversion effort. The Department currently uses weighted averages for day services.

Budget Neutrality Factors

DWRS rate setting frameworks calculate rates based on statewide cost components such as wages, employee benefits, employer-paid taxes, paid time off, indirect staff time, and program expenses. Budget neutrality factors, applied at the end of the calculations, are the only framework factors in the rate setting statute that are not attributed to provider costs. DHS is required to remove these factors by December 31, 2018 according to the corrective action plan approved by CMS. This proposal will remove these after-model budget neutrality factors from DWRS, as a requirement of federal compliance, effective January 1, 2018, on a rolling basis as individuals' service agreements renew.

After-model "budget neutrality" adjustments currently in statute were based on 2013 spending and were used in the initial implementation of DWRS in order to ensure that the new rate structure would not result in dramatic changes to aggregate spending for the disability waivers. Budget neutrality factors are the only framework factors in statute which are not attributed to provider costs. Removal of these factors will result in rate frameworks that compensate service providers at the average amount that it costs to provide the service.

The following Budget Neutrality Factors will be removed from the rate setting frameworks:

Component	Service Bucket	Current Value
Budget Neutrality Factor	Unit with Program	0.94
Budget Neutrality Factor	Unit without Program	0.796
Budget Neutrality Factor	Residential	1.003

The current inclusion of these after-model values in rate calculations results in rates that are significantly below the average costs required to provide unit-based services. It also results in rates that are above the average costs to provide residential services. Removal of these factors will result in rate frameworks that fully compensate service providers at the average amount that it costs to provide services.

Component Value Changes
Rate setting calculations in DWRS are comprised of cost components representing providers' average costs to provide the service. The current cost components were determined through research conducted in 2009 through 2012. This proposal will modify cost components for some rate setting frameworks in which updated research found that the current value is exceptionally above or below what current data suggests.

The 2013 authorizing legislation required DHS to conduct analysis and recommend adjustments to component values used to calculate rates. Findings from the most recent study, completed in June 2016 by Truven Health Analytics, are the basis for the cost component changes recommended in this proposal. While this study looked at all non-wage components required to provide HCBS services, this proposal is recommending changes only to components that had the largest variance between the new research findings and the current factor values. Those values are as follows:

Component	Service Bucket	Current Value	New Research	Difference
Program Plan Support (indirect time)	Unit with Program	3.1%	15.5%	12.4%
Client Programming & Supports	Unit with Program	8.6%	4.7%	-3.9%
Client Programming & Supports	Unit without Program (except respite)	8.6%	2.3%	-6.3%
Program Related Expense Ratio	Unit without Program	6.1%	2.9%	-3.2%
Program Plan Support (indirect time)	Unit without Program (except respite)	3.1%	7.0%	3.9%

In conjunction with the removal of the budget neutrality adjustments, these proposed changes to component values will help ensure continued access to community delivered unit-based services. A biennial Gaps Analysis conducted by DHS found that HCBS recipients most frequently cited unit-based services as services they had difficulty accessing. Unit-based services are lower-cost alternatives to facility-based residential and day services which are more structured and offer less flexibility than unit-based services. The rate setting changes in this proposal will ensure that unit-based services are priced appropriately according to the actual costs of providing these services.

These proposed changes are based on statutorily required research and analysis on the cost of providing services across the state. Additionally, rate setting frameworks are required by CMS to be rebased at least every five years. These cost components will be modified within DWRS effective January 1, 2018, on a rolling basis as individuals' service agreements renew.

Service-Specific Rate Methodology Changes
In addition to the non-wage component value changes for unit-based services, this proposal recommends to make changes to the rate-setting methodologies for two specific unit-based services, Independent Living Skills Training and Respite Care Services. These changes have been identified as a result of required research on DWRS implementation and are recommended in order to maintain compliance with rate setting implementation to ensure that rates appropriately reflect cost and ensure service access.

This proposal recommends the development of a new service titled Independent Living Skills (ILS) Training Specialist. Independent living skills training services are services that develop, maintain and improve the community-living skills of a person. This proposal creates a new tier of Independent Living Skills Training (ILS) services that will set rates based on the staff expertise, and resulting wage compensation, required to effectively evaluate, assess and create ILS service planning. This higher tier of ILS will assist with the evaluation, assessment, and creation of ILS service planning to address skill development needs of a person in the areas of communication, community living and mobility, interpersonal skills, reduction and elimination of maladaptive behavior, self-care and sensory and motor development in acquiring functional skills. Additionally, this service oversees documentation, reassessment and modification of the Independent Living Skills Training plans, and may provide training to support Independent Living Skills Training provider staff.

This proposal also recommends the rate methodology for Respite Care Services with daily units be converted from a statewide static rate methodology under DWRS to a market rate methodology. Respite services are short-term care services provided due to the absence or need for relief of primary caregivers normally providing care. This service was the leading service identified by lead agencies, providers, and individuals in the Biennial Gaps Analysis as having limited service access across the state. In addition to this research finding, fiscal analysis of DWRS has found that the rate for daily Respite is insufficient for many providers to meet the needs of service recipients. After the implementation of DWRS, DHS has received a large volume of rate exceptions for Respite daily services.

Having a statewide rate methodology that compensates appropriately according to service costs for the majority of providers is challenging for this particular service due the following:

- The wide variability in the nature of the service being provided to individuals results in large discrepancies in provider costs;
- The costs required of out of home respite providers to maintain service access (such as capital costs) when the volume of service demand is unpredictable is challenging to estimate in statewide rate frameworks

Other services that have market rate methodologies have similar variability in costs depending on the nature of the service needed by the individuals. These include services such as crisis respite, specialist services, transitional services, and transportation. Converting respite daily services would enable lead agencies and providers to set rates based on the individual's needs and the specific services provided to them. It would enable providers to be compensated based on the unique service costs of their programs, and as a result will assist in addressing service access across the state.

The changes recommended for ILS Training and Respite Care services will be effective January 1, 2018 or upon federal approval. Both changes will require waiver plan amendments. This proposal does not recommend changes to respite services with 15 minute units.

Automatic Inflationary Adjustments

This proposal modifies existing language in the rate setting for Minnesota's disability waivers involving automatic inflationary rate adjustments occurring over time.

Current law requires two separate inflationary adjustments to occur in the rate setting frameworks in July 2017 and every five years thereafter. Rate frameworks consist of wage components and non-wage cost components such as employer-paid taxes, benefits, paid time off, and administrative costs. Wage values are required to be changed according to updated Minnesota-based Bureau of Labor Statistics (BLS) wage data. Non-wage cost components are required to be modified according to changes in the national Consumer Price Index (CPI). When done in conjunction, the duplicative nature of the two adjustments result in rate changes that exceed the pace of inflation.

Due to the calculation formulas in the DWRS, when both the BLS and CPI adjustments are done in conjunction, most rates increase beyond the rate of inflation. Most of the cost components required to be updated according to CPI are defined as percentages of the direct care staff wage and their values were determined based on research conducted on Minnesota home and community based providers' costs. Because the majority of these cost factors are applied not as additive factors but as multiplicative factors to the wage value, the total dollar amount compensated for each cost is increasing according to the percent increase in the staff wage *and* an increase in the CPI. The cumulative dollar impact of applying both adjustments exceeds the rate of inflation for most cost factors in the formula.

Applying the CPI to all non-wage cost components in the DWRS frameworks also will set values beyond the appropriate values of cost found in targeted research specific to Minnesota HCBS providers. Many of these cost categories for HCBS service providers would not likely change in the same matter as trends in the national Consumer Price Index, such as employer taxes that are dictated by federal and state law, and paid time off that is quantified as a percentage of time applied to the direct care staff wage time. Automatic adjustments to these values would likely increase the cost components beyond what the costs experienced by service providers in Minnesota.

This proposal modifies this secondary inflation adjustment by only applying it to factors that are not a function of wage. These factors include transportation, client programming and supports, and facility costs. This would remove the requirement to apply CPI increases to cost components that already receive increases as a function of wage increases. For example, within the rate calculation, the cost component for taxes is a percentage applied to the wage value. Inflationary adjustments specified under current law results in the dollar value compensated to the provider for employer paid taxes to increase by the percentage that the wage increases in the BLS. In addition, the dollar value compensated to the provider for employer paid taxes will increase further by the percentage that the national CPI increases. The result is a duplicate inflationary adjustment. This proposal will remove the requirement to increase the component by the additional CPI change.

This proposal also clarifies historical rate increases enacted in the 2013 and 2014 legislative session for disability service providers would offset increases as a result of the CPI and BLS adjustments. The current economic forecast, and those before it since November 2014, assumed treatment in this manner and therefore would not have a cost. However, if the language is not clarified during this session, the November 2017 forecast will assume plain reading of the law and forecast historical rate increases stacked on top of CPI and BLS adjustments. Forecast treatment in this manner would result in an 18.41% total increase in the disability waiver rate system once fully implemented and cost $31.8 million in FY18-19 and $114.1 million in FY20-21.

These proposed changes will result in cost components that more accurately reflect costs over time, a primary requirement of CMS. This change will be effective July 1, 2017, on a rolling basis as service agreements renew.

Provider Cost Review and Audit

In conjunction with modification of automatic CPI and BLS adjustments, this proposal requires a review of provider costs in order to provide data-based recommendations to the legislature every five years. CMS requires the re-basing of HCBS rates on regular intervals. This proposal will require HCBS providers to submit cost information to the department. It will also provide for department resources to audit information submitted. The department will use data gathered to recommend changes to the rate setting frameworks in reports currently required to be submitted to the Legislature every four years. This proposal will ensure that the rate setting methodology appropriately reflects provider costs over time.

This proposal includes funding for the development and administration of an online cost submission portal; maintenance of data systems; technical assistance and guidance to providers submitting data; two FTEs to audit a statistically significant random sample of provider submissions; and one FTE to provide analytics and recommendations on rate setting frameworks to the legislature.

Transportation Research

This proposal recommends required research to be conducted in order to develop comprehensive recommendations for a statewide rate setting methodology for transportation services funded through home and community based waivers. A healthy transportation network is vital to home and community based services. Access to transportation increases individuals' ability to access needed services and achieve community integration. However, currently access to transportation has been identified as a significant gap by providers, individuals, and lead agencies in the agency-conducted Gaps Analysis study. Currently, there is not a statewide rate setting methodology for transportation rates. In some areas, it is authorized as a per-trip service and in other services it is bundled within service rate frameworks. Development of a statewide rate setting methodology for transportation will further the state's rate setting implementation of DWRS and will help ensure that individuals have access to needed services across the state.

This proposal funds research and analysis necessary to make recommendations to the legislature to redesign transportation funded through waiver services to better align with transportation and transit planning across the state and provide people who use services with needed transportation. The department will use an external contract to do the work. This project will seek to:

- Study all aspects of the current transportation service network, including but not limited to the fleet available, the different rate setting methods currently used, methods that individuals access transportation, and the diversity of available provider agencies;
- Identify current barriers for individuals accessing transportation and for providers providing waiver services transportation in the marketplace;
- Identify possible efficiencies and collaboration opportunities in order to increase available transportation, including other MA funded transportation and available regional transportation and transit options;
- Study the transportation solutions in other states for the delivery of home and community based services;
- Study provider costs required in order to administer transportation services;
- Develop recommendations for the coordination and increased accessibility of transportation across the state; and
- Develop recommendations for the rate setting of waivered transportation

DHS will partner with MnDOT, and transportation service providers to ensure appropriate, statewide solutions are identified. The proposal requires research, analysis and oversight of the initiative by department staff. This proposal requires DHS to provide recommendations to the legislature by January 15, 2019.

Creation of New Employment Services
This proposal recommends the creation of three new employment services and modification of current day services in order to promote access to services that will help support people seek, retain, and maintain access to integrated, competitive employment. To transform Minnesota's day and employment waiver service system, this proposal establishes three new employment support services and rate methodologies. These services will replace the current Supported Employment Services and their rate methodologies will be based on the staff expertise required to assist individuals in their employment goals.

Employment Exploration Services (EES) are community-based orientation services that introduce a person to competitive employment opportunities in their community through individualized educational activities, learning opportunities, work experiences and support services. EES will result in the person making an informed decision about working in competitively paying jobs in community businesses.

Employment Development Services (EDS) are individualized services that actively support a person to achieve paid employment in their community. EDS assists people with finding paid employment, becoming self-employed or establishing microenterprise businesses in their communities.

Employment Support Services (ESS) are individualized services and supports that assist people with maintaining paid employment in community businesses. ESS are to occur in integrated community settings. People receiving ESS assistance on an individual basis or in a group should have the opportunity to experience and meaningfully interact with co-workers without disabilities and people in the community without disabilities.

In addition to these three new employment services, this proposal removes the partial day unit for Day Training and Habilitation (DT&H) services to increase clarity and choice in the specific services a person is receiving and being billed for. DT&H services that do not span six or more hours will be billed in 15-minute units. Currently, units are billed in daily, partial day, and 15 minute units. Daily units are defined as DT&H services that span six or more hours in one day. Both daily units and 15-minute units have a statewide rate setting methodology through the Disability Waiver Rate System (DWRS) as required by CMS. However partial day units are negotiated rate amounts for services provided with no defined span of time.

With this proposal, DT&H services that do not span six or more hours will be required to bill in 15-minute units. Service rates will then be calculated through the statewide rate setting methodology, and they will be billed specifically for services provided to the individual.

The intended results of this proposal are to:

- Have a consistent formula for setting rates for DT&H services;
- Pay specifically for the services that are rendered to individuals; and
- Have the ability to account for the level of services that are being provided

As a final component of the employment service transformation, DHS will seek to define and establish criteria for services provided by Day Training and Habilitation and Prevocational Services, including moving center-based employment to

Prevocational Services. DHS will work with stakeholders, and use available data, such as the Gaps Analysis, DHS employment data base, and National Core Indicators, to separate and define services that have been bundled in DT&H, and establish criteria for center based work to assure people have experiences and options when making informed choice through a person centered planning process. DT&H services will include the services that prepare individuals for community inclusion and wrap around the new employment services. Waiver amendments that address center-based employment and clarify the definition of other services provided by a DT&H will be developed, posted for a 30 day public comment period and submitted to CMS in 2018.

The three new employment services in this proposal require waiver plan amendments and will be effective January 1, 2018 or upon federal approval. Removal of DT&H partial day units will be effective when the banding period is complete, January 1, 2019 or 2020 upon federal approval of the additional year of banding.

IT Related Proposals:

This proposal will require programming changes to the Rate Management System (SSIS) and MMIS. In addition, there are systems costs that are for the Disability Waiver Rate Setting system, MNCHOICES and costs that are not directly associated with a major system. These are small costs that are included for each of the components for this proposal.

The provider audit requires systems development resources to develop an online tool to accept and import electronic files from providers, as well as maintain systems operations in the building and developing of data warehouse tables and data views.

Results:

The department uses the following studies in order to assess fiscal policy indicators:

Component Value Research: The department conducts analysis on the DWRS in order to assess the accuracy and effectiveness of rate setting methods. Findings from the most recent study, completed in June 2016, are the basis for the cost component changes recommended in this proposal.

This analysis will continue ongoing to ensure that cost components accurately reflect the costs required to provide HCBS services in Minnesota. Component value analysis in the past has involved voluntary surveys to providers on the cost components required to provide HCBS services, as well as an environmental scan of other primary data sources from other state or federal agencies. The provider cost audit in this proposal will allow the department to conduct robust research on provider costs in which data submission is required and quality assurance measures are completed. From this data collection, the following measures will be assessed:

- Does the Disability Waiver Rate Setting methodology accurately reflect provider costs?
- Are there particular cost components that should be modified?
- Are there particular cost components required of particular services that should be amended?
- Do provider costs have statistically significant variation in different regions across the state?

These research questions will be assessed ongoing and research findings will be made available to the Legislature and stakeholders ongoing.

Gaps Analysis: The department also conducts biennial studies assessing areas of the state and particular services in which service access may be hindered. In this study, HCBS recipients most frequently cited unit-based services as services that they have difficulty accessing. Examples of the unit-based service most often rated as having significant or large gaps were Respite Care and Supported Employment. This biennial study will continue to assess service access across the state.

Statutory Change(s):

M.S. §256B.4913, subd. 4; §256B.4914, subds. 5, 8, 9, 16

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			(2,197)	(7,285)	(9,482)	(9,506)	(19,041)	(28,547)
HCAF								
Federal TANF								
Other Fund								
Total All Funds			(2,197)	(7,285)	(9,482)	(9,506)	(19,041)	(28,547)
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	33 LW	MA Waivers- BNF adjustment	1,476	5,653	7,129	9,016	18,403	27,419
GF	33LW	BNF interactive Effects	(21)	(160)	(181)	(409)	(1,441)	(1,850)
GF	11	Systems cost- BNF- 50% FFP	2	0	2	0	0	0
GF	33 LW	MA waivers- Component value changes	(32)	60	28	778	3,988	4,766
GF	11	Systems cost- Component value 50% FFP	2	0	2	0	0	0
GF	33 LW	MA Waivers- Remove CPI/BLS duplication	(2,777)	(8,120)	(10,897)	(12,086)	(27,806)	(39,892)
GF	11	Systems- CPI/BLS- 50% FFP- DWRS	2	0	2	0	0	0
GF	33 LW	New employment services	(2,126)	(7,645)	(9,771)	(11,820)	(18,501)	(30,321)
GF	55	Disability Linkage Line- Employment	100	100	200	100	100	200
GF	11	Systems- MMIS- New employment Services	4	1	5	1	1	2
GF	11	Systems- SSIS – New employment services	2	0	2	0	0	0
GF	11	Systems- Other-50% FFP- New employment services	29	6	35	6	6	12
GF	33LW	Non-wage Component changes for Employment services	1,320	3,841	5,161	5,515	4,981	10,496
GF	33 LW	Remove Partial day units for DT&H	(959)	(2,467)	(3,426)	(2,653)	(2,849)	(5,502)
GF	11	Systems- MMIS- Remove Partial Day	1	0	1	0	0	0
GF	11	Systems- DWRS- Partial day- 50% FFP	1	0	1	0	0	0
GF	33 LW	New ILS rate level	194	840	1,034	1,484	2,886	4,370
GF	11	Systems- DWRS 50% FFP- New ILS Rate level	1	0	1	0	0	0
GF	33 LW	Respite at Market rate	27	137	164	312	941	1,253
GF	15	CSA administration- Provider survey and audit	150	380	530	294	294	588
GF	11	Systems- provider audit- 50% FFP	282	56	338	56	56	112
GF	15	CSA admin- Transportation study	250	250	500	0	0	0
GF	11	Systems- DWRS/MNCHOICES/MNSPA- 50%- contract	15	3	18	3	3	6
GF	REV1	CSA admin-35	(140)	(220)	(360)	(103)	(103)	(206)
Requested FTE's								
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	15	CSA administration	1	3		2	2	

Change Item Title: Individual Community Living (CS-76)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	470	626	(1,220)	703
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	470	626	(1,220)	703
FTEs	**6**	**9**	**9**	**7**

Recommendation:

Effective July 2017, the Governor recommends reforming, realigning, and expanding income supports, supportive services, and community-based infrastructure needed to increase the number of adults with disabilities who can remain in their own home or move out of institutions, facilities or homelessness into their own home in the community, based on their need and choice.

Rationale/Background:

People with disabilities are often stuck in institutions or group homes, bouncing between friends' couches and crisis beds, and sleeping on mats in homeless shelters. Three main issues prevent people with disabilities from accessing housing in the community:

- *Many people with disabilities cannot afford to live in the community.* Only 1 out of 3 people with disabilities who live in their own homes can sustainably afford their housing. More than 30,000 people with disabilities who have low income get help paying for housing through Group Residential Housing (GRH) and Minnesota Supplemental Aid (MSA) Housing Assistance, but these programs allow only a small portion of program recipients to live in a place of their own in the community. Most recipients live in group or congregate settings.
- *People with disabilities often lack the support they need to live successfully in the community.* Affordable housing is not always enough for a person with a disability to be able to find and maintain housing. Issues such as mental illness symptoms and cognitive challenges can make it difficult for someone to search for and secure housing, interact with landlords and neighbors, and adhere to the requirements of a lease. The right supports, provided by a professional with knowledge and experience in housing, can significantly mitigate these factors. DHS recently identified over 51,000 adults with disabilities who are in unstable housing or potentially segregated settings. Of this group, only about half were connected to a program that could potentially help them with housing in the community. People are disconnected for many reasons, including ineligibility due to a lack of or incorrect diagnoses, the complexity of the difficult-to-navigate system, and inadequate funding.
- *Access to affordable housing in the community is inequitable.* People with disabilities who also have low income, have mental illness, or live outside the metro area are overrepresented in group settings and in homelessness counts. American Indians and Blacks are more likely than other racial and ethnic groups to be experiencing homelessness or living in large facility settings.

Minnesota currently has two 100% state-funded income support programs intended to help address housing needs for people who have both disabilities and limited income – Group Residential Housing (GRH) and Minnesota Supplemental Aid (MSA) Housing Assistance.

GRH pays for room and board costs for adults with low-income who have a disability. Recipients of GRH live in licensed facilities (e.g. Adult Foster Care, Board and Lodge, Assisted Living) or in their own home with a signed lease. In either case, a provider or "vendor" manages the room and board expenses on behalf of the individual. Individuals receiving GRH, whether in

licensed facilities or their own home, are assured to have basic needs met (shelter, food, utilities, bed, laundry, etc.). Today, most GRH recipients reside in group settings (85%), and the rest receive GRH income supports in their own home in the community (15%). However, the proportion of GRH recipients living in their own home continues to increase.

Some people with disabilities prefer not to live in a licensed facility and/or have a vendor managing their room and board needs, and would rather manage their own budget to meet their needs. Minnesota Supplemental Aid provides a general income supplement of $81 to about 30,000 people receiving or eligible for Supplemental Security Income (SSI). For MSA recipients with housing costs higher than 40% of their monthly income, MSA Housing Assistance provides an additional direct cash benefit of $194. However, the amount of MSA Housing Assistance is not enough support more people to live in the community. In addition, MSA Housing Assistance has limited eligibility, so has not been available to many people with disabilities. This includes people in Group Residential Housing settings who want to move out and/or manage their own room and board needs, but who need income supports to do so. In part due to the low amount of the MSA Housing Assistance benefit, only 3% of MSA recipients receive the extra income support provided through housing assistance to help them afford to live in the community.

Comparison of GRH and MSA Housing Assistance recipients, Group vs. Community, (July 2016)

Income Support Program	Group settings	Community settings	Total
Group Residential Housing	17,114	3,670	20,784
MSA Housing Assistance	0	811	811

GRH also pays for monthly supplemental services for about 5,800 out of 21,000 people who receive GRH. About 170 service provider agencies deliver supplemental services to people living in over 1,100 locations around Minnesota. Approximately half of individuals receiving GRH-funded services live in a licensed facility and half live in their own home in the community.

Today, at its core, GRH supplemental services provide a limited set of services for residents who qualify, including: medication reminders, assistance with transportation, arranging for meetings and appointments, and arranging for medical and social services, up to 24-hour supervision. However, there are several exceptions in law authorizing rates for some providers to provide additional services for people with special needs. Types of additional services vary, but can include mental health services, or health supervision by a licensed nurse, or intensive services for individuals with long histories of homelessness and chemical dependency. The types of settings that receive higher-than-average GRH supplemental services vary, from short-term programs to permanent supportive housing projects – a person's own home. Some of the settings that receive special rates were designed specifically to provide housing stability for American Indian adults who have cycled in and out of treatment facilities, jail, and homelessness.

A 2014 report to the Minnesota legislature recommended changes to GRH supplemental services to better align payment rates with individual need and level of care. Those recommendations would better target state funds to support people who will not qualify for services funded by Medical Assistance due to their living situation. For example, some GRH settings do not meet home-and-community based characteristics required for waiver services or personal care assistance services. A 2016 report due to the Minnesota legislature will propose policy shifts to free up to GRH state funds paying for services for people living in their own homes. Instead, those dollars could support a match for Medicaid housing-related services.

In June 2015, the Centers for Medicare and Medicaid Services (CMS) issued an Informational Bulletin regarding the coverage of housing-related activities and services for individuals under Medicaid. The bulletin identifies how housing-related activities and services can be incorporated into a Medicaid benefit set for individuals to achieve optimal community integration. The 2016 legislature directed DHS to design a housing support service to help people with disabilities locate and secure stable housing as well as maintain housing through support services.

While some individuals do access health care services that support their housing-related needs through Medicaid, such as waiver services, mental health services and case management, gaps in terms of eligibility and provider capacity can lead to limited effectiveness. Landlords and housing developers often need assurance that if they work with people with disabilities who have multiple barriers, there will be services available to support them in their housing. Services that have a healthcare focus can provide that incentive and remove barriers for people with disabilities.

There is very limited community infrastructure to adequately support the needs of people with disabilities who want to live in the community. There is a great deal of up-front work that is needed to engage individuals to better connect them to services and

educate them about options for living in the community. Advocates, providers, and government staff are often at a loss to understand community living resources to help people meet their needs. People with disabilities are often shut out of the private rental market due to lack of or bad rental history, criminal history and behavioral issues so dedicated trained professionals with housing expertise are necessary to help break down these barriers.

There is also a growing need to support counties and tribes in their role overseeing the GRH program. The 2015 State Legislature enacted a series of GRH program policy changes to enhance the quality and consistency of services and housing for people with low incomes and disabilities, assure equal access to housing and services across all counties and tribes, and to simplify program rules. One of the most significant changes allows more counties and tribes to contract with GRH providers who support people living in their own homes with signed leases. Since these changes were implemented, the number of GRH recipients living in their own home with signed leases has continued to grow.

Proposal:

This proposal includes three main components: Income Supports, Support Services, and Community Living Infrastructure. By combining these three crucial elements, this proposal will increase the number of adults with disabilities living in stable, integrated housing in the community.

This proposal is intended to increase the number of people who can access community living, as an alternative to institutions, facilities and homelessness, according to the needs and choice of the individual. The overall goal of this proposal is to shift dependence on group homes and expensive facilities to empower people to live in more integrated settings in the community. By implementing this proposal:

- People will have more options to choose where they want to live.
- More people will remain in their own home and avoid institutional stays or homelessness.
- More people will move out of institutions, hospitals and group settings to the community.
- High level of care facilities will open up for people with high needs, reducing backlog and waiting lists.
- Minnesota will have a better functioning system to support people with disabilities who want to live in the community.

Because this proposal is not limited to a particular disability diagnosis or population type, it will benefit a wide range of the adults with disabilities. The Housing and Supports Division will lead DHS staff from across the department, including the Adult Mental Health, Alcohol and Drug Abuse, Disability Services and Aging divisions, to implement this proposal. DHS will also work closely with counties and local service providers to ensure eligible individuals will be able to access these programs.

Income Supports

This proposal would realign existing income support programs – GRH and MSA Housing Assistance – to help more people afford community living and allow for greater choice. Specifically, the proposal would expand eligibility for MSA Housing Assistance to include people moving out of GRH settings and increase the benefit to an amount that will help people afford to live in the community. This is intended to better align MSA Housing Assistance with GRH in order to allow individuals to choose the income support program that best suits their need and provide more people the option of managing their own housing benefits.

These changes will help an estimated 1,467 people, including 126 new recipients (average monthly) move into or stay in the community in FY21, and an estimated 1,850 people, including 370 new recipients (average monthly), at full implementation. The proposal would also rename the GRH program to clarify that the program is not limited to “group” or congregate settings but can also be used to support people in their own home in the community.

This results in a net increase in spending from the state general fund of $3 million in FY21 (assuming a September 2020 start date). The services will cost $4.2 million annually once fully implemented.

Housing Support Services

Establish two new Medical Assistance (MA) benefits services to support individuals living in the community:

Housing Transition Services

These are services designed to help people locate and obtain housing in the community and include:

- Tenant screening and housing assessment
- Developing an individualized housing support plan
- Assisting with housing search and application process
- Identifying resources to cover one-time moving expenses
- Ensuring new living environment is safe and ready for move-in
- Assisting in arranging for and supporting details of the move
- Developing a housing support crisis plan
- Payment for accessibility modifications to new housing

Tenancy Support Services

These are services designed to help people maintain stable housing and include:

- Prevention and early identification of behaviors that may jeopardize continued housing
- Education and training on role, rights and responsibilities of tenant & landlord
- Coaching to develop and maintain key relationships with landlords/property managers
- Advocacy and linkage with community resources to prevent eviction when housing is at risk
- Assistance with housing recertification processes
- Coordination with tenant to review, update and modify housing support and crisis plan on a regular basis
- Continuing training on being a good tenant / lease compliance / household management

The target population for Housing Support Services is people whose disability or disabling condition(s) limit their ability to obtain and/or maintain stable housing, as evidenced by homelessness or residence in institutions and other segregated settings. In order to receive these services, a recipient must be currently residing in – or transitioning to - a Home and Community Based Setting. Combined, these two new services are estimated to support an estimated 5,088 people, including 694 that are new recipients, to move into or stay in the community by FY2021.

Enrolled providers are expected to come from many different sectors, including supportive housing for people experiencing homelessness, chemical dependency treatment and community providers, GRH Supplemental Service providers, Housing Access Services grantees, Home and Community-Based Waiver providers, Relocation Service Coordinators, and mental health providers. Services will be designed to be accessible to providers with housing expertise and to providers working with diverse populations (in order to address disparities among this population). Services must be made available statewide per CMS guidelines.

To help offset the cost of these new services, this proposal would repurpose existing state funds to help cover the non-federal share. Specifically, GRH Supplemental Services currently utilized for people who live in their own home with a signed lease but who will be eligible new services under the MA benefits that would be duplicative, will be decreased. In addition people who are currently receiving or are eligible for Housing Access Coordination or Transitional Services Supports (EW) under a waiver will be able to access the service through the state plan instead. This proposal would also allow DHS to realign priorities for existing state housing support service grants currently targeted for single adults (e.g. Housing with Supports for Adults Serious Mental Illness, Long Term Homeless Supportive Service Funding, and homeless grants) to be targeted at supporting other groups who may not be able to readily access the new services (e.g., homeless families and youth).

This proposal would leverage further savings by eliminating service rate enhancements that have been earmarked for specific GRH settings but which are not tied to unique enhanced programming or requirements to maintain housing tax credits and other funding commitments, which are dedicated to specific permanent supportive housing GRH programs. The service rates for these programs would be reduced to the standard rates paid to other similar providers.

The creation of a new Medicaid benefit for Housing Transition Services and Housing Tenancy Supports is estimated to begin in July 2019 and cost $8 million in FY20-21. This will be offset by a $13.9 million in FY20-21 reduction to existing GRH supplemental services that are considered duplicative of the new benefit. Eliminating GRH service rate enhancements for specific site-based GRH programs that receive higher service rates than other similar programs and aligning these rates with the standard GRH service rate will result in $3.7 million per biennium in savings to the general fund in both FY18-19 and FY20-21.

Community Living Infrastructure

This proposal funds the community-based infrastructure necessary to support the needs of people with disabilities who want to live in the community.

County and tribe infrastructure support

The proposal would provide allocations to counties and tribes which could be used for the following purposes:

- Outreach to people who are homeless or living in institutions or facilities. Funding to locate, contact, and engage people who are homeless, unstably housed, or who want to relocate from hospitals, treatment centers, corrections, or other facilities into their own home in the community. This funding will identify individuals in need, screen for basic needs, and assist with referral to community living resources to meet an individual's need and choice.
- Housing Resource Specialists. Funding to pay for regional housing resource specialists who can support individuals with disabilities, advocates, providers, and government staff. The role of a housing resource specialist is to know and provide technical assistance and consultation on housing-specific resources, including HUD, MN Housing, DHS, public housing authorities, and private-market resources available to individuals with disabilities and low income.
- Funding to counties and tribes to administer and monitor programs. Funding for their role in administering the GRH program. The amount of funding awarded to each county and tribe is based on the number of GRH settings they manage and the amount of time required for oversight of GRH providers. This funding will support counties and tribes in their duties and in implementing state policy directives.

This proposal would provide allocations for counties and tribes of $1.4 million annually in FY18-19, and increasing to $1.5 million annually in FY20-21.

DHS quality assurance trainers for counties, tribes, and providers

The 2015 Governor's budget proposal included funding for 2 FTEs to provide, for the first-time, dedicated GRH trainers for counties, tribes, and providers. It did not move forward. The Department identified these positions as priorities to receive internal funding for one year, ending June 30, 2017. Training requests for the staff in these positions has been overwhelming, as has positive feedback following trainings completed to date for filling this previous gap. This request continues the funding for these positions in the base.

DHS Staff

This proposal would require the addition of seven new DHS staff:

- 5 FTEs for the new Housing Support Services MA benefit, including 2 FTEs who will ensure federal compliance for state wide coverage by recruiting new providers, providing trainings and technical assistance, ongoing data collection and reporting for the project and 3 FTE in provider enrollment will manage the increased amount of new providers who will be enrolling to provide this new service (2FTE will be temporary/unclassified for two years, 1 FTE will be on-going).
- 1 FTE will provide grant management, oversight, and technical assistance
- 2 FTE trainers will provide in-person training to counties, tribes, and providers throughout the state
- 1 FTE will manage and coordinate community living activities and staff

Systems Impact

This proposal will require changes to both the MAXIS and MMIS systems. The total systems fiscal impact is outlined below.

MSA Housing Assistance Expansion

- $43K total one-time cost for the MAXIS system changes, no additional mailing costs as we will be implementing this at the same time as the current MSA Shelter Needy Mass Change process. No ongoing annual 20% maintenance cost.

GRH Support Services Rate Change

- $51K total one-time cost for the MAXIS system changes, no additional mailing costs as we will be implementing this at the same time as the current GRH Rate Change process. No ongoing annual 20% maintenance cost.
- $14K total one-time cost for a second update to the rate change in 2020

GRH Program Name Updates

- $51K total one-time cost to implement program name changes in the MAXIS system. No ongoing annual 20% maintenance cost.

MMIS Update

Costs are below.

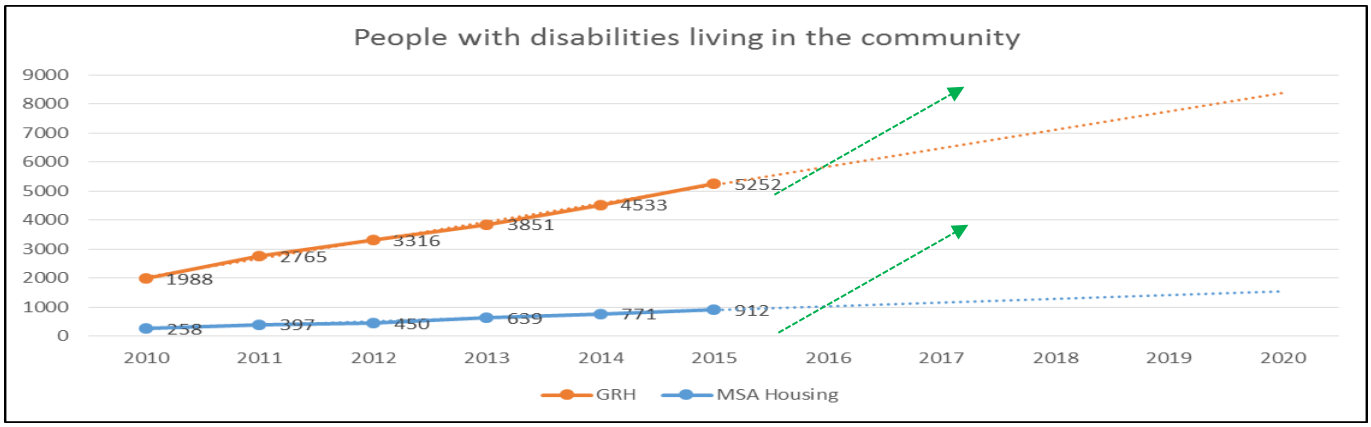
Process	Estimated Hours	Estimated Cost	State Share (29%)
Project Management	1040 hours	64,313.60	
BA requirements gathering and document	1200 hours	73,428	
Technical development	1235 hours	103,431.25	
BA/QA testing	640 hours	39,161.60	
Release Management	12 hours	793.68	
Total:	4127 hours	$286,128	$82,977
Ongoing system cost		$56,225.63	$16,305

IT Related Proposals:

Caveats to the systems estimates:

- This proposal is being viewed as a single proposal that is not part of a package
- The proposal is passed by the legislature by 06/2017
- The effective date of 07/2017 may change based on other legislative priorities that are as yet unknown
- MMIS system constraints (e.g. module contention) due to other projects priorities may impact the required effective date
- System modernization schedule may impact the required effective and implementation date

Results:



Current

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Percent of GRH recipients with signed Interim Assistance Agreement	14.6%	16.0%	May 2014 May 2015
Quality	Percent of GRH applications processed within 30 days	52%	58%	May 2014 May 2015
Results	Number of GRH recipients moving out of homelessness	1,930	2,267	May 2014, May 2015
Quantity	Percent of MSA recipients who receive MSA housing assistance	2.0	2.4	Dec. 2013 Dec. 2014

Proposed

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Results	Number of people receiving income supports who live in a community setting	N/A	N//A	
Results	Number of people moving from institutions or residential settings into community living	N/A	N//A	
Results	Number of people with stable housing over time	N/A	N//A	
Results	Increased racial equity across group and community living settings	N/A	N//A	

Statutory Change(s):
256D, 256I, 256P, 256B

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			470	626	1,096	(1,220)	703	(518)
HCAF								
Federal TANF								
Other Fund								
Total All Funds			470	626	1,096	(1,220)	703	(518)
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	33 ED	MA Elderly & Disabled	0	0	0	1,965	4,141	6,106
GF	33 AD	MA Adults without Children	0	0	0	634	1,338	1,972
GF	24	MN Supplemental Assistance	0	0	0	0	3,032	3,032
GF	25	Group Residential Housing	(1,835)	(1,835)	(3,670)	(6,280)	(11,247)	(17,527)
GF	47	Child & Economic Support Grants	1,680	1,680	3,360	1,780	2,880	4,660
GF	15	Housing Supports Admin (FTEs – 6 9,9,7)	814	1,034	1,848	991	815	1,806
GF	15	Housing Supports Other Admin	20	20	40	20	20	40
GF	Rev1	FFP @ 35%	(292)	(369)	(661)	(354)	(292)	(646)
GF	16	Systems (MAXIS & MMIS)	83	96	179	24	16	40
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	15	Housing and Support Services Division	6	9		9	7	

Change Item Title: HCBS Reform: Corporate Foster Care Moratorium Exceptions (CS36)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	76	67	67	67
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	76	67	67	67
FTEs	**1**	**1**	**1**	**1**

Recommendation:

Effective July 1, 2017, the Governor recommends the creation of two targeted and budget neutral exceptions to the moratorium on expansion of corporate foster care capacity. The components of this proposal allow the state to support individual choice and health and safety requirements, while addressing waiver population growth, demographic changes, and program changes.

The HCBS Reform proposals continue the redesign of home and community based services to align with changing expectations of those receiving services, provisions in the Americans with Disabilities Act, and long term sustainability of services. These proposals support better outcomes, administrative efficiencies, and increase functionality of waiver management tools. Together, these proposals enable people to receive flexible, individualized services where they live and work.

Rationale/Background:

The moratorium on the growth of child and adult corporate foster care and community residential settings was put into place by the legislature in 2009 as a savings measure to promote more cost effective services appropriate to meet a person's needs. Corporate foster care is a very expensive service model. It is also one of a range of services options that are available so people can receive the most appropriate services to meet their needs while encouraging a better flow and transitions from safety net services to more community-based settings. There are currently five exceptions to the moratorium in state statute:

- Foster care or community residential settings that require Minn. Chapter 144D housing with services registration (this is required when 80% or more of the residents are age 55 or older);
- New foster care and community residential setting licenses replacing foster care licenses that were in existence on May 15, 2009, or community residential setting licenses that were in existence on December 31, 2013, and determined to be needed by the commissioner;
- Foster care licenses or community residential setting licenses determined to be needed by the commissioner for the closure of a nursing facility, ICF/DD, or regional treatment center; restructuring of state-operated services that limits the capacity of state-operated facilities; or allowing movement to the community for people who no longer require the level of care provided in state-operated facilities;
- New foster care or community residential setting licenses for persons requiring a hospital level of care including Community Alternative Care (CAC) waiver and Brain Injury (BI) waiver for people at a neurobehavioral hospital level of care (BI-NB); and
- New foster care or community residential setting licenses of community residential settings for the transition of people from Personal Care Attendant (PCA) to home and community-based services.

Enrollments in the disability waiver programs increased by approximately 10,240 persons between 2009 (when the corporate foster care moratorium was put in place) and 2015. Accommodating the increased population within moratorium limits represents a significantly reduced reliance on the corporate foster care model. Despite reduced reliance, actual corporate foster

care capacity has increased modestly during the moratorium, leaving no room to accommodate the limited expansion permitted under the terms of this proposal.

Proposal:

This proposal requests limited expansion of corporate foster care and community residential setting capacity to address current unmet needs. Based on the analysis of DHS and input from stakeholders, the exceptions in this proposal are situations where modest growth in the corporate foster care and community residential licensed setting capacity is warranted; however, there aren't current exceptions to the moratorium in law that address these situations. These additional exceptions are targeted to honor the community of choice of people who have a need for the level of services provided in a licensed corporate foster care or community residential setting.

These two limited exceptions to the moratorium are:

1. Allow people who are transitioning from the Residential Care waiver service to choose to access waiver services in a foster care or community residential setting in the community where they prefer to live. The residential waiver service will be discontinued.
2. Allow people who are currently receiving services in unlicensed settings that are similar to services provided in a corporate foster care or community residential setting to choose to receive services in a licensed setting.

Proposed Exception #1: Residential Care Closure Conversions

Residential Care waiver service will be discontinued from the Brain Injury (BI) and Community Access for Disability Inclusion (CADI) waivers on June 30, 2018. This waiver service is being discontinued because this service is intended to provide only a minimal amount of service, which is often different than the level of service needed or actually provided to the person. In addition, this service does not have adequate health, safety, and rights standards and safeguards necessary for people who meet the level of care required by the waiver programs. As part of the transition to alternative services, a lead agency with a person receiving residential care may request an exception to the foster care moratorium provided the person meets the following: (1) the person's foster care or community residential setting services are cost neutral in comparison to the service cost of the Residential Care waiver service, (2) the person was given an informed choice of services, service providers, and location of the services; and (3) the person choses to receive foster care or community residential setting waiver services. We estimate up to one hundred (100) beds will be added, based on a person's choice, over a three year period.

Proposed Exception #2: Unlicensed Settings

There are currently unlicensed settings statewide that function identically to a corporate foster care or community residential setting with 24/7 services and shift staff models of support. As these settings are discovered, they may need to be licensed to provide necessary protections to people. This proposal includes a time-limited period when unlicensed settings of this type convert to a licensed corporate foster care or community residential setting rather than closing the site with possible homelessness or institutional care for the individuals currently living there. This exception will only be available when the services provided in a person's foster care or community residential setting are cost neutral compared to the current services they receive in the unlicensed setting. If the setting requires a license, but does not receive a license in the available time period, people will not be able to receive services in that setting. DHS has developed policy clarification on when a setting is considered a person's own home and doesn't require a license, which will help eliminate these settings in the future. DHS is currently analyzing data to determine the potential number of beds that may be necessary to address this need.

Both exceptions do not have a service cost since individuals are already receiving disability waiver services and are only eligible for these exceptions if the current cost is no more than or equal to the cost of the individual's service in a corporate foster care setting. The overall corporate foster care capacity will not be reduced as a result of this proposal. This proposal provides additional choices for lead agency case managers to offer to people who will already need to transition to other service options because of the elimination of the Residential Care service. There is a cost for a FTE for provider enrollment who will be responsible for enrolling any changes in provider status.

Results:

Type of Measure	*Name of Measure*	*2009*	*2013*	*2018*
Results	Percent of people on the disability waivers with high needs. This measure shows that people with disabilities and high needs are staying in their homes or communities.	77.5%	79%	Increasing

Statutory Change(s):
M.S. §245A.03

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			76	67	143	67	67	134
HCAF								
Federal TANF								
Other Fund								
Total All Funds			76	67	143	67	67	134
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	13	Provider enrollment	117	103	220	103	103	206
	REV1	Admin FFP (35%)	(41)	(36)	(77)	(36)	(36)	(72)
FTEs								
GF	13	HCA – PE	1.0	1.0		1.0	1.0	

Change Item Title: HCBS Reform: Individual Budgeting Recommendations (CS62)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	0	0	325	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	0	325	0
FTEs	**0**	**0**	**0**	**0**

Recommendation:

Effective July 1, 2019, the Governor recommends that the Minnesota Department of Human Services study and develop an individual budgeting model for disability waiver recipients. An individual budgeting model will increase recipient choice in the authorization and purchasing of home and community based services (HCBS).

The HCBS Reform proposals continue the redesign of home and community based services to align with changing expectations of those receiving services, provisions in the Americans with Disabilities Act, and long term sustainability of services. These proposals support better outcomes, administrative efficiencies, and increase functionality of waiver management tools. Together, these proposals enable people to receive flexible, individualized services where they live and work.

Rationale/Background:

Currently, there are inconsistencies in how lead agencies authorize funds and people receiving services often do not have access to the amount of money available to purchase the services they need and want in order to plan for services and select providers. This may mean that everyone does not have the same access to services.

An individual budget methodology will provide information to the person looking for services, which will assist in the planning process by providing an estimate of the amount of money available to purchase services based on information in the individual's assessment. This information will allow the person to make individualized choices on the type of support they wish to purchase and will support the person-centered planning process.

Proposal:

This proposal provides one-time funding to contract with an external vendor to study an individual budgeting model for waiver recipients and provide implementation recommendations to the legislature in 2021. An individual budget model will increase a person's knowledge of service options which will further service choice and service satisfaction. This proposal includes updating the Consumer Directed Community Supports (CDCS) budget methodology as well as establishing an individual budgeting model for traditional waiver services. This proposal requires DHS to:

- Study and establish an individual budgeting model for traditional waiver services;
- Develop an updated methodology for Consumer Directed Community Supports budgets; and
- Provide recommendations to the legislature by January 15, 2021

This proposal requires input and cooperation from people with disabilities, family members, lead agency and provider partners as well as advocates. The proposal requires research, analysis and oversight of the initiative by department staff.

Administrative funding is requested in order to obtain the appropriate expertise to study and develop an individual budgeting model. The department will secure a contract with an external vendor to do this work. The contractor activities include national case study research, analysis of current program usage and expenditures, stakeholder engagement, and development of individual budgeting options and transition plan. Current department staff will administer the contract.

IT Related Proposals:
This proposal does not include IT-related costs.

Results:
This proposal achieves the following:

- People will have the support and information necessary to advocate for themselves and direct their own services.
- Peoples' level of satisfaction with services they receive will improve as measured by a participant survey
- People have increased choice and are able to exercise control over who delivers services and what services are delivered
- People will make choices within budget given to them, and design innovative solutions to meet their needs
- There will be increased consistency in the management and authorization of waiver funds.
- Providers deliver high quality services that are designed to meet the needs of the person

DHS conducts the National Core Indicators study to assess outcome measures for services provided to individuals and their families. This study is a national study and outcome data is compared to other states. Key measures in this study include the following focus areas: employment, rights, service planning, community inclusion, choice, health, and safety.

In the focus area of choice, the most recent study conducted in 2014-2015 found that:

- 42% of people felt that they had choice or input in choosing where they go during the day. Nationally the average was 63%.
- 39% of respondents reported that they chose or could request to change their staff, compared to 66% nationally
- 77% reported that they had input in choosing their daily schedule, compared to the national average of 83%
- 82% reported that their case manager asks them what they want, compared to 87% nationally
- 86% reported that they helped make their service plan, compared to 87% nationally

An individual budget methodology would assist individuals in the service planning process by providing access to information on the amount of money available to purchase services and available providers to deliver needed services. The measures listed above would be replicated in order to measure choice and involvement in the service planning process over time.

Statutory Change(s):
Rider.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund						325	0	325
HCAF								
Federal TANF								
Other Fund								
Total All Funds						325	0	325
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	15	CSA Admin				500		500
GF	REV1	FFP (35%)				(175)		(175)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**

Change Item Title: HCBS Reform: Limit Billable Days for Residential Services to 350 Days (CS81)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	(780)	(3,243)	(5,394)	(11,354)
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	(780)	(3,243)	(5,394)	(11,354)
FTEs	**0**	**0**	**0**	**0**

Recommendation:

Effective January 1, 2018, the Governor recommends limiting the number of billable units for individuals receiving foster care services and supported living services in a corporate foster care setting under the disability waivers. Rate calculations for these services currently include an absence factor that increases each daily service rate to account for days in which service cannot be billed but providers' costs remain constant. This proposal would align the number of eligible billable days with the absence factor included in the daily rate.

The HCBS Reform proposals continue the redesign of home and community based services to align with changing expectations of those receiving services, provisions in the Americans with Disabilities Act, and long term sustainability of services. These proposals support better outcomes, administrative efficiencies, and increase functionality of waiver management tools. Together, these proposals enable people to receive flexible, individualized services where they live and work.

Rationale/Background:

In 2014, under the direction of federal Centers for Medicare and Medicaid services, DHS implemented a statewide rate setting method for foster care services and supportive living services in a corporate foster care setting. Under this new system, rates are set based on statewide average costs required to provide the service such as staff wages, employee benefits, taxes, and program expenses. An absence/utilization factor is one cost component in the rate setting calculation method. This factor increases the daily rate in order to account for days in which the provider is unable to bill but still maintains the same level of costs. In instances where an individual has no unbillable days, the provider still receives the increased daily rate as it is applied to all rates calculated through the new rate setting methodology.

This proposal would apply to all rates calculated by the new rate setting method, but would only impact instances in which there are fewer than 15 annual unbillable days.

Similar billing policies have been found in other states that have absence factors built into their daily rates. These states include Georgia and Virginia.

Proposal:

This proposal aligns the maximum number of days billed with the absence factor built into the daily rate by placing a limit on the number of individual service days which can be authorized for foster care services and supportive living services in a corporate foster care setting for each service recipient. This proposal limits the number of days authorized and billed for in a year to a maximum of 350 days per person. Currently, the rate frameworks include an absence/utilization factor of 3.9%. This factor compensates the provider for the average number of days that an individual is away from the home, because while the provider is unable to bill for these days, they largely maintain the same level of costs. This factor results in an increased daily rate in order to account for unbillable days.

Currently, individuals can be authorized for 365 days of service. If an individual has no unbillable days, the provider receives the increased daily rate and is also able to bill for all days. If the service provider renders service for all 365 days and bills for all 365 days, the service provider is receiving a higher annual amount of 3.9% for that person than if there were no absence factor built in. For people who have more unbillable days than the factor allows, providers are able to request rate exceptions only if the person has exceptionally high needs that necessitate increased costs to serve the person.

This proposal will result in decreased program spending for foster care services and supportive living services in a corporate foster care setting under the HCBS disability waivers. It does account for exceptions that may be granted for people who are especially high need and require more than 350 days of service. Reducing the number of days billed for these services is estimated to reduce state spending by $4 million dollars in the SFY 18-19 biennium.

IT Related Proposals:

MMIS changes are needed to incorporate a limit to the number of days that can be authorized and billed.

Results:

Service authorization and billing data will measure compliance with this billing policy.

Statutory Change(s):

M.S. §256B.4914.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			(780)	(3,243)	(4,023)	(5,394)	(11,354)	(16,748)
HCAF								
Federal TANF								
Other Fund								
Total All Funds			(780)	(3,243)	(4,023)	(5,394)	(11,354)	(16,748)
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	33	MA - LW	(782)	(3,243)	(4,025)	(5,394)	(11,354)	(16,748)
GF	11	MMIS	2		2			
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**

Change Item Title: HCBS Reform: Increase Individual PCA Hour Limit to 310 Hours per Month (CS82)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	907	1,026	1,089	1,131
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	907	1,026	1,089	1,131
FTEs	**0**	**0**	**0**	**0**

Recommendation:

Effective July 1, 2017, the Governor recommends increasing the monthly limit for Personal Care Assistance (PCA) workers from 275 hours per month to 310 hours per month. This policy will also apply to Community First Services and Supports (CFSS), once available.

The HCBS Reform proposals continue the redesign of home and community based services to align with changing expectations of those receiving services, provisions in the Americans with Disabilities Act, and long term sustainability of services. These proposals support better outcomes, administrative efficiencies, and increase functionality of waiver management tools. Together, these proposals enable people to receive flexible, individualized services where they live and work.

Rationale/Background:

Recipients and provider agencies report difficulties finding the number of workers needed to provide all of the hours a recipient is eligible to receive. Allowing an individual PCA to work up to 310 hours a month will help ease the impact of the worker shortage. Additionally, recipients are unable to find additional trusted PCAs to provide services beyond the current 275 hour per month limit, and are going without services.

Direct care/support workforce development is not keeping pace with the growing demand for assistance. Future demands will challenge vulnerable people, families, Medicaid and other payers of long-term services and supports. According to DEED, Minnesota has about 135,000 persons in the direct care/support professions and will need an additional 59,000 in the coming years.

This proposal will assist in creating a timely and responsive workforce to meet the needs of PCA-eligible recipients

Proposal:

The Personal Care Assistant (PCA) program is an existing program. A PCA worker 275 hour monthly maximum limit was established in 2010 legislation as a budget saving mechanism.

Increasing the maximum number of hours a PCA can work to 310 hours per month provides flexibility for people to access services from trusted PCAs and limits the number of people that go without services when they are unable to find another PCA. 310 hours is based on a person working 10 hours per day, 31 days a month.

This proposal will lead to increased flexibility for PCAs to work more hours to meet labor shortages. Results for recipients may include better outcomes, increased staff retention and meeting health and safety needs. Timely and responsive workforce to meet people's needs.

Increasing the number of hours a PCA may work in a month may result in overtime costs for providers, although the current limit may already have overtime costs.

This proposal increases state spending for PCA and CFSS services because the higher monthly limit for PCA workers will allow them to provide more service to recipients who are not currently able to use all of the time for which they are authorized. The estimates recognize that there are other limits, such as recipients' authorizations and requirements for overtime pay, which will continue to affect how many hours a PCA is able to work.

IT Related Proposals:

MMIS changes are needed.

Results:

- We believe that the difference between the numbers of hours of PCA services a person is authorized to use and the number of hours the person actually uses will decrease as a result of this change. People who have been going without services because of the current limit of 275 hours in a month will use additional services with the same worker up to the new limit of 310 hours. This will allow PCA services to better meet the needs of people currently unable to access services in excess of 275 hours per month.
    - There are other factors that contribute to this measurement such as the workforce shortage for this service and the periods of hospitalization that people who use this service may experience. Changes in this measurement will not be a conclusive indicator of the result of this change.
    - We would recommend refining the measure to focus on those PCA recipients who are authorized to use 10 hours of services per day. The current measure is across the entire population of PCA recipients.
- For the past five fiscal years, the percent of the amount of authorized services used has been stable between 80-82%.

Statutory Change(s):

M.S. §256B.0659, subd. 11 (a) (10); §256B.85, subd. 16 (d)

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			907	1,026	1,933	1,089	1,131	2,220
HCAF								
Federal TANF								
Other Fund								
Total All Funds			907	1,026	1,933	1,089	1,131	2,220
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	33	MA LW Personal Care Assistance	902	1,026	1,928	1,089	1,131	2,220
GF	11	Systems cost	5	0	5	0	0	0
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**

Change Item Title: HCBS Reform: Disability Waiver Consolidation Study (CS85)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	71	115	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	71	115	0	0
FTEs	**0**	**0**	**0**	**0**

Recommendation:

Effective July 1, 2017, the Governor recommends researching and developing recommendations on consolidating the four disability home and community-based services (HCBS) waivers into one program. Administrative funding is requested to obtain the appropriate expertise to conduct the analysis and provide recommendations to the Department of Human Services. The Department of Human Services will provide implementation recommendations, based on the study results, to the legislature by January 15, 2019.

The HCBS Reform proposals continue the redesign of home and community based services to align with changing expectations of those receiving services, provisions in the Americans with Disabilities Act, and long term sustainability of services. These proposals support better outcomes, administrative efficiencies, and increase functionality of waiver management tools. Together, these proposals enable people to receive flexible, individualized services where they live and work.

Rationale/Background:

The four separate disability waivers were created at separate times to address needs for specific populations, with different institutional cost effectiveness comparisons. Over time, efforts have been made to provide consistency across the waiver programs in the services that are provided, standards for the services, the processes used to determine eligibility and guide support planning, how rates are established, and the policies that govern the programs. In the federal HCBS rule that was released in January 2014, states were given the choice to combine multiple populations under a single waiver, which opened the door for Minnesota to further simplify by combining the four disability waivers under a single waiver. Because of the complexity of the waiver programs, the fiscal implications, and the different populations they support, it is necessary to do a thorough analysis of the feasibility and impact of using the new federal authority to combine the disability waivers.

Combining the waiver programs may create administrative efficiencies, and manage growth more equitably across the programs. It will also make the waiver easier to understand for consumers and their families.

Proposal:

An external vendor will provide recommendations to the Department of Human Services (DHS). Based on the results of the study, DHS will provide implementation recommendations to the legislature by January 15, 2019.

This proposal authorizes the research and development of recommendations to:

- Research what other states are doing around combining or separating populations under home and community-based services (HCBS) disability waivers, including the rationale for their decisions and results;
- Analyze federal authority to combine populations under one HCBS waiver program;
- Conduct focus groups and input opportunities to partners, including people receiving services, family members, lead agencies, service providers, and advocacy organizations;
- Analyze the feasibility for Minnesota to combine the four disability HCBS waivers into one program; and

- If the analysis indicates that this may be a feasible option for Minnesota, provide recommendation to DHS on the best strategies for integrating home and community services for people with disabilities into one HCBS waiver program, including alignment of funding with the needs of the person, fiscal and programmatic impact, and expected outcomes.

Combining the four disability HCBS waivers into one waiver will reduce complexity of the system for people receiving services and their family members. It will also likely result in administrative efficiencies for DHS and lead agencies, including counties and tribes.

The contract activities for the administrative funds requested include national case study research, analysis of federal requirements and Minnesota's waiver programs, focus groups with stakeholders, evaluation of feasibility, and development of potential consolidation options and transition plan.

IT Related Proposals:

A business analyst will be involved in the study in SFY 19 to assess the impact and work needed in the MMIS system to consolidate the waivers.

Results:

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Number of people on waiting lists by urgency factor	New	New	
Quality	Increased number of people reporting satisfaction with their services	New	New	

Statutory Change(s):

Session law

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			71	115	186	0	0	0
HCAF								
Federal TANF								
Other Fund								
Total All Funds			71	115	186	0	0	0
Fund	**BACT #**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	15	CSA- admin- Contract	110	140	250	0	0	0
GF	REV1	FFP @35%	(39)	(49)	(88)	0	0	0
GF	11	Systems- 50% state share	0	24	24	0	0	0

Change item title: HCBS Rule Implementation (CS41)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	3,037	803	669	669
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	3,037	803	669	669
FTEs	**4.75**	**6**	**4**	**4**

Recommendation:

Effective July 1, 2017, Governor recommends increasing funding to implement Minnesota's plan to meet federal home and community-based services (HCBS) rule requirements. The rules require changes related to home and community-based settings that will enable Minnesotans with disabilities and older adults who are served in HCBS programs to better access the benefits of community living and to receive services in the most integrated setting.

Rationale/Background:

The federal Centers for Medicare and Medicaid Services (CMS) issued the Home and Community Based Services (HCBS) rule on January 16, 2014, which became effective on March 17, 2014. The rule was developed to assure that home and community-based services are different than institutional services, recognizing that even though the service is not provided in an institution, the setting may feel like an institution to the person receiving the services. These requirements are aligned with the values and outcomes in the American with Disabilities Act and in Minnesota's Olmstead Plan. The rule raises expectations for what is possible for older adults and people with disabilities; our system needs to evolve to assure all people:

- have the information and experiences with which to make informed choices;
- are provided an array of options to fully support community inclusion; and,
- have their rights protected.

States have until March 17, 2019, to achieve compliance with the rules' HCBS setting requirements for existing programs. The rule affects all HCBS waivers and programs, which in Minnesota are the: Alternative Care (AC) Program; Brain Injury (BI) Waiver; Community Alternative Care (CAC) Waiver; Community Access for Disability Inclusion (CADI) Waiver; Developmental Disabilities (DD) Waiver; and the Elderly Waiver (EW). With two years remaining in the 5-year transition period allowed in the rule, it is vital that resources are available to take significant steps to achieve full compliance with the rule and ensure people who use Medicaid-funded services are able to be integrated into their communities.

CMS requires states to submit a transition plan to serve as a blueprint to comply with CMS' regulations. DHS anticipates initial approval of our systemic assessment and remediation plan by the end of 2016. Final approval of our statewide transition plan is contingent upon legislative action on this proposal.

Each state's transition plan must include an assessment of the extent to which its standards (regulations, policies, licensing requirements) assure that each element under the HCBS federal regulations is adequately addressed. DHS has fulfilled this requirement by conducting a systemic assessment that compared the HCBS required qualities and provider controlled residential characteristics under the rule to state regulations.

The HCBS Rule requires that all home and community-based settings meet the HCBS standards outlined in the rule, including full access to the community; individual rights of privacy, dignity and respect; and autonomy and independence in making life choices. Any modification to these additional requirements for provider-owned or controlled home and community-based

residential settings must be supported by a specific assessed need for the person and justified in the person's person-centered service plan.

The HCBS Rule also includes additional requirements for provider-owned or controlled home and community-based residential settings. These requirements include:

- The individual has a lease or other legally enforceable agreement providing similar protections;
- The individual has privacy in their unit including lockable doors, choice of roommates and freedom to furnish or decorate the unit;
- The individual controls his/her own schedule including access to food at any time;
- The individual can have visitors at any time; and
- The setting is physically accessible.

Minnesota must demonstrate compliance with the HCBS settings rule in order to continue to renew its HCBS waivers with CMS and to continue to receive federal financial participation (FFP) for these Medicaid services in Minnesota. If Minnesota is unable to comply with the March 17, 2019 timeline, the state is at risk of:

- CMS issuing non-compliance actions, including the risk of losing over $850M annually in federal financial participation for the aging and disability waiver services affected by this rule. The affected services account for 60-70% of all waiver spending.
- HCBS providers not having the resources or technical assistance to modify their services needed to transition to 100% compliance.
- People relocating or having fewer options of HCBS services and settings due to an inadequate supply of HCBS Rule compliant providers.

DHS has worked intensively with a stakeholder group to identify provider expectations and responsibilities necessary to comply with the HCBS rule throughout the process of interpreting the rule and developing a transition plan. DHS has also provided information to stakeholders through multiple meetings, trainings, listening sessions, and the HCBS transition plan webpage, as well as held multiple opportunities for people to give public comment into the process and the development of the transition plan.

Proposal:

This proposal requests administrative funding to implement Minnesota's transition plan to meet federal HCBS rule requirements.

The guidance issued by CMS for states to comply with the HCBS rule requires states to use multiple methods to validate compliance of settings. As noted in Minnesota's Home and Community-Based Services Final Rule Statewide Transition Plan, Minnesota will assess and use the following validation strategies to ensure compliance with rule requirements:

- Provider attestation requirement for each setting (initial assessment)
- Desk audit/reviewing provider-submitted supporting documentation of compliance (validation)
- Provider site-specific compliance plans and technical assistance (remediation)
- Person's experience assessments (validation and remediation)
- On-site visits and technical assistance (validation)
- Tiered standards for new settings (remediation)

This proposal requests funding to contract for the conduct of setting-specific technical assistance, including targeted technical assistance to culturally-specific providers. This technical assistance will include compliance assessments, managing and tracking setting-specific corrective action plans, and reporting to DHS on the status of the transition and rule compliance. The contractor(s) will also prepare a package of evidence for each setting that will be submitted to CMS for review.

The HCBS rule and the guidance issued by CMS for states to use in complying with the HCBS rule includes documentation and policy requirements for all HCBS providers. This proposal requests administrative funding to assure providers meet these requirements, including four FTEs to document provider compliance with completing the necessary provider attestation

documents, uploading provider validation documents, developing and monitoring completion of the provider assessment activities such as desk audits and on-sight assessment finding, and the provider corrective action plan, if required. These FTEs will also conduct ongoing monitoring of provider compliance with the HCBS rule standards during initial and renewal licensing processes, as well as review Lead Agency compliance and personal experience responses on the support plan to validate provider attestation responses. Finally, the FTEs will support and provide training to lead agencies, providers, people receiving services and their families in both aging and disability waiver programs.

In addition, two temporary FTEs will be used in FY 18-19 during the transition period. In licensing, one of these positions will help with the transition to enforcement of the settings rule standards, including development of training plan and curriculum for county licensors and HCBS providers. Provider enrollment will use the other position to update enrollment records as information is gathered about providers and provide addition support for revalidation of settings that do not have a completed attestation.

The proposal requests administrative funding to provide targeted outreach to minority communities regarding the impact and implications of the HCBS rule. The proposal also requests funding for the Disability Linkage Line to provide support to people in understanding the rule and the choices that are available to them.

IT Related Proposals:

Systems changes are needed to measure provider and Lead Agency compliance. Software development and training on protocol changes are required to ensure ongoing abilities of DHS to monitor compliance with the HCBS Standards Rule beyond 2019 in the MnCHOICES and MnSPA systems.

Results:

Technical assistance and training for participants and providers, as well as site-specific assessments are critical to ensure the state becomes compliant with the HCBS rule. As a result of complying with the HCBS rule, the state will build on Minnesota's foundation of HCBS and improve options for people receiving home and community based services and supports. This proposal is successful if:

- Settings where HCBS services are delivered in Minnesota are 100% compliant with the HCBS Standards Rule.
- The number of people that live and spend their day in settings that fully support community inclusion increased due to the effectiveness of person-centered planning and informed choice protocols, and provider capacity to deliver services that bring plans to reality.
- Data from person experience surveys, lead agency reviews and National Core Indicator surveys aligned with provider reports and licensing review outcomes.
- Minnesota will complete implementation of the statewide transition plan by March 17, 2019.

Statutory Change(s):

Session law or a rider will be required. The language will provide the authority to spend the funding over a two-year period.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			3,037	803	3,840	669	669	1,338
HCAF								
Federal TANF								
Other Fund								
Total All Funds			3,037	803	3,840	669	669	1,338
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	14	CCOA-Admin	1,125	267	1,392	267	267	534
GF	15	CSA- Admin	3,099	484	3,583	484	484	968
GF	13	HC-Admin	160	184	344	103	103	206
GF	REV1	FFP	(1,577)	(364)	(1,941)	(299)	(299)	(598)
GF	55	Disability Grants	100	100	200	100	100	200
GF	11	Licensing Admin	121	105	226	0	0	0
GF	11	MN.IT@DHS	9	27	36	14	14	28
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	14	CCOA- FTE	.75	1		1	1	
GF	15	CSA- FTE	1.5	2		2	2	
GF	13	HC- FTE	1.5	2		1	1	
GF	11	Licensing- FTE	1	1		0	0	

Change Item Title: Implement Center for Medicaid and Medicare Services Home Health Care Rule (CS53)

Fiscal Impact (whole dollar)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	97	130	131	132
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	97	130	131	132
FTEs	**0**	**0**	**0**	**0**

Recommendation:

Effective July 1, 2017, the Governor recommends changing the requirements for Minnesota Health Care Programs payment of home health services to comply with a new federal regulation. This regulation requires documentation of a face-to-face encounter with a physician or a non-physician practitioner (including through the use of telehealth) with the eligible beneficiary within a reasonable timeframe prior to the authorization of home care services and certain medical equipment (DME). This requirement is mandated by the federal Centers for Medicare and Medicaid Services (CMS).

Rationale/Background:

This CMS home health rule aligns the timeframes for the face-to-face encounter with similar regulatory requirements for Medicare reimbursement of home health services. CMS published final regulations to implement this change on February 2, 2016.

The overall benefit of this rule is the expected increase in program integrity resulting in improved outcomes of home health services for Medicaid beneficiaries as a health care provider will be required to document the need for home health care services and certain medical equipment prior to authorization.

Additionally, this rule will potentially provide individuals with disabilities a greater ability to engage in activities of daily living in the community.

Proposal:

This rule requires physicians or other qualified medical professionals to have a face-to-face encounter (including through the use of telehealth) with the Medicaid eligible beneficiary within 90 days prior to 30 days after the start of home health services in order to authorize the services. This aligns the timeframes for the face-to-face encounter with similar existing regulatory requirements for Medicare home health services. The rule also requires that recipients have a face-to-face visit, including via telemedicine, no more than six months prior to receiving certain medical equipment as defined by CMS and reviewed annually.

The CMS home health rule also clarifies that Medicaid home health services and items are not limited to home settings and may be provided in the community where normal life activities take them other than an institutional setting. This aligns with the goals for people to receive person-centered services in the most integrated setting of their choice. Home health services include nursing services, home health aide services, and therapy services.

We anticipate that the fiscal impact for implementation of this rule will primarily impact physician services. The fiscal impact to this proposal includes additional face-to-face physician visits required by federal rule for the authorization of durable medical equipment and home health services

IT Related Proposals:

The claims module in MMIS will be changed to enforce the face-to-face with a medical person before home care services and medical equipment is provided to a recipient. The verification of the visit cannot be done prior to a claim being submitted for the home care service or purchase of medical equipment when the recipient is on a waiver or service agreement.

Results:

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Face to face visits are completed before receiving service	New	New	

Statutory Change(s):

M.S. §256B.0625, subd. 6a; M.S. §256B.0653, subd. 2, subd. 3, 4, 5, 6, and 7.

Fiscal Detail:

Net Impact by Fund (dollars in $1,000s)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			97	130	227	131	132	263
HCAF								
Federal TANF								
Other Fund								
Total All Funds			97	130	227	131	132	263
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	33 – AD	MA – Adults with no kids	2	3	5	4	5	9
GF	33 - ED	MA – Elderly & Disabled	26	37	63	37	37	74
GF	33 – FC	MA – Families with children	59	88	147	88	88	176
GF	11	Mn.IT @ DHS (MMIS, mailing)	10	2	12	2	2	4
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**

Change Item Title: Eliminate Home Care Nursing Communicator Service (CS52)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	(15)	(15)	(15)	(15)
Revenues	0			
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	(15)	(15)	(15)	(15)
FTEs	**0**	**0**	**0**	**0**

Recommendation:
Effective July 1, 2017, the Governor recommends eliminating the ability for Home Care Nursing (HCN) and Personal Care Assistance (PCA) service providers to bill for communicator services for people who are dependent on a ventilator upon admission to the hospital. This is a duplication of services that are required to be provided by the hospital.

Rationale/Background:
The home care nursing communicator statute was enacted in in 1988 and since that time, the Americans with Disabilities Act has changed what entity is responsible for providing access to communication assistance and advancing technology has expanded options for communication supports for persons dependent on a ventilator.

A ventilator-dependent patient should not be required or need to bring a home care nurse or personal care assistant with them to the hospital to assure effective communication with the hospital staff. Federal law and regulations require hospitals to provide access to people with disabilities including the provision of effective communication. Assistive technology that provides communication augmentation or interpreter services are examples of provisions hospitals could make to assure effective communication.

Proposal:
This proposal repeals Minnesota Statutes, §256B.64 that allows for ventilator-dependent recipients of Medical Assistance who have been receiving home care nursing or personal care assistance services in the community to continue to have home care nursing or personal care assistance services during admission to a hospital. Fewer than 10 people are using this service each year.

At the time that this service was enacted, Minnesota established a special fund to reimburse home care providers for this communicator or interpreter service. That special fund is no longer operational. Current expenditures for this service are coming from the general fund using a manual and time-intensive process. When this service is eliminated, DHS will notify home care providers and hospitals but no system changes will be needed to prohibit billing.

IT Related Proposals:
NA

Results:
This proposal eliminates potential duplication and unnecessary services. People living in the community will receive appropriate supports provided by hospital staff while they are hospitalized.

Statutory Change(s):
Repeal M.S. §256B.64 – Attendants to Ventilator Dependent Recipients

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			(15)	(15)	(30)	(15)	(15)	(30)
HCAF								
Federal TANF								
Other Fund								
Total All Funds			(15)	(15)	(30)	(15)	(15)	(30)
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	33	State only- general fund	(15)	(15)	(30)	(15)	(15)	(30)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**

Change Item Title: Workforce Data Collection (CS86)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	507	511	275	275
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	507	511	275	275
FTEs	**2.0**	**4.5**	**2.5**	**2.5**

Recommendation:

Effective the day following final enactment, the Governor recommends requiring home and community-based services (HCBS) and Intermediate Care Facilities for People with Developmental Disabilities (ICF/DD) providers to submit data to the Department on their workforce, including rate of pay and benefits, staff turnover, and other labor measures, in order to analyze workforce pressures in the HCBS system.

Rationale/Background:

Two recent rules issued by the US Department of Labor are expected to have an impact on HCBS and ICF/DD providers. The services potentially impacted by the new rules include home and community-based services waivers for older adults and people with disabilities, personal care assistance (PCA), home care services, and services provided in intermediate care facilities for people with developmental disabilities (ICF/DD). However, the Minnesota Department of Human Services does not have information available on the wages and hours worked by HCBS and ICF/DD workers, so we are not able to estimate the impact of new Department of Labor rules on providers' costs or the extent to which these costs can be managed under current rates. In many of these services, Medical Assistance is the sole payer, so providers are not able to raise their rates to account for increased costs.

The new labor regulations have illuminated the lack of information available on the HCBS and ICF/DD workforce. This includes information such as what workers in this field earn, benefits, overtime, and staff retention pressures faced by businesses, among other issues. A stable workforce is critical to ensuring quality HCBS and ICF/DD services. Lack of workers can create service shortages. We are interested in collecting this information from HCBS and ICF/DD providers on an annual basis to be better able to analyze, monitor and respond to future workforce issues.

Proposal:

Effective no earlier than January 1, 2018, HCBS and ICF/DD providers will be required to report data to the department on worker wages, benefits, overtime, travel costs and staff retention on an annual or semi-annual basis. Data will be used to monitor and analyze worker impacts to the HCBS and ICF/DD service system.

This proposal requires administrative resources to collect, analyze, and report on HCBS and ICF/DD workforce issues. In the first two years, this will require developing an online tool for providers to import files as well as staff to work with stakeholders, provide communication and technical assistance to providers, monitor compliance, validate and analyze the data. This effort will require 4.5 FTE's in FY19. After the initial development and data collection, 2.5 FTEs will be needed permanently to continue analyzing and reporting on the efforts, monitoring ongoing data collection, as well as providing assistance to providers.

IT Related Proposals:

This proposal requires Mn.IT resources to implement a provider portal tool to collect the data from providers.

Results:

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quality	Percent of people with disabilities served in their homes and communities rather than institutions.	92.9%	94.0%	2008 to 2015
Quality	Percent of seniors served in their homes and communities rather than institutions.	60.3%	71.3%	2008 to 2015

Measure: The percentage of seniors and people with disabilities who receive long-term services and supports at home through waivers or state plan home care programs. The services may include personal care, homemaker, home-delivered meals, supplies and equipment, or home health services.

Statutory Change(s):

M.S. §256B.4912.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			507	511	1,018	275	275	550
HCAF								
Federal TANF								
Other Fund								
Total All Funds			507	511	1,018	275	275	550
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	11	Systems	225	160	385	80	80	160
GF	14	CCOA Admin-salary	233	420	653	240	240	480
GF	14	CCOA admin- contract	200	0	200	0	0	0
GF	13	HC Admin-salary	0	120	120	60	60	120
GF	REV1	FFP	(151)	(189)	(340)	(105)	(105)	(210)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	14	CCOA Admin	2	3.5		2	2	
GF	13	HC Admin	0	1		.5	.5	

Change Item Title: Self-Directed Workforce Negotiations (CS63)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	19,132	29,213	27,565	29,146
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	19,132	29,213	27,565	29,146
FTEs	**0**	**0**	**0**	**0**

Recommendation:

Effective July 1, 2017, the Governor recommends allocation of funds to meet obligations under the contract between the State of Minnesota and the Service Employees International Union (SEIU) negotiated for FY 2018-2019.

Rationale/Background:

The 2013 Legislature authorized collective bargaining for individual providers of direct support services. (Laws of Minnesota 2013, chapter 128, article 2). In August 2014, workers in self-directed programs in the state voted to form a union. M.S.§179A.54 states that individual providers of direct support services, as covered under section 256B.0711, subdivision 4, shall be considered executive branch state employees for the sole purpose of collective bargaining. The current contract between the state of Minnesota and these workers' exclusive representative, SEIU will expire June 30, 2017. This request is to fund contractual obligations for FY 2018-2019.

The state completed negotiations in January 2017 with the Service Employees International Union (SEIU), which represents the union. The union includes workers in the Personal Care Assistance (PCA) choice program, and the other self-directed programs, Consumer Directed Community Supports, and the Consumer Support Grant. Federal Medicaid requirements do not allow differential payment rates based on union membership so all workers in these programs would benefit from the changes in this proposal.

Proposal:

This proposal includes $800,000 of one-time individual provider training in state fiscal year 2018 and 2019. The training needs and priorities, frequency and locations, and partnerships with other organizations will be determined by a training and orientation committee made up of union and State of Minnesota representatives.

The proposal also includes the following for all individual providers:

- Increases the minimum wage floor in state fiscal year 2018 to $13/hour
- Increases paid time off (PTO) accrual rate to 1 hour for every 43 hours worked
- Establishes holiday pay at time and a half for hours worked on one holiday in FY18 and two holidays in FY19

Costs for increasing wage floors, holiday pay, and PTO requirements are incorporated into the Medical Assistance payment rate for the Personal Care Assistance program, and the budgets for Consumer Directed Community Supports, Alternative Care, and the Consumer Support Grant. This represents a 3.09% rate increase on July 1, 2017 to pay for the wage and PTO costs negotiated in the agreement and a 0.1% rate increase on July 1, 2018 to pay time and a half for hours worked on the additional holiday added in FY 19.

Effective July 1, 2018, for service recipients who have complex needs, defined as those with eligibility for 12 or more hours of PCA services per day as described in Minnesota Statutes 256B.0652, this proposal gives a 10% increase to the rate for the Personal Care Assistance services, and the budgets for Consumer Directed Community Supports, Alternative Care, and the Consumer Support Grant. Systems changes and administrative resources are needed to administer this change.

Additional stipends of $500 for training is available July 1, 2018 for individual providers who have completed designated, voluntary trainings made available through or recommended by the committee. This training is capped at $2,500,000 (or 5,000 individual providers) in fiscal year 2019.

Enhancements are made to the individual provider worker registry at a cost of $375,000/year. This funding will be used to provide marketing, outreach and technical assistance to people with disabilities, older adults and workers to use the registry to find a match to meet their needs.

This proposal includes an expansion of the participant protection language of Minnesota Statute, section 256B.0651 for home care service recipients. The revision assures that participant protections are available whenever DHS implements provider sanctions.

IT Related Proposals:

Implementing a 10% rate increase for service recipients who have complex needs, defined as those with eligibility for 12 or more hours of PCA services per day as described in Minnesota Statutes 256B.0652, will require an indicator in MMIS to identify the individuals eligible to receive the enhanced rate, edits in MMIS for PCA services to be billed at the higher rate for only those identified individuals, and system changes to allow enhanced budgets in Alternative Care, Consumer Directed Community Supports, and the Consumer Support Grant for only those identified individuals.

Results:

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quality	Increased staff retention rates in self-directed programs	New		
Quantity	Increased number of hours worked as compared to hours authorized by self-directed workers	New		

Statutory Change(s):

Session law; rider

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			19,132	29,213	48,345	27,565	29,146	56,711
HCAF								
Federal TANF								
Other Fund								
Total All Funds			19,132	29,213	48,345	27,565	29,146	56,711
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	33	MA Grants – LW	13,523	18,986	32,509	20,097	21,268	41,365
GF	33	MA Grants - ED	4,569	6,414	10,983	6,790	7,185	13,975
GF	34	Alternative Care	183	257	440	272	287	559
GF	53	Aging Grants (Registry)	375	375	750	375	375	750
GF	55	Disability Grants	400	3,150	3,550	0	0	0
GF	15	CSA Admin	77	38	115	38	38	76
	REV1	Admin FFP @ 35%	(27)	(13)	(40)	(13)	(13)	(26)
	11	Systems – complex needs (MMIS, SSIS)	32	6	38	6	6	12
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**

Change Item Title: Sustaining Deaf and Hard of Hearing Services (CS87)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	1,085	1,057	1,057	1,057
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	1,085	1,057	1,057	1,057
FTEs	**3.0**	**3.0**	**3.0**	**3.0**

Recommendation:

Effective July 1, 2017, the Governor recommends sustaining current level services for the DHS Deaf and Hard of Hearing Services Division and modernizing the Deaf and Hard of Hearing Services Act to improve the delivery of services to Minnesotans who are deaf, deafblind and hard of hearing.

Rationale/Background:

This proposal requests funding to sustain current level services for people who are deaf, deafblind and hard of hearing. Hearing loss interferes with a person's social interaction, communication and ability to acquire information. The impact on a person's life varies depending on degree of hearing loss and when the hearing loss occurred. A person who is hard of hearing or who develops a hearing loss later in life has to learn about coping strategies, communication techniques, hearing aids and other technology to accommodate diminished hearing. This person also has to develop assertive, self-initiated ways of gaining information to replace what used to 'happen naturally' as incidental learning. Incidental learning is what takes place in daily interactions with others, when we overhear others' conversations, listen to the radio. Vision becomes highly valued because vision is the sense most commonly used to compensate for hearing loss. A person who is born deaf may have a difficult time acquiring English because English is an auditory, spoken language. American Sign Language (ASL) is a natural visual language and is the foundation of Deaf Culture. People who are deaf and use ASL have a different world view and different life experiences than people who can hear. People who are deafblind experience an exponential impact from having a dual sensory disability because they cannot rely on their vision to compensate for their hearing loss or their hearing to compensate for their vision loss.

To have successful outcomes, services for people who are deaf, deafblind and hard of hearing must be designed and delivered within the appropriate cultural and linguistic context. In some situations, providing a reasonable accommodation such as a sign language interpreter, real-time captioning or an assistive listening device is an acceptable way to serve people who are deaf, deafblind and hard of hearing. For people who are especially vulnerable such as a person who is deafblind or a person who is deaf with mental health needs, services are most effective when intentionally designed for the service recipients through direct client services.

The Department of Human Services Deaf and Hard of Hearing Services Division (DHHSD) is Minnesota's only statewide provider of comprehensive services for people who are deaf, deafblind and hard of hearing. DHHSD offers several specially designed, direct service programs including 1) direct, one-to-one individual assistance with resolving barriers to communication access and day-to-day problem solving, 2) information and technical assistance to individuals with hearing loss, their families and agencies, organizations and service providers who encounter people with hearing loss, 3) training about hearing loss and its impact on a person's ability to be self-sufficient and independent, 4) culturally affirmative and linguistically accessible mental health services for adults, 5) Telephone Equipment Distribution program for people with communication disabilities who don't benefit from standard telephone equipment, and 6) highly specialized grant-funded programs provided by community partners. Without DHHSD services, Minnesotans who are deaf, deafblind and hard of hearing would not have another source for these supports.

Another key role for DHHSD is identifying the needs of people who are deaf, deafblind and hard of hearing and establishing services to fill the gaps. This is challenging since few service providers have the specialized expertise to serve this population. DHHSD often receives only one proposal in response to Requests for Proposals and occasionally receives none. In those cases, DHHSD has to recruit a possible provider and offer ongoing support and technical assistance on how to develop appropriate services.

In fiscal year 2016, DHHSD:

- Assisted 228 consumers who have complex needs and require ongoing help with problem solving;
- Provided 7,584 instances of information/referral/technical assistance;
- Trained 7,054 service providers, medical personnel, law enforcement agencies, people with hearing loss, family members and others about the impact of hearing loss, reasonable accommodations and strategies for managing hearing loss;
- Provided therapy to 132 adults who are culturally Deaf and have mental health needs;
- Offered consultation services with other mental health agencies 485 times;
- Assisted 1,903 new and ongoing participants in the Telephone Equipment Distribution program; and
- Served 578 individuals in DHHSD grant-funded programs provided by community partners.

Improved service delivery. With funding from the 2015 legislature, DHHSD hired an independent company to look at the needs of Minnesotans who are deaf, deafblind and hard of hearing and to analyze DHHSD's structure and services. DHHSD is established in law in the Deaf and Hard of Hearing Services Act (DHHSA) in Minn. Stat. §256C.21 – 256C.26. The DHHSA was first enacted in 1980. Since that time, various federal and state laws have been passed that have improved access and services for people who are deaf, deafblind and hard of hearing. As that has occurred, parts of the Deaf and Hard of Hearing Services Act have become outdated and obsolete. For example, under current law DHHSD is required to deliver its services through regional service centers. The bricks-and-mortar model may no longer be a necessary or effective mechanism for providing services. As video technology continues to improve, DHHSD is able to serve some of its consumer base – such as people who have high speed internet service – using technology rather than meeting with them in an office.

With information from the independent analysis and ongoing fact-finding, DHHSD has identified needed changes in the Deaf and Hard of Hearing Services Act. The changes will allow DHHSD to modernize its service options and methods of delivering services to better meet the needs of Minnesotans who are deaf, deafblind and hard of hearing now and in the future.

Proposal:

Funding increase. The Deaf and Hard of Hearing Services Division is requesting $1,238,000 in state fiscal year 2018 and $1,195,000 starting in state fiscal year 2019 into the future. This proposal requests funding to accomplish the following:

1) Sustain children's mental health services started in northwestern and northeastern Minnesota in FY16. Fifty (50) children per year will be served. Culturally affirmative and linguistically accessible mental health services for children were established in northeastern and northwestern Minnesota in FY16 and services began on July 1, 2016. Prior to this program, the northern regions of the state did not have these services available.
2) Continue mental health therapy services for adults in the northwestern region of the state. DHHSD hired a full-time therapist to work in the Moorhead Deaf and Hard of Hearing Services Division regional office. In the last two quarters of FY16, the northwest region had a 62% increase in the number of people who are deaf receiving mental health services. The mental health therapist also consults with hospital social workers, caregivers, Indian tribal services and family members on issues surrounding hearing loss and mental health and provides training on effective mental health treatment for people who are deaf, deafblind and hard of hearing.
3) Sustain statewide psychological assessments and therapeutic services for adults in the Twin Cities area. A post-doctoral psychologist who is deaf and fluent in American Sign Language began providing services in July 2016. The position was created to provide culturally affirmative and linguistically accessible psychological assessments statewide as well as therapy.
4) Create psychiatric services that will be delivered in American Sign Language. DHHSD will develop a model for addressing the needs of people who are deaf, deafblind and hard of hearing and in need of psychiatric services. Psychiatric care of these individuals depends on understanding the language. Establishing rapport, obtaining history,

understanding the patient's mental health, obtaining informed consent for treatment, describing medication options, and understanding medication management are all linguistic tasks. For people who use ASL, this includes careful evaluation of subtle nuances of the language that can be easily mistaken for tics, exaggerated emotions, mania, hypomania, or a personality disorder by untrained psychiatrists.

As with the other mental health services provided by DHHSD, this requires a much different model than providing communication accommodations to a person with a hearing loss. Many believe providing a sign language interpreter as a reasonable accommodation is the FIRST solution. For mental health services, the use of an interpreter as the first solution is largely ineffective. Truly successful outcomes occur when the therapeutic plan and services are provided within the context of a Deaf person's culture, language, and life experience. This applies to all mental health services from psychiatry and psychological assessments to therapy and related services.

5) Sustain self-directed services for people who are deafblind. The expanded services in FY16 allowed DHHSD to add 41% of people on the program waiting list to the DHHSD DeafBlind Consumer Directed Services program. The remaining people on the waiting list will begin services in FY17. Without continued funding, these people will lose their services and move back to the waiting list.
6) Maintain grant-funded service hours for adults and children who are deafblind. New funding in FY16 increased the number of service hours for adults and children who are deafblind by a total of 7%. Adults who are deafblind now receive an average of 2.2 service hours per week. Children and families now receive an average of 3.6 service hours per week. For adults, these services help them accomplish day-to-day activities that usually require vision and hearing. For children, the services help them learn how to function with limited hearing and vision, develop language, and discover their home and community environment.
7) Continue the expanded services for people who are deafblind in the Twin Cities regional DHHSD office. This office had a 93% increase in the number of contacts from people who are deafblind in FY16 after hiring a full-time deafblind specialist. This person helps Twin Cities' participants in the DeafBlind Consumer Directed Services program plan their long-term supports budgets and services. She also works with other individuals who are deafblind and need help with problem solving, removing barriers to communication access and understanding service systems.

Improved service delivery. This proposal also will allow DHHSD to move forward with implementing some of the recommendations from the analysis of DHHSD's services and operations. It revises and strengthens the Deaf and Hard of Hearing Services Act (DHHSA) in Minn. Stat. 256C.21 – 256C.26 to provide flexibility in the service delivery system design and a clear, modern role for the DHHSD. Specific areas where the Deaf and Hard of Hearing Services Division needs to modernize include:

1) Service delivery model. Current statute requires services to be delivered through regional service centers. This proposal allows DHHSD to consider other models for deploying staff in rural areas such as working remotely from home or sharing office space with other agencies. The division would also have the flexibility to use a first-point-of-contact centralized information/referral/intake process for people who contact the division.
2) Clear service descriptions and definitions. DHHSD currently has a very broad mandate under the Deaf and Hard of Hearing Services Act. Since the Act was first passed, the landscape of accessible programs and services has changed dramatically. This proposal focuses DHHSD on the services most needed.
3) Link to immigrant populations. DHHSD has not had enough resources to concentrate on service development for immigrants who have hearing loss. These populations require uniquely designed services not only because they are new to the U.S. but also because of the stigma in their native countries that is often associated with being labeled disabled.
4) Age-related hearing loss. Hearing loss is inevitable for most people as they age. People who experience hearing loss later in life come to DHHSD for information about hearing loss and technology, strategies for coping with hearing loss, and resources to pay for hearing aids.

IT Related Proposals:

This is not an IT related proposal.

Results:

- Percent increase in number of new clients served in the northwest regional DHHSD office mental health program.
- Percent of clients in DHHSD mental health programs making regular progress on treatment goals.
- Number of people served in the statewide DHHSD mental health program does not decrease.
- Number of mental health service hours provided by the DHHSD mental health program is maintained.
- Percent of clients from the waiting list in DHHSD programs for people who are deafblind who begin services.
- Number of 'case file' clients who are deafblind with complex needs served in the DHHSD regional office program does not decrease.

Statutory Change(s):

Minn. Stat. §256C.21 – 256C.26.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			1,085	1,057	2,142	1,057	1,057	2,114
HCAF								
Federal TANF								
Other Fund								
Total All Funds			1,085	1,057	2,142	1,057	1,057	2,114
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	15	DHHSD administration expenses	438	395	833	395	395	790
GF	54	DHHS grants	800	800	1,600	800	800	1,600
GF	REV1	FFP 35%	(153)	(138)	(291)	(138)	(138)	(276)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	15	CSA administration – DHHSD	3.0	3.0		3.0	3.0	

Change Item Title: Phase II Nursing Facility Value-Based Reimbursement Implementation (CC53)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	(871)	(2,302)	(2,057)	(1,524)
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	(871)	(2,302)	(2,057)	(1,524)
FTEs	1	1	1	1

Recommendation:

The Governor recommends making clarifying, technical and policy changes to the Value-Based Reimbursement (VBR) system for nursing facilities. There are several different effective dates within this proposal noted below.

Rationale/Background:

The 2015 Minnesota Legislature passed a nursing facility reform bill that invested $138.2 million for FY 16-17. Beginning on January 1, 2016, Medicaid payment rates became based on the actual annual costs reported by the providers. This new Value-Based Reimbursement (VBR) system is used to establish the payment rates for 372 nursing facilities that provide over 9.5 million resident days of service annually. There are roughly 29,000 licensed nursing facility beds. Since the work on the implementation of this payment reform began last year, several issues were discovered that require legislative intervention to ensure the integrity of the VBR moving forward. It is necessary to update these issues now since the new payment system was effective January 1, 2016.

Proposal:

This proposal consists of multiple changes to the new VBR system. These changes provide administrative simplification, address several problems related to the administration of VBR and modify provisions in law that were designed to work in the previous rate setting system, but that do not work in the new cost based system. They are as follows:

- Provide cost category determination authority to the commissioner in consultation with stakeholders. This is needed to ensure consistent cost reporting from providers so that accurate and consistent cost data is used by DHS to set providers' rates. Consistent classification requirements will help prevent providers from getting paid twice for the same item(s). A double payment can occur if a certain type of cost is included in metro area facilities' reported other operating costs while at the same time, outstate facilities may have classified these same costs as a care related cost. Metro facility rates are used as the basis for setting the other operating rates for all facilities throughout the state. Additionally, as changes in this industry occur and new technologies come to market, DHS needs a mechanism for determining in a timely manner where new costs should be classified. Effective for costs incurred on and after October 1, 2013.
- Simplify the rate setting process by consolidating numerous rate changes to coincide with the annual VBR rate change on January 1 and allowing for one additional mid-year rate change on July 1 annually. Under current law, payment rates are increased for a variety of reasons throughout the year. Further, the majority of these rate increases are retro-active. Private pay consumers contact DHS and the Ombudsman's Office on regularly to express their frustration with this unpredictability and frequency of rate changes. The current system makes it difficult for private pay consumers to budget and is administratively burdensome for DHS and providers. This proposal will make the occurrences of rates changes more predictable and consistent. Effective July 1, 2017.
- Continue suspension of the Critical Access Nursing Facility (CANF) program. With the passage of VBR, the CANF program was suspended through December 31, 2017. The intent of this suspension was to allow time to evaluate the

implications of replacing CANF rates with VBR rates for facilities with this special designation. The CANF program was authorized in the 2014 session and appropriated $1.5 million a year for critical access nursing facilities. Nursing facilities could apply for the program through a RFP process. Because little time has passed since the suspension was put into place under the new VBR system, it is premature to evaluate this change in rate setting methodology for CANFs. This proposal extends this suspension through December 31, 2019 so that a more meaningful analysis can be done. Effective July 1, 2017.

- Repeal the minimum wage rate increases in M.S. §256B.441, Subd. 64. These rate increases were established under the previous reimbursement system which was a rate on rate model. Under VBR, rates are now cost based, therefore, the minimum wage rate increase provision is no longer needed. This provision will eliminate paying providers twice for their increased salary costs related to the increase in the minimum wage: once under the old reimbursement system which pays primarily prospectively, and secondly, under the new VBR in their cost-based rate which is retrospective. Effective for rates that go into effect on and after October 1, 2017.
- Provide ongoing evaluation of VBR with a biannual report to the legislature. First report due to the legislature January 1, 2019.
- Expand the commissioner's authority to reduce case mix penalties. Under §144.0724, Subd. 6, DHS may reduce the penalty amount imposed on a provider for failing to submit resident assessments timely if the penalties incurred by a facility are equal or greater than 1.0 percent of their annual total operating costs. The current threshold creates a financial burden in circumstances under which the penalty was not intended to apply, particularly on small facilities in remote geographic areas of the state. This provision reduces the threshold test, allowing DHS the ability to reduce penalties in cases where the penalty is out of proportion with the error that lead to the penalty, particularly in circumstances where access to services may be jeopardized. Effective upon enactment.
- Clarify the way employer health insurance costs under §256B.441, Subd 11a are described in the law. The current definition of employer health insurance costs specifically includes the employer's portion of the health insurance premium and expenses of the full-time employees, their spouse and dependents. It is also clear that the employer's costs for the health insurance premium and expenses of the part-time employee's spouse and dependents are excluded from the definition of employer health insurance costs but is silent as to whether or not these costs are to be recognized in a different cost category. This provision directs DHS to treat the premium and expenses of the part-time employees spouse and dependents as non-allowable costs as the legislature intended. Effective July 1 2017.
- Update M.S. §256B.50, Subd. 1b to reflect standard electronic communication practices. This section of law refers to the distribution of provider payment rate notifications via the U. S. Postal Service. DHS discontinued the use of the mail service for the distribution of this information and relies on electronic notifications instead.
- Change the effective date of the annual property rate adjustment in M.S. §256B.434, Subd.4 to align with all of the other annual rate changes that occur on January 1st under the new nursing facility VBR system. Prior to VBR, the payment rate year began on October 1st; all rates were updated annually on this date. Under VBR the annual rate change now occurs on January 1; however this specific section of law was not updated to reflect this change. This will extend the existing suspension of the inflation through December 31, 2018, adding an additional three months to the suspension currently in law. Effective upon enactment.

Many of the change items in this proposal clarify language, reduce administrative burden, or conform old policies to fit into VBR without seeking to increase or decrease costs.

The items in this proposal that will have savings are:

- Consolidate numerous different rate change effective dates to coincide with the annual VBR rate change on January 1 and one mid-year change on July 1 annually.
- Suspend CANF until January 1, 2020. Currently this is in the forecast in FY18 ($1.25 million federal and state share) and FY19 ($3 million federal and state share).
- End the minimum wage prospective rate increases.
- Extending the suspension of the property rate inflation rate adjustment by three months.

The items in this proposal that have costs are:

- Increasing authority to reduce case mix penalties.
- Ongoing evaluation of VBR with a biannual report to the legislature with one FTE to manage the evaluation.
- Expand the commissioner's authority to reduce case mix penalties.

No or immaterial local government impact is expected.

IT Related Proposals:

No systems changes are needed.

Results:

This proposal will result in a clear direction and consistency that is needed to move forward with the administration of VBR. Intended results include the avoidance of provider appeals related to how DHS categorizing costs when establishing payment rates for nursing facilities. Reduced administrative burdens for providers and DHS. Reduced private pay consumer complaints.

Statutory Change(s):

M.S. §256R and §256B.434

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			(871)	(2,302)	(3,173)	(2,057)	(1,524)	(3,581)
HCAF								
Federal TANF								
Other Fund								
Total All Funds			(871)	(2,302)	(3,173)	(2,057)	(1,524)	(3,581)
Fund	BACT#	Description	FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
GF	33 LF	Consolidating rate changes	(322)	(349)	(671)	(352)	(355)	(707)
GF	33 LF	End prospective Minimum wage rates (these are preliminary estimates)	(122)	(443)	(565)	(762)	(1,094)	(1,856)
GF	33 LF	Cost in change for the case mix penalties	50	54	104	54	54	108
GF	33 LF	Continue CANF suspension	(625)	(1,500)	(2,125)	(875)	0	(875)
GF	33 LF	Extend property rate inflation suspension by three months	0	(204)	(204)	(295)	(302)	(597)
GF	14	Ongoing evaluation of VBR- staff and contract	230	216	446	266	266	532
GF	REV1	CCA admin-35% FFP	(81)	(76)	(157)	(93)	(93)	(186)
		Requested FTE's						
Fund	BACT#	Description	FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
GF	14	CCOA admin	1.0	1.0		1.0	1.0	

Change Item Title: Expansion of Return to Community (CC42)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	1,637	(579)	(326)	(215)
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	1,637	(579)	(326)	(215)
FTEs	**4.0**	**4.0**	**4.0**	**4.0**

Recommendation:

Effective January 1, 2018, the Governor recommends expanding the Return to Community Initiative to serve: 1) people for whom home care is ending; 2) people who have requested assistance to go home via the federally mandated Section Q requirement for nursing homes; and 3) people who are at risk of readmission to nursing home or hospital. The proposal also creates a new caregiver support program for these target groups.

Rationale/Background:

This proposal will impact the state's budget both short term and long term as more boomers age into long term care and need services. Without these supports, the aging of the population will overwhelm the state's human services long term care system, spend down to Medical Assistance (long term care) at greater rates, increase state spending, and create long waiting lists for nursing home and assisted living care over the next several decades. This effort is critical to help the state manage these issues and support family caregivers more effectively to assist in addressing the growing work force shortage.

This proposal expands a highly successful evidence-based reform initiative called Return to Community (RTC). The RTC initiative provides supports to help people make critical decisions due to their frailty and are not yet enrolled in Medical Assistance because they have resources to buy services. By using Community Living Specialists (CLS) who work at the Area Agencies on Aging, the RTC program helps people leave a nursing home when they should have successfully left already based on their level of care but have not. Since it began in 2010, RTC has helped nearly 4,000 people leave nursing homes. As part of the Reform 2020 initiative, the RTC program doubled its staffing levels (focusing only on nursing home residents) in 2014. The RTC program reached a milestone of assisting 3,000 people in April 2015 and will reach its next milestone of 4,000 by the end of October 2016. On average, 70% of people transitioned by the program remained in their home for at least another year. By remaining at home, they are either able to avoid eligibility for Medical Assistance or they use the Elderly Waiver or Alternative Care services at a lower monthly cost than nursing home care.

Family and informal caregivers provide the vast majority of unpaid care needed by older adults and others to remain at home. Six in ten caregivers are employed—full time or part time—and juggling work and caregiving demands. According to AARP's 2016 Family Caregiving and Out-of-Pocket Costs report, more than three quarters (78%) of caregivers are incurring out-of-pocket costs as a result of caregiving. On average, caregivers are spending roughly $7,000 per year ($6,954) on out-of-pocket costs related to caregiving in 2016. By supporting family and informal caregivers, we can sustain them in their roles. Self-directed grants are an investment strategy for supporting high-risk caregivers.

Individual Community Living Support (ICLS) is a new service that will begin upon receipt of CMS approval. ICLS is designed to address the needs and preferences of older adults and their family members, and to address trends in the overall long-term services and supports delivery system. ICLS is a flexible service that offers a variety of components, including cuing and reminders to support people with daily activities, verbal guidance to help them maintain or regain skills that support independence, household management and intermittent physical assistance. ICLS also includes the ability to provide remote support and check-ins.

The proposal will have several impacts: 1. a reduction in the number of people spending down to Medical Assistance Long Term Services and Supports (LTSS); 2. An increase in access to services thereby ensuring more people remain in their homes and avoid institutional care; and 3. An increase in caregivers who will access assistance and help maintain older adults at home and thereby help to address the work force shortage in long term care.

The number of people entering nursing homes or assisted living is likely going to continue trending upward but has slowed to a lower rate because of the reform efforts that the Continuing Care for Older Adults Administration and the Minnesota Board on Aging have partnered to implement. This proposal will further that trend. The reality is that the aging of the baby boom generation will simply drive up the number of people "spending down" to become eligible for MA. These reforms are critical to slow the trend, and if possible, reverse it.

Proposal:

This proposal expands the RTC program to several new targeted groups at risk of spend down to Medical Assistance and offers a new caregiver supports initiative. The reform proposal generates savings by helping people avoid spend down to Medical Assistance Long Term Care or choose less costly options.

The proposal provides grants to the six area agencies on aging who administer the RTC program. Area agencies outside the metro currently receive about $350,000 each to perform the work for their regions. The metro area receives $900,000 for the work because it has the higher share of long term care settings. This proposal will more than triple the number of people receiving services (from an average of 1,600 a year to 4,500 a year).

This proposal adds four FTEs to the Minnesota Board on Aging for grants management, compliance review (site visits), performance management, and quality reviews for the service. It adds approximately 40 new community living specialists and case aids at the area agencies on aging that manage the Senior LinkAge Line®. Performance management information that include discharge goals and other metrics are currently provided to each Community Living Specialist during a site visit. CLS staff have a goal of discharging six people per month.

The number of people estimated to be served in the new initiative is 4,207. This initiative will triple the number of people currently served by Return to Community by expanding the people who receive assistance in a variety of critical pathways to long term care which include the populations identified above. The new target groups are based on calls to the Senior LinkAge Line® from people who needed this level of assistance in 2015. Starting January 1, 2018, the new populations to be targeted are:

1. Older adults who are discharged from a hospital to the community who are at risk of readmission due to a variety of factors including caregiver burnout or memory concerns;
2. Older adults who expressed a wish to return home upon admission to a nursing home in response to the federal mandated Section Q requirement on the admission assessment;
3. Older adults whose Medicare certified home care has come to an end and as a result are at risk of readmission to a hospital or nursing home; and
4. The caregivers of the older adults served in this proposal who are at risk of caregiver burnout and considering formal placement of the older adult.

This proposal also adds a new self-directed caregiver supports grant for family caregivers. This grant, to be administered by the Area Agencies on Aging (AAAs), is a small amount of funding that caregivers can use to purchase services that can help them maintain their caregiver role while also maintaining their own health. The self-directed budgets would be managed by a fiscal support entity (FSE) according to a spending plan. The caregiver would develop an initial spending plan with the CLS and it would be finalized with assistance from the FSE.

Lastly, this proposal amends licensing statutes to include ICLS as a basic support service licensed by DHS. Adding ICLS as a basic service will ensure the health, safety and well-being of recipients are met as required by CMS. This change in statutes allows comprehensive home care providers (licensed by the Department of Health), the option to get a home and community-based services (HCBS) designation on their home care license to provide ICLS. This would expand those provider's ability to provide more services desired by consumers.

Currently, there are two FTE's at DHS who perform program reviews and compliance site visits, oversee implementation of protocols, and manage the evaluation and performance management metrics which are delivered at intervals to the Community Living Specialists. The staff are monitored to ensure sufficient discharges are achieved in order to validate the savings. The proposal adds an additional four FTEs needed for performance management support to successfully implement the new initiative. One FTE would conduct program reviews and support RTC expansion, another FTE would develop and implement fiscal support entity operational protocols, one FTE would serve as the team lead and provide policy guidance and work plan oversight and the fourth FTE would be an office specialist who would be responsible for data entry, editing content changes within the Senior Linkage Line.

There are currently 22 CLS staff plus four case aides who are performing the Community Living Specialist work at the area agencies on aging. This funding is provided through grants to the area agencies on aging. The new funding will add to the base funding for the grants. The current base grant amount statewide for the Return to Community grants is $3,548,000. In FY 18, the new grants would increase the existing appropriation by $2,366,689 due to phase in and by FY 21, the grant appropriation increases by $4.6 million with ongoing funding. In FY 21, the overall base grant appropriation including the existing funding will be about $8.148 million. The number of people served will increase from 1,600 with an additional 4,200 being served to an estimated total of 5,800 per year. The Community Living Specialist staff, social workers or nurses requiring a minimum of two years' experience working in long term care facilities, are estimated to triple in size. A fiscal support entity provider would be brought on by a single area agency on aging to manage the caregiver self-direction option. These grants begin in FY 2020 (and are part of the total above). The grant appropriation in FY 2020 is $333,788 and in FY 2021, the grant appropriation is $476,840. A small amount of the grant funding each year would be set aside to retain an evaluator and develop outreach materials for the service.

The proposal savings are achieved by delaying or avoiding Medicaid conversion, maintaining individuals in a less costly setting for LTSS, minimizing acute care costs, out of pocket costs, and other non-LTSS costs. The RTC effort as originally designed assumes Medicaid conversion, on average, is less likely in the community than in a nursing home, Medicaid LTSS costs per month are less, on average, in the community than in a nursing home, and LTSS cost savings achieved in the community may be offset by increased non-LTSS costs, particularly from the perspective of Medicare and consumers.

IT Related Proposals:

N/A.

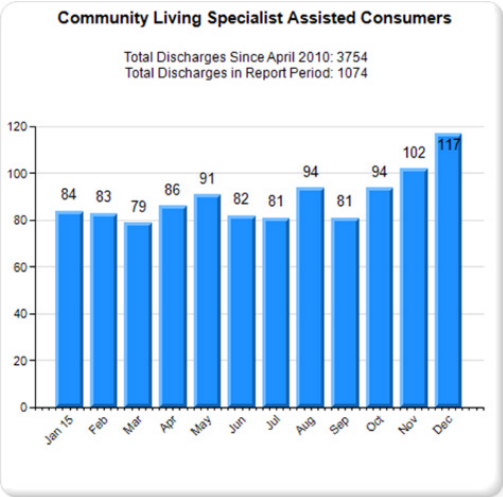
Results:

The existing program ensures performance through close monitoring of several measures at the agency and staff level. The measures fall into several categories. Examples are provided under each category below:

Performance of individual staff:

- 100 percent of support plans are completed by person assisted and done correctly with all documentation required
- 6 discharges per month goal is met consistently
- Consumer safety, impact
- 90% of consumers report quality of help met their expectations
- 90% of follow up after discharge is completed within 72 hours of discharge
- Community Engagement and Outreach
- 85% or community presentations by Senior LinkAge Line® staff and volunteers mention return to community
- 50% of nursing homes made a referral each year
- Systemic Impact
- Number of people discharged who met an effectiveness "E-score" of 30% or higher meaning the older adult have a 70% chance of leaving the nursing home without a CLS based on health characteristics and history.
- A goal of ten targeted individuals per month who would not have left on their own to achieve the savings goals.

An example of one of the statewide measures provided to the area agencies directors on their monthly dashboard is shown below:



Statutory Change(s):

Minn. Stat. §256B.971.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			1,637	(579)	1,059	(326)	(215)	(541)
HCAF								
Federal TANF								
Other Fund								
Total All Funds			1,637	(579)	1,059	(326)	(215)	(541)
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	53	Aging and Adult Services grants	2,367	4,057	6,424	4,097	4,138	8,235
GF	53	Aging and Adult Services grants-caregiver grants	0	0	0	334	477	811
GF	14	CCOA Admin	411	442	853	442	442	884
	REV1	FFP on Admin @ 35%	(144)	(154)	(298)	(155)	(155)	(309)
GF	33 LF	MA Nursing Facilities	(1,951)	(9,781)	(11,732)	(10,139)	(10,512)	(20,652)
GF	33 EW	MA Elderly Waiver	718	3,654	4,372	3,809	4,019	7,828
GF	33 ED	MA ED Basic	241	1,223	1,464	1,307	1,397	2,704
GF	33	MA Clawback	(13)	(63)	(76)	(65)	(67)	(132)
GF	34	Alternative Care	8	43	51	44	46	90
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	14	CCOA Admin	4	4		4	4	

Change Item Title: Minnesota Adult Abuse Reporting Center (MAARC) Enhancements (CC47)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	1,448	1,132	1,192	1,254
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	1,448	1,132	1,192	1,254
FTEs	2.00	2.00	2.00	2.00

Recommendation:

Effective July 1, 2017 the Governor recommends increased funding to support the work of the Minnesota Adult Abuse Reporting Center (MAARC) to meet the state's policy for safe environments and services for vulnerable adults. This proposal makes policy modifications to the Vulnerable Adult Act, increases resources for the reporting system, and makes technological enhancements to the state's adult protection data system.

Rationale/Background:

The Minnesota Adult Abuse Reporting Center (MAARC), enacted by the Legislature in 2013 as part of the Reform 2020 package, shifted the county-based system for reporting suspected maltreatment of vulnerable adults to a centralized 24/7 reporting system operated by the Commissioner of Human Services. MAARC began operations on July 1, 2015. MAARC receives phone and web based reports of suspected maltreatment of vulnerable adults from the public and mandated reporters 24 hours a day, seven days a week, and 365 days a year.

In FY16, the first year of operation, MAARC received 51,000 reports of suspected maltreatment of a vulnerable adult involving 111,218 allegations. This represents a 33% increase in reports and a 161% increase in reported allegations from the prior fiscal year when counties were responsible for their own reports. Approximately 25% of MAARC reports were made using the web reporting system. MAARC reporting is estimated to increase an additional 25% following the public education campaign initiated in mid-June 2016. Due to the difference between the estimated and actual volume of reports received by MAARC and additional processing time required for reports based on the technical capabilities required for the centralized reporting IT system, the original appropriation for the MAARC operations is estimated to be $824,000 short for FY17 for the operation of the reporting center. In addition to requesting funds to cover this deficit, this proposal requests an increase to the appropriation to address additional call volume due to the current public awareness campaign.

MAARC reports are entered into the state's Social Services Information System (SSIS) and electronically referred through SSIS to the lead investigative agency (LIA) responsible for the civil investigation and to county agencies responsible for emergency and ongoing adult protective services (APS). Lead investigative agencies are DHS-Office of Inspector General (OIG), Minnesota Department of Health-Office of Health Facility Complaints (OHFC) and each county social service's adult protection unit. DHS-OIG and MDH-OHFC use their own internal IT systems. Counties use SSIS. Multiple systems create challenges in the ability to coordinate data reporting and track critical steps in the response to reports.

When Mn.IT is unable to provide 24/7 support of the current IT system, policy staff receive notifications from the call center when a systems component (for example, the phone system, SSIS connection through CITRIX, the liquid office form, etc.) stops working. This causes a delay in addressing the outage and delays in referring reports to the agencies responsible. It also increases the staffing costs associated with receiving and manually entering reports into the system. This proposal includes Mn.IT funding to address these software and technological needs.

MAARC is statutorily required to provide data for the commissioner to track critical steps from reporting through investigation disposition and individual remediation to the vulnerable adult. Data is used for public reporting, state and federal requirements and for county Human Service Performance Management outcomes. SSIS does not have the capability to provide person centered data required for the Human Service Performance Management outcomes, to meet CMS Health and Safety requirements, or for required baseline and goal evaluation data for the Olmstead Plan. This proposal includes enhancements to state systems needed to meet these requirements.

This proposal includes funding to the DHS Office for Inspector General (OIG) for maltreatment investigations and adult protective services for vulnerable adults who are the subject of MAARC reports for which DHS OIG is the responsible lead investigative agency. OIG funding is for two additional staff to address the increased number of reports received by the DHS OIG.

Policy modifications are required to clarify and remove outdated language from the county based system for coordination of the investigation and adult protective services. Statutory references related to the county designated reporting system need to be consistent with the current state centralized system for web and phone reporting. MAARC standard intake requirements need to be updated to include additional information to support suspected maltreatment investigations and adult protective services actions. The definition of a "caregiver" needs to be revised to remove the threat of a civil maltreatment report substantiation for families providing support to a vulnerable adult as informal family caregivers. The exception in the definition of abuse that states acts are not recognized as abuse when the act is authorized under a now-repealed rule governing aversive and deprivation procedures needs to be removed. MAARC standard intake requirements need to be updated to include additional information to support suspected maltreatment investigations and adult protective services actions.

Language requiring lead investigative agencies to coordinate for the protection of the vulnerable adult passed in 2013, but the data management allowing this coordination did not pass. This proposal re-introduces data sharing ability related to MAARC reports and clarifies coordination with state and federal agencies, tribes, law enforcement and counties. This proposal reflects awareness that coordination across agencies is necessary to protect the increasing number of vulnerable adults.

Proposal:

This proposal provides resources to meet operational and technology needs of the Minnesota Adult Abuse Reporting Center (MAARC), and investigations of reports of suspected maltreatment of vulnerable adults at the local level.

This proposal also makes policy changes to the vulnerable adult act that will result in better person centered protection for vulnerable adults, and better coordination between state agencies for protection of vulnerable adults. Resources for the operations and technological support required to manage the number of reports received by MAARC will result in timely protection for vulnerable adults who are the subject of reports. Improved data reporting will allow the state to meet Olmstead goals and resolve currently unmet federal Center for Medicare and Medicaid Services (CMS) data reporting required for the state to support over 70,000 vulnerable Minnesotan's in the state's home and community-based service system. Increased resources for protection of vulnerable adults and the investigation of maltreatment will result in the prevention of repeat maltreatment and safety for an increased number of maltreated vulnerable adults through increased investigation and remediation of suspected maltreatment and an increased number of vulnerable adults receiving adult protective services.

These changes are effective July 1, 2017.

The investments include:

- $824,000 increase per year in base funding for MAARC operations to cover current deficits.
- An additional $1.04 million in the first biennium and $1.6 million in the second biennium increase in base funding for MAARC operations due to anticipated growth in report volume due to the outreach and marketing campaign.
- $534,000 in FY 2018 for MN.IT for required data reporting and technology improvements. There is also $50,000 in ongoing maintenance funding. This funding is part of the SSIS system.
- $193,000 per year for 2.0 FTEs for the Office of the Inspector General to increase protection to vulnerable adults who are subject of a MAARC report for which DHS is the agency responsible for investigation and protection.

IT Related Proposals:

This proposal includes $534,000 in FY 18 for a person centered data reporting system to meet CMS and Olmstead reporting requirements to collect and create warehouse for required data reporting. It also includes ongoing maintenance funds.

Results:

The intended result is protection of vulnerable adults consistent with statute and policy through:

- IT support for MAARC is working 24 hours, 7 days a week and 365 days a year.
- Counties are able to respond timely to maltreatment reports
- Reports are received by LIAs within the required legal timeline.

Statutory Change(s):

M.S. §626.5572, subd. 2, 4; §626.557, subd.4, 9, 12b, 18; §256M.40

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			1,448	1,132	2,580	1,192	1,254	2,446
HCAF								
Federal TANF10								
Other Fund								
Total All Funds			1,448	1,132	2,580	1,192	1,254	2,446
Fund	BACT#	Description	FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
GF	14	CCOA Admin- MAARC operations deficit	824	824	1,648	824	824	1,649
GF	14	CCOA Admin- MAARC volume increase	390	648	1,038	740	835	1,574
GF	11	OIG- Licensing FTEs	193	193	386	193	193	386
GF	REV1	FFP	(493)	(583)	(1,076)	(615)	(648)	(1,263)
GF	11	MN.IT@DHS	534	50	584	50	50	100
		Requested FTE's						
Fund	BACT#	Description	FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
GF	11	Licensing	2	2		2	2	

Change Item Title: Protect Vulnerable Adults in Health Care Settings

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
Department of Health				
General Fund				
Expenditures	1,162	2,030	2,401	3,405
Revenues				
State Government Special Revenue				
Expenditures	688	688	1,032	1,032
Revenues	688	688	1,032	1,032
Department of Human Services				
General Fund				
Expenditures	132	143	203	207
Revenues				
Net Fiscal Impact = (Expenditures – Revenues)	1,294	2,173	2,604	3,612
Total FTEs	15.5	21.5	27	34.5

Recommendation:

The Governor recommends protecting the 125,000 vulnerable adults in licensed health care and home care settings by expanding the Minnesota Department of Health's (MDH) Office of Health Facility Complaints to keep pace with the seven-fold increase in maltreatment complaints. Current funding supports investigating only ten percent of complaints received from families and other community members and only one percent of incidents self-reported by providers, which requires prioritizing complaints alleging actual harm. This proposal allows MDH to double the number of investigations, complete investigations within statutorily required deadlines, and investigate allegations of moderate harm to prevent such situations from resulting in serious harm later on.

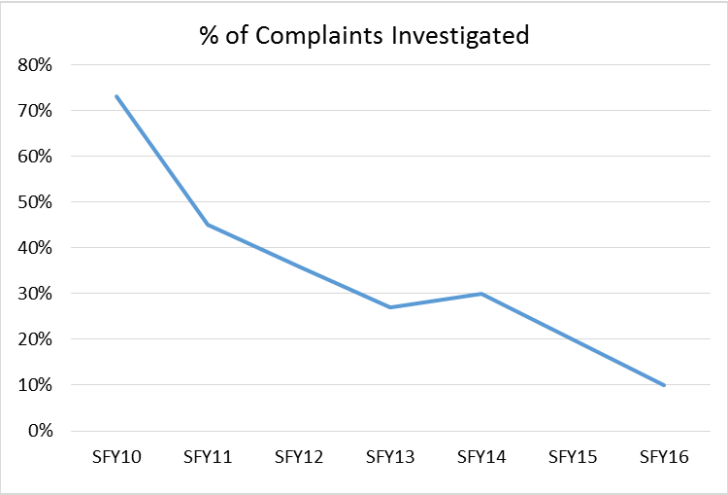
This proposal is revised from the the Governor's original recommendation released in January to further increase funding and to eliminate an assumption of additional federal funding to offset the cost of the expansion. Since January, the department has learned that the federal Centers for Medicare and Medicaid (CMS) is unlikely to match the proposed increase in state funds. The revised proposal is funded with $3.192 million in FY 2018-19 and $5.806 million in FY 2020-21 from the general fund, and an increase in fees paid by nursing home and home care providers of 10% in FY 2018 and another 5% in FY 2020.

By law, regulatory fees paid by nursing homes are considered an operating cost for the purposes of setting cost-based nursing home reimbursement rates. As a result, the increased fees being charged in this proposal will result in higher Medical Assistance rates which results in a general fund cost to the Department of Human Services.

Rationale/Background:

A vulnerable adult is anyone over 18 years of age who is vulnerable due to age or illness, physical or mental disabilities or psychiatric problems, and is reliant on people outside of the family for care. The Minnesota Vulnerable Adults Act ensures safe environments and services for vulnerable adults through a centralized reporting system for maltreatment complaints and coordinated investigation of suspected maltreatment by state and local agencies. Maltreatment includes abuse, both physical and emotional; neglect; and financial exploitation, including drug diversion. As one of the lead investigative agencies under the Vulnerable Adults Act, MDH's Office of Health Facility Complaints (OHFC) investigates maltreatment complaints for the 90,000 people receiving state-licensed home care and the 35,000 people receiving care in 2,600 state-licensed health care facilities such as nursing homes, hospitals, and hospices. OHFC investigates maltreatment complaints under a combination of the Vulnerable Adults Act, state licensure law, and federal Medicare and Medicaid regulations. Enforcement is done by responding to complaints of maltreatment and through regular inspections of health care settings. OHFC receives complaints from families

and other community members, as well as from facilities, which are required to report to OHFC allegations of possible maltreatment that occur in their facilities.



The number of maltreatment complaints has grown exponentially in recent years due to a rapidly aging population requiring service, and the creation of a statewide common entry point for complaints. The Minnesota Adult Abuse Reporting Center (MAARC) is a centralized system operated by the Department of Human Services that allows Minnesotans to easily report online or by phone allegations about maltreatment of vulnerable adults. Since FY 2010, maltreatment complaints received by OHFC have grown by nearly 600 percent, from less than 500 to nearly 3,500. After MAARC was implemented in July 2015, there was a 28% increase in complaints received from MAARC. The number of maltreatment complaints routed from MAARC is expected to increase further due to a current public awareness campaign. Provider self-reports are also growing substantially, from 3,115 in FY 2010 to 20,791 in FY 2016.

Due to the rapid growth of complaints, current funding is sufficient to investigate only ten percent of maltreatment complaints and one percent of provider self-reports alleging maltreatment. OHFC priorizes current caseload based on severity of complaints, and is only able to investigate complaints alleging actual harm due to funding constraints. Failing to investigate the vast majority of complaints has serious consequences for vulnerable adults and their families:

Thousands of complaints are not investigated so maltreatment continues, and less severe issues may escalate to more serious harm. Complaints received in FY 2016 that did not result in serious harm and therefore were not investigated include:

- 4,128 falls
- 275 drug diversion
- 986 medication mismanagement
- 2,867 unexplained injuries
- 341 unexplained fractures
- 963 abuse by staff
- 965 emotional abuse by staff
- 4,031 resident to resident altercations

If less serious issues like these were addressed early on, individuals might not be seriously harmed in subsequent incidents. For example, one resident at a nursing home had numerous falls which did not result in any serious injury. No investigation was conducted and the resident continued to fall. Eventually one of the subsequent falls led to a serious injury and death.

Family members are not notified about the status and results of an investigation in a timely manner. Current law requires notifying complainants five days after an allegation of maltreatment is made about whether an investigation will be conducted. Unfortunately, it takes three weeks to review allegations and notify complainants. Investigations are supposed to be completed within 60 days but it takes two or three weeks to get an investigator on site and six to eight months to complete an investigation. As a result, only 15% of investigations are completed within 60 days. This deprives family members of knowing what is going on with their loved ones and also knowing whether they should intervene on their behalf. Further, because of the time it takes to complete investigations, the public does not know about complaints occurring in facilities where their loved ones live.

Facilities aren't required to make the changes necessary to protect vulnerable adults. Nursing homes are required to report to OHFC if an incident occurred and what changes the nursing home is making to eliminate this problem. At current staffing levels, OHFC can only verify that changes were made on about five percent of these self-reports. For 95% of reports received, OHFC must take the word of the facility that corrective actions were made. Subsequent surveys often find changes were not made or were not effective. In some situations, facility employees are the perpetrators of maltreatment. When OHFC is unable to adequately investigate complaints, the employees identified as alleged perpetrators could continue to abuse, neglect, or exploit vulnerable adults.

Total Maltreatment Complaint Allegations Received, Total Investigated and Total Not Investigated

	Total Complaint Allegations	Total Complaint Allegations Not Investigated	Percent of Complaint Allegations Not Investigated	Total Complaint Allegations Assigned for an Onsite Investigation	Percent Investigated Onsite
SFY10	493	133	27%	360	73%
SFY11	1,137	622	55%	515	45%
SFY12	1,223	787	64%	436	36%
SFY13	1,835	1,343	73%	492	27%
SFY14	1,816	1,280	70%	536	30%
SFY15	2,665	2,139	80%	526	20%
SFY16	3,419	3,071	90%	348	10%

Total Maltreatment Provider Self-Report Allegations Received, Total Investigated and Total Not Investigated

	Total Provider Self-Reports Allegations Received	Total Provider Self-Reports Allegations Not Investigated	Percent of Provider Self-Reports Allegations Not Investigated	Total Provider Self-Reports Allegations Assigned for an Onsite Investigation	Percent Provider Self-Reports Investigated Onsite
SFY10	3,115	2,884	93%	231	7%
SFY11	11,686	11,351	97%	335	3%
SFY12	15,444	15,120	98%	324	2%
SFY13	18,289	18,082	99%	207	1%
SFY14	18,233	18,006	99%	227	1%
SFY15	14,289	14,162	99%	127	1%
SFY16	20,791	20,689	99%	102	1%

Proposal:

This proposal increases the Office of Health Facility Complaints (OHFC) by 34 positions over four years – from 52 to 86.5 full time equivalents, including an additional 23.5 investigators. The new investigators would be a mix of registered nurses with expertise in health care as well as professionals with criminal justice/social service backgrounds to investigate financial exploitation and abuse. The proposal also includes staffing to focus on expanded data collection and reports, trends and analysis, and systems improvement.

Once fully phased in, the additional staffing capacity will allow OHFC to:

- Double the number of investigations
- Complete investigations within the required timeframes
- Provide the public and families with complete and timely investigation results
- Develop more efficient and streamlined processes devoted to conducting investigations, communicating with families, and helping providers correct problems and improve care

OHFC is funded by a mix of state general fund, federal Medicare and Medicaid dollars, and licensing fees paid by providers. Since the department does not anticipate the federal Centers for Medicare and Medicaid Services (CMS) will match the

proposed increase, this proposal is funded by a mix of general fund and fees. Together, nursing homes and home care providers account for 94 percent of complaints to OHFC, therefore the proposal is partially supported by increasing fees paid by these two provider types by 10 percent effective July 1, 2017, and by another 5 percent effective July 1, 2019. Regulation of federally-certified nursing homes is partially supported by federal Medicare and Medicaid funds. Because nursing facilities can include the cost of regulatory fees in payments they receive from Medicaid, there is a fiscal impact to the Medical Assistance program at the Department of Human Services associated with this proposal.

The following tables summarize the fee increases needed to support the proposal:

Home Care	Current Fee	Fee Increase 7/1/2017	New Fee 7/1/2017	Fee Increase 7/1/2019	New Fee 7/1/2019
greater than $1,500,000	$6,625	$662	$7,287	$364	$7,651
greater than $1,275,000 and no more than $1,500,000	$5,797	$579	$6,376	$319	$6,695
greater than $1,100,000 and no more than $1,275,000	$4,969	$497	$5,466	$273	$5,739
greater than $950,000 and no more than $1,100,000	$4,141	$414	$4,555	$228	$4,783
greater than $850,000 and no more than $950,000	$3,727	$372	$4,099	$205	$4,304
greater than $750,000 and no more than $850,000	$3,313	$331	$3,644	$182	$3,826
greater than $650,000 and no more than $750,000	$2,898	$290	$3,188	$159	$3,347
greater than $550,000 and no more than $650,000	$2,485	$248	$2,733	$137	$2,870
greater than $450,000 and no more than $550,000	$2,070	$207	$2,277	$114	$2,391
greater than $350,000 and no more than $450,000	$1,656	$166	$1,822	$91	$1,913
greater than $250,000 and no more than $350,000	$1,242	$124	$1,366	$68	$1,434
greater than $100,000 and no more than $250,000	$828	$83	$911	$46	$957
greater than $50,000 and no more than $100,000	$500	$50	$550	$27	$577
greater than $25,000 and no more than $50,000	$400	$40	$440	$22	$462
No more than $25,0000	$200	$20	$220	$11	$231

Nursing Home	Current Fee	Fee Increase 7/1/2017	New Fee 7/1/2017	Fee Increase 7/1/2019	New Fee 7/1/2019
Nursing home per bed fee	$91	$9	$100	$5	$105

IT Related Proposals:

The proposal includes ongoing funds for technical support to create more efficient, automated processes.

Results:

With the additional staff requested through this proposal, OHFC will be able to double the number of investigations, investigate more allegations of lesser harm that will prevent serious harm from occurring, and complete the investigations within statutory timeframes. This will result in safer and healthier environments for vulnerable adults, the ability of health care providers to focus on improving the overall care provided to vulnerable adults, and improve the care delivered by facility employees. The families of vulnerable adults will have more confidence that their family member receives the best care possible. The families searching for health care providers will have the most current information to help select a safe setting for their loved ones.

Statutory Change(s):

M.S. 144.122 License, Permit, and Survey Fees
M.S. 144A.472 Home Care Provider License

Net Impact by Fund (dollars in $1,000s)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			132	143	275	203	207	410
HCAF								
Federal TANF								
Other Fund								
Total All Funds			132	143	275	203	207	410
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	33 - ED	MA – Elderly & Disabled	132	143	275	203	207	410
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**

Change Item Title: Assisted Living Consumer Survey and Report Card (CC58)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	185	891	1,549	1,549
Revenues	0	1,476	1,476	1,476
Other Funds				
Expenditures	0	0		0
Revenues	0	0		
Net Fiscal Impact = (Expenditures – Revenues)	185	(585)	73	73
FTEs	**1**	**1**	**1**	**1**

Recommendation:

Effective July 1, 2017, the Governor recommends creating an assisted living (AL) consumer survey process and report card to establish quality reporting in assisted living and registered housing with services establishments (RHWS). This proposal has four parts consisting of: (1) building on existing survey and research efforts, such as National Core Indicators (NCI); design report card measures, including measures from survey data, with stakeholder input; (2) develop AL/RHWS survey instrument and online report card; (3) test the report card tool; and (4) implement a report card over two years.

Proposal:

This proposal creates a report card to increase consumer information about assisted living facilities. The scope of this work is limited to registered housing with services establishments with an Assisted Living (AL) designation. The report card will include measures from existing data sources, as well as new measures from new data gathered through consumer surveys. Both private pay and Medical Assistance (MA) payer residents would be surveyed. This proposal has four parts.

1) July 2017: Design the online report card and measures via stakeholder engagement. Build upon existing survey instruments and research data, such as NCI, Minnesota Department of Health (MDH) surveys, licensing information, MinnesotaHelp.Info metrics, and Home Care Compare;
2) January 2018: Develop survey instrument and an online platform that connects to survey data to feed a publically accessible report card;
3) July 2018: Pilot the face-to-face consumer survey and report card; and
4) July 2019: Fully launch survey processes and report card tool. These surveys are funded via a provider fee and repeated every other year to maintain current survey information in the report card.

Roughly 37,000 people would be surveyed every two years.

As evidenced in the Nursing Home Report Card, surveys of assisted living residents will increase transparency for assisted living consumers and their families, increase consumer information about the products available, and incent providers to increase quality.

Funding for this request pays for a contractor to conduct face-to-face interviews with AL tenants and administrative resources at the Department of Human Services to oversee the contract; facilitate the stakeholder process to get input into the report card metric design, survey questions design; and report card implementation.

Rationale/Background:

Assisted living is a growing model of support to older Minnesotans who are looking for more accessible places to live that have services that help people live semi-independently. There are three components to quality in assisted living: (1) the assisted living setting which includes the quality and maintenance of the physical building space (provided by the housing with services establishment and governed by landlord-tenant law); (2) home care services (with compliance by MDH Provider Compliance);

and (3) services such as housekeeping or meal preparation. There are approximately 54,000 assisted living beds in Minnesota in about 1,176 assisted living facilities. Many of these facilities are enrolled to receive Medicare or Medical Assistance payments for the services or home care provided within the facility. These three components may be offered by one company/provider; or the housing with services establishment and the arranged home care entity may be separate entities.

Unlike nursing facilities, data on the quality of the services provided in these facilities is not easily accessible to the public. Providers have developed some quality information including awards and designations that offer consumers a way to measure one assisted living provider against another. However, the state-generated information related to quality is limited to Home care surveys by MDH, and Medicare Home Care compare for Medicare-certified home care providers and only on the home care agencies delivering care inside a setting. The Department of Health surveys are on a three year cycle so only a few hundred surveys have been completed.

Minnesotahelp.info was tasked in developing a report card concept based on existing data. In response, it gathered focus group information over the past several years and learned that: (1) People feel the report card label is negative; (2) both providers and consumers want quality information; and (3) providers are currently generating information about their quality but it is not gathered by an independent third party. During the design and development stage of this proposal, we will develop a final name for the tool.

In developing a solution for a report card using the Minnsotahelp.info web site infrastructure, the Minnesota Board on Aging explored additional ways to gather quality data from an independent source and determined that consumer reviews would be one approach. It is in the process of piloting this process but ultimately consumer reviews are a fairly subjective approach to gathering quality and only measure a particular customer's experience and satisfaction – not outcomes and customer satisfaction is only one small measure of quality.

As a payer of services for those enrolled in Medicaid, the Department has an interest in ensuring services provided in these settings are provided in a quality manner, produce better outcomes for people who live there, and are an effective investment in taxpayer dollars.

An existing contract with a survey vendor to test survey questions and existing data sources (such as Home Care Aware) will be leveraged to utilize existing survey data and measures wherever possible. Using these resources reduces the preliminary expense of this proposal. One FTE will be needed for contract oversight and facilitate the stakeholder process to get input into the report card metric design, survey questions design, and migrate survey data into report card. A pilot survey will be conducted in FY 19 and a survey of about 37,000 people would be started in FY 20. Surveys will be conducted every two years. The funding for the survey would be appropriated each year starting in FY 20 with the option to expend the funds in either year of the biennium.

AL establishments will be charged a fee to recover the costs of the face-to-face interviews. These fees would be collected through the Department of Health at the time of the annual Housing with Services registration and deposited as non-dedicated revenue to the general fund. These funds would be appropriated to DHS as a general fund biennial appropriation. The total fee per unit for each facility would be $28.80. There are about 1,100 establishments.

IT Related Proposals:

IT investments are needed to develop the online report card. A new URL domain will be created unique to the report card. Existing infrastructure could be utilized (NF Report Card or MinnesotaHelp.Info). Includes systems costs for MDH in FY18 for fee collection.

Results:

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Number of consumers surveyed	New	New	
Results	Improving quality metrics of AL facilities over time	New	New	

Statutory Change(s):

M.S. §144D.03, subd. 1b; 144G.02, subd. 2; Rider

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			185	(585)	(400)	73	73	146
HCAF								
Federal TANF								
Other Fund								
Total All Funds			185	(585)	(400)	73	73	146
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	14	CCOA Admin – 1FTE Salary & Overhead	133	120	253	120	120	240
GF	14	CCOA Admin – Contract	77	1121	1198	20	20	40
GF	14	CCOA Admin - Survey cost	0	0	0	2,201	2,201	4,402
GF	REV1	CCOA admin @35% FFP	(74)	(434)	(508)	(819)	(819)	(1,638)
GF	REV2	Provider Fees- through Department of Health- phased in over five years.	0	(1,476)	(1,476)	(1,476)	(1,476)	(2,952)
GF	11	Systems Costs (website)	49	84	133	27	27	54
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
Gf	14	CCOA admin	1	1		1	1	

Change Item Title: Health Care Purchasing & Coverage Reform (HC-41)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	(812)	(4,478)	2,865	(8,144)
Revenues				
Other Funds				
Expenditures	131	354	709	676
Revenues				
Net Fiscal Impact = (Expenditures – Revenues)	(681)	(4,124)	3,574	(7,468)
FTEs	**11.5**	**14**	**14**	**14**

Recommendation:

The Governor recommends modernizing how the state purchases health care and investing in efforts that promote a more accessible, affordable and seamless coverage continuum for enrollees in the state's public health care programs. The goal of this reform package is to provide better value to the state and reduce coverage gaps, while improving health outcomes for enrollees in Minnesota's public health care programs.

This proposal has a net all state fund savings of $4.8 million in the FY2018-19 biennium and a savings of $3.9 million in the FY2020-21 biennium.

Rationale/Background:

Minnesota is a national leader in applying innovative strategies to how it purchases, delivers, and covers health care services for people with low-incomes. There are a number of opportunities for Minnesota to build on successful initiatives and to address on-going challenges.

Integrated Health Partnerships

The Integrated Health Partnerships (IHP) initiative, an accountable care model, incentivizes health care providers to provide higher quality and lower cost health care. Under the IHP program, providers or groups of providers voluntarily contract with the Department of Human Services (DHS) to be held accountable for the total cost of care for enrollees in Medical Assistance (MA) and MinnesotaCare, both managed care and fee-for-service, in exchange for the opportunity to share in any savings that are achieved.

There are currently 19 IHPs who cover nearly 370,000 people across the state. IHPs represent a variety of providers ranging from integrated health systems to independent physician practices to regional provider collaborations. IHPs generate savings and improve health outcomes through care models that provide for more intensive primary care relationships for persons with chronic conditions, and more collaboration with mental health care providers and other community resources. IHPs have produced strong results; in 2014, there was a 14 percent decrease in hospitalization rates and a 7 percent decrease in emergency room visits for people receiving care through the IHP model.

In May 2016, DHS published and received responses to a Request for Information (RFI) to solicit feedback on for improving the IHP program, including sustainability and infrastructure needs, payment and performance on cost, member attachment, integration of services, and quality and patient outcome measurements. This feedback has helped inform and guide DHS on opportunities to expand and improve the initiative.

Access to Critical Services for MA and MinnesotaCare Enrollees

Access to dental care for public program enrollees is a recognized problem in Minnesota. In the MA program, utilization rates for dental care by children and adults are well below the rates for the privately insured population. Attempts have been made over the past several legislative sessions to improve access to dental care for MA and MinnesotaCare. There have been substantial

rate increases for critical access dental providers who see a higher proportion of people on public programs as well as rural dental providers. Despite these efforts, access to dental services remains a serious issue that Minnesota needs to address.

Studies performed by DHS in 2014 and 2015 show that due to administrative complexity and low reimbursement rates, many dentists are discouraged from serving public program enrollees. The Minnesota Office of Legislative Auditor also identified DHS' current administrative and payment structures as potential barriers to dentists participating in the program. A comprehensive approach that restructures both the administrative and payment structure for dental services is needed to address the lack of access to dental care for enrollees.

Limited access to long-acting reversible contraceptives (LARC) after childbirth is another issue faced by enrollees in MA. While MA covers all forms of LARC without prior authorization, utilization is still relatively low. One likely reason is due to the high cost of the LARC procedure for providers and the way the payments are structured in MA. For example, hospitals and FQHCs are paid a bundled rate for an infant delivery or a related clinic visit and therefore not adequately reimbursed for the LARC procedure itself under MA. New purchasing strategies for LARCs are needed to incentivize providers to offer these products and expand access for MA enrollees.

Although many women plan to access a contraceptive method at their postpartum visit, research indicates that up to 40 percent do not attend their follow-up appointment and, therefore, never receive contraception. LARCs are safe and effective options for contraception for many women. These products include Intrauterine Devices (IUD) and hormonal implants. LARC methods can prevent unintended pregnancy for 3-to-10 years, depending on the product selected. These methods can reduce the risk of preterm birth, low birth weight, and perinatal death.

MinnesotaCare Enrollment Timing

While Minnesota has a comprehensive coverage continuum compared to other states, coverage gaps persist for enrollees. The MinnesotaCare program has one of the most persistent coverage gaps as a result of the timing of when coverage begins. Currently, when a person is determined eligible for MinnesotaCare, their coverage does not begin until the following month leaving them without coverage for the month in which they are applying. As a result, some people who transition to MinnesotaCare from MA or a qualified health plan experience a gap in coverage between when their former coverage ends, and when they are successfully enrolled in MinnesotaCare. This also impacts enrollees who report changes and are redetermined eligible for MinnesotaCare near the end of the month. Additionally, some individuals who file a paper application are more likely to have a delay in coverage than people who apply online. By making coverage through MinnesotaCare available at the beginning of the month in which a person applies, as in the MA program, the state could eliminate this gap and help enrollees maintain continuous coverage and avoid a potential tax penalty due to a gap in coverage.

Family Glitch

The federal "family glitch" is another frequently raised coverage gap with respect to MinnesotaCare. Under the ACA, individuals who have access to "affordable" employer-sponsored coverage are not eligible for MinnesotaCare or advanced premium tax credits. Coverage is deemed affordable under the ACA based on the employee's contribution compared to his or her household income. However, this threshold is only applied to coverage for the employee and not the employee's family. This means that, if the coverage is determined affordable for the employee under this threshold, it is automatically deemed affordable for the employee's family. As a result, some families are excluded from being eligible for MinnesotaCare or advanced premium tax credits, even though the additional cost of coverage for their family exceeds the federal affordability threshold. Addressing this issue would require a federal "1332 State Innovation Waiver".

MA Coverage for Children in Foster Care

Some children in foster care also face barriers to coverage in MA. While children who qualify for Title IV-E benefits in foster care are eligible for automatic enrollment, children who do not qualify for Title IV-E are not. Despite the fact that most children who receive non-IV-E foster care qualify for MA, the administrative barriers of applying for and/or renewing coverage often leads to delays or unintentional loss of coverage.

Barriers to Coverage for People involved with the Criminal Justice System

People who are involved with the criminal justice system also face barriers to coverage. Each year, about 7,000 people are released from facilities operated by the Minnesota Department of Corrections, and many of these individuals are released without health care coverage. Of the approximate 7,000 people released from state correctional facilities each year, 5,500 do

not receive specialized assistance in applying for coverage. Because many people released from correctional facilities struggle with mental illnesses and substance use disorders, it is believed that improved access to health care coverage through application assistance will improve their health outcomes and reduce recidivism.

Navigator Payment Disparities
Currently, navigator entities providing application assistance receive an incentive payment when they successfully enroll an individual into MA and MinnesotaCare, $25 and $70 respectively. In FY 2015, roughly 1,000 navigators across the state of Minnesota provided application assistance to about 41,000 MA and MinnesotaCare enrollees. The disparities between these two incentive payments unfairly impact organizations for assisting people to enroll in MA.

Proposal:

This proposal builds on Minnesota's successes as a national leader in health care and supports the state's goals of ensuring better value for taxpayers and better health outcomes for our residents. Along with enhancing the state's ability to modernize and streamline its purchasing and delivery systems, this package also improves administrative efficiencies and addresses long-standing issues in access to services, barriers to coverage, and health disparities. This proposal includes the following elements:

Health Care Purchasing and Service Delivery Reform
Minnesota also has the opportunity to leverage the state's purchasing power to address issues related to access within the state's public health care programs.

Improving integration of care and health outcomes
Through enhancements to the IHP demonstration, this proposal will better connect people who seek care to social services, grant providers more timely access to needed information, and promote the use of integrated care among participating providers. This includes incorporating a population-based payment for IHP providers to consolidate and simplify the existing payment structure. This payment will allow IHP providers to receive an upfront payment of shared savings, tied to benchmarks on quality and cost. Through this new payment, IHP providers will be able to better stabilize their revenue and reduce the initial financial impact of participating in the program. This will also provide more opportunities for new providers, such as certified health care homes, to participate in coordinating services for patients in the IHP program. DHS estimates that this new payment structure would result in an additional 193,000 beneficiaries being served by IHP program.

Other components of this proposal consist of new contracting requirements and provider incentives to better connect beneficiaries with existing community supports and social service organization and improvements in the exchange of electronic health information among participating and authorized providers. By contracting with state-certified Health Information Exchange (HIE) vendors, DHS will be eligible to receive 90 percent federal Medicaid matching funds for this effort. The state share of the grant funding and the savings to the MA and MinnesotaCare programs are included in the fiscal detail.

In addition to these enhancements, this proposal will help reduce duplicative services in managing enrollee care by establishing an "advanced track" for providers to choose which will allow them to take on more accountability for managing the health outcomes of their patient populations. Specifically, this proposal will help clarify the roles and responsibilities of IHPs and managed care organizations for the patients that seek care from providers that select this advanced track.

Together with the LARC proposal, the enhancements to the IHP model will generate enough savings that offset the cost of new investments that will increase rates for dental providers, address coverage barriers for certain children in foster care, and enhance application assistance for people being discharged from correctional facilities.

Expanding Access to Dental Care for MA and MinnesotaCare Enrollees
This proposal will create a simpler and more efficient model for purchasing dental services by allowing the state to use a competitive bidding process to select up to two vendors to deliver dental care to enrollees. Implementing alternative administrative structures for dental will result in increased administrative efficiencies for the state, counties, and providers, as well as simplify and improve the consumer experience. Through a common administrative structure for the delivery of dental benefits, the state will reduce the amount of administrative costs it pays to administer the dental program as well as reduce the burden and costs MA providers face when billing multiple payers.

This proposal will also provide a 54 percent rate increase over the current MA fee schedule for all dental services under MA and MinnesotaCare. This investment is made possible by repurposing both the critical access and the rural dental add-on payments for an across-the-board increase that will remove the payment disparities among dental providers across the state. The goal of this investment and reform is to encourage a greater number of dental providers to participate in the MA and MinnesotaCare programs.

The fiscal estimate assumes savings related to the new administrative structure and the repeal of the add-on payments as well as the cost of the dental rate increase. This change is effective on January 1, 2019.

Improving Birth Outcomes
DHS would volume purchase LARC and establish a provider grant program for hospitals, Federally Qualified Health Centers, and Indian Health Service providers for postpartum administration to women under the age of 22. Manufacturers of LARC products would be invited to bid for their products to be available through the grant program. The department would be required to select at least one product, but no more than four different options, to be available to providers.

Improving access to LARC contraceptives for women enrolled in MA immediately after a birth through the grant structure will reduce provider costs to stock the device and improve the enrollee access to safe and effective contraception. This effort will reduce the risk of premature birth and improve outcomes for postpartum mothers and their babies.

The fiscal estimate recognizes the state share of the cost of the LARC grants after receipt of enhanced federal matching funds, available upon federal approval, and recognizes savings to the MA program from fewer deliveries and from fewer months of MA eligibility for infants.

<u>Efforts to Reduce Disparities and Gaps in coverage</u>
This proposal also includes several initiatives to eliminate gaps in coverage for public program enrollees and reduce disparities. These include the following:

Eliminating MinnesotaCare Coverage Gaps
This proposal will allow MinnesotaCare coverage to begin the same month that a person applies and pays their premium. This coverage gap fix will go into effect January 1, 2019. This will eliminate the gap in coverage that many people currently experience and aligns the process with MA. This proposal also directs DHS to seek a federal 1332 waiver to eliminate the federal “family glitch” for people eligible for MinnesotaCare and requires a report back to the legislature regarding needed statutory and buget authority.

Continuous Coverage for Children in Foster Care
This proposal will allow children in foster care who do not receive Title IV-E benefits to be enrolled into MA automatically, like children receiving Title IV-E. The fiscal estimate assumes coverage for an average of 320 foster care children. This coverage change takes effect January 1, 2019 and requires federal approval.

Improving Access to Health Care Coverage for People Involved with the Criminal Justice System
This proposal will provide funding for staff to assist people who want to apply for health care coverage prior to their release from a state correctional facility. Completed applications will be centrally processed at DHS to ensure that eligible people will have access to health care coverage upon their release from the correctional facility into the community. The fiscal estimate assumes that providing this assistance to people leaving correctional facilities will result in approximately 2,700 adults gaining health care coverage through MA.

Aligning Navigator Incentive Payments
Effective July 1, 2017, this proposal reallocates existing DHS administrative funds to increase payments for eligible organizations that provide application assistance for MA from $25 to $70 per enrollee, which is equal to the incentive provided to entities assisting people with enrollment into MinnesotaCare and Qualified Health Plans (QHPs) through MNsure. Equalizing this payment amount will fairly pay organizations for reaching and assisting all populations regardless of income, and is consistent with DHS and administration-wide goals to improve access to affordable care and reduce the percentage of Minnesotans lacking health insurance.

Administrative Funding

Finally, this proposal includes funding for administrative and staffing needs related to the coverage of non-Title IV-E foster children, providing application support for people discharged from correctional facilities, managing a new dental benefit administrator, and the changes to Integrated Health Partnerships. The expansion of IHP will require additional staff to work with the provider community and for policy and administrative staff needed to develop and maintain policy on prospective payments, administer the IT grants, and support other changes that will strengthen partnerships with community supports and social service organizations and increase accountability for patient population health outcomes. The cost for these additional resources is reflected in the fiscal detail.

Equity and Inclusion:

Minnesota is among the healthiest states in the nation and enjoys relatively high rates of health insurance coverage. However, when compared with white people in Minnesota, people of color and American Indians residing in the state experience significant disparities in health status and in rates of health insurance coverage. While the majority recipients enrolled in Medical Assistance and MinnesotaCare are white, people of color, especially African Americans and American Indians make up a disproportionate share of total program enrollment. In fact, over 60 percent of African Americans and American Indians residing in the state were enrolled in the programs in July 2014. In 2015, Minnesota boasted the fifth lowest rate of un-insurance in the country at 4.3 percent. However, the rates of un-insurance for African Americans and American Indians residing in the state was roughly double the statewide average, and the rate for Hispanics was about three times the state average. Minnesota's health care programs play a significant role in providing health care coverage to racial and ethnic minority populations in the state, and to the extent that these programs can affect the health status of recipients may also play a large role in reducing health disparities.

IT Related Proposals:

The following elements of this proposal will require IT changes:

- Gaps in coverage for MinnesotaCare enrollees: This will require extensive system changes to MMIS and METS. The METS and MMIS interface will be programmed to permit MinnesotaCare coverage via managed care plans to begin when MinnesotaCare eligibility begins. The MMIS premium billing system will be programmed to issue premiums bills for months of coverage in accordance with the begin date of eligibility.
- Closing the coverage gaps for children in non IV-E foster care requires changes to the MAXIS and MMIS systems.
- The dental proposal requires changes to the MMIS system for payment of the new rate schedule.

Results:

- DHS currently uses a core set of quality measures to understand provider performance through our IHP program and managed care that are intended to measure performance based on statewide Medicaid benchmark as well as reward through payment higher quality care. DHS will continue to monitor performance on those measures and new measures as they are added to the core set.
- For dental access, DHS will use the HEDIS measure for annual dental visit for both children and adults, number of active providers enrolled in public program, and the number of helpdesk calls received regarding dental access. DHS will evaluate these measures to assess whether the assumed increase in dental access in this proposal is realized.
- For continuing to improve health coverage and gaps in coverage for public program, DHS will continue to use the Minnesota Health Access Survey, which includes the statewide uninsurance rate to assess whether the proposed have an impact on the number of uninsured in the state. Minnesota currently has one of the lowest uninsurance in the nation at 4.1%

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quality	Optimal Diabetes Care Composite	Not currently available		
Quality	Optimal Vascular Care Composite	Not currently available		
Quality	Depression Remission at 6 Months	Not currently available		
Quality	Optimal Asthma Control Composite – Adults and Children	Not currently available		
Quality	Asthma Education and Self-Management - Adults and Children	Not currently available		
Quality	Patient Experience (CG-CAHPS)	Not currently available		
Quality	Patient Safety Composite (PSI-90)	Not currently available		
Quality	Patient Experience (HCAHPS)	Not currently available		
Quality	Annual dental visit (HEDIS)	Not currently available		
Quantity	Number of helpdesk calls received on dental access issues	Not currently available		
Quantity	Number of active treating providers enrolled in MA/MinnesotaCare	11,963	12,833	FY2016
Quantity	Statewide uninsurance rate	8.2%	4.3%	2013, 2015

Statutory Change(s):
§256L.04, §256L.05,

Net Impact by Fund (dollars in thousands)			**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
General Fund			(812)	(4,478)	(5,290)	2,865	(8,144)	(5,279)
HCAF			131	354	485	709	676	1,385
Other Fund								
Total All Funds			(681)	(4,124)	(4,805)	3,574	(7,468)	(3,894)
GF	33	MA Grants	(2,055)	(7,165)	(9,220)	(1,519)	(12,585)	(14,104)
HCAF	31	MinnesotaCare Grants	(13)	145	132	484	451	935
GF	13	HCA Admin (Contract)	400		400	0	0	0
GF	13	HCA Admin (FTE)	677	754	1,431	758	758	1,516
HCAF	13	HCA Admin (FTE)	0	180	180	196	196	392
GF	REV1	FFP @ .35	(377)	(327)	(704)	(334)	(334	(668)
GF	11	Systems	148	42	190	42	42	84
HCAF	11	Systems	144	29	173	29	29	58
GF	51	Health Care Grants for HIE	125	250	375	250	250	500
GF	13	HCA Admin (Justice Involved FTE)	270	270	540	270	270	540
GF	13	HCA Admin (Dental Vendor)	0	3,088	3,088	6,179	6,282	12,461
GF	REV1	FFP (Dental Vendor @35%)	0	(1,390)	(1,390)	(2,781)	(2,827)	(5,608)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	**13**		**11.5**	**14**		**14**	**14**	

Change Item Title: MinnesotaCare Buy-In Option for Individual Market

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	12,925	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	12,925	0	0	0
FTEs	**92**	**0**	**0**	**0**

Recommendation:

The Governor recommends offering Minnesotans who are eligible to purchase a qualified health plan (QHP) on the individual market the option of purchasing a private MinnesotaCare product through MNsure. This proposal seeks to ensure access to affordable and comprehensive health care coverage options for consumers who do not have health care coverage through their employer or a public program.

This proposal has a one time cost to the Health Care Access Fund of $12.9 million in the FY2018-19 biennium.

Rationale/Background:

Starting in 2017, states have the option to pursue federal authority to waive certain rules of the Affordable Care Act (ACA). This authority under section 1332 of the ACA, also known as a *state innovation waiver*, allows states to develop and implement creative strategies for providing health care coverage, while retaining the basic protections and goals of the ACA. To receive federal approval, a state must show that its alternative approach provides coverage to as many residents and ensures access to care that is at least as comprehensive and affordable as would have been provided without the waiver. States must also show that such a waiver will not increase the federal deficit.

With the recent premium increases and a reduced number of participating carriers, consumers purchasing health insurance in Minnesota's individual market have limited options when it comes to affordable coverage. To address this issue, the Governor recommends that Department of Human Services (DHS) expand on the success of the bipartisan MinnesotaCare program and its legacy in providing comprehensive and affordable coverage options for low-income Minnesotans over the last two decades. This includes maximizing and leveraging the state's purchasing power for its public health care programs in order to get better value for the consumer and the state.

Currently, MinnesotaCare operates as a basic health program under section 1331 of the ACA. It provides subsidized coverage to people who are ineligible for Medical Assistance with incomes up to 200 percent of federal poverty level. Federal funding for the program is based on the federal tax credits and subsidies that would have been available to this population in the exchange. Federal law requires all carryover or excess funds for the BHP program to be kept in a trust fund by the State and only used for reducing enrollee premiums and cost-sharing or providing additional benefits to enrollees.

Proposal:

Under this proposal, DHS will develop a state-purchased product to be offered as a more affordable alternative to consumers eligible to buy a qualified health plan on the individual market. This new product will be based on the MinnesotaCare program. It will be made available to consumers in the commercial Qualified Health Plan (QHP) market starting on November 1, 2017 through January 31, 2018 and any applicable enrollment periods thereafter. Coverage purchased during 2017 open enrollment would be effective for services provided on or after January 1, 2018. DHS will seek all necessary waivers, including authority under section 1332 of the ACA, to implement this proposal.

This product will offer eligible consumers a similar benefit set and provider network as the standard MinnesotaCare program, which provides more robust coverage than the minimum requirements set forth under the ACA for the standard QHP product. Consumer premiums will reflect the full cost of care and administrative costs to operate the program. Two product levels will be offered equivalent to a silver- and a gold-level product in the QHP market. A silver level plan provides for a 70 percent actuarial value (AV) and a gold level plan provides for an 80 percent AV. This means that the plan would cover either 70 or 80 percent of a person's health care expenses for the year, respectively. As with the purchase of any qualified health plan, individuals eligible for advance federal premium tax credits and federal cost-sharing subsidies will be able to apply this assistance to reduce the cost of the product. The projected statewide average premium for the buy-in option is $451 for a silver level product.

DHS will continue to purchase for the current MinnesotaCare program and Medical Assistance along with this new buy-in option from managed care and managed care like entities. This proposal will require entities participating in Medical Assistance and MinnesotaCare to offer the new MinnesotaCare buy-in option as well. To ensure consumers have statewide access providers will be required to participate if they also participate in the state's employee health plan as is the case currently with Minnesota's public health care programs.

Under this proposal, DHS would receive the value of advance premium tax credits and cost sharing subsidies available to eligible individuals purchasing the buy-in option through the state's health insurance exchange, like a health insurance carrier offering a QHP in MNsure. This proposal assumes that these federal payments, along with the enrollee premiums paid to DHS, would be sufficient to fund the cost of enrollee coverage and the administrative costs to operate the program without additional state funds. Therefore the fiscal detail table only reflects the initial costs related to the initial implementation and ramp up necessary to establish the buy-in option at DHS.

The proposal also requires DHS to seek federal authority to utilize the existing surplus of funds in the BHP trust fund, as established under Minnesota Statutes 16A.724, for purposes of establishing a reserve to support cash-flow, coverage, claims and liabilities for the standard MinnesotaCare program as well as the new buy-in option. This would allow DHS to meet any cash flow deficiencies related to the timing of the receipt of federal funds or enrollee premium payments by DHS and the need to expend funds to cover for enrollee claims.

Administering the new product in MNsure like a QHP will require ongoing funding to support call center operations, establish and maintain benefit and eligibility policy, develop and manage the waiver processes and meet federal reporting requirements, establish new accounting processes and support ongoing financial operations, provide enrollee notices and communications, and support managed care rate setting and contracting processes. The fiscal detail table includes the first nine months of administrative funding needed to implement and administer this program and the costs of actuarial work for rate development for the 2018 plan year.

The table below represents specific details regarding the anticipated state cost to support specific business functions.

Function	FTEs	FY2018 Cost (thousands)
Member help desk and communications support	4	$329
Enrollee call center, recipient communications, and training staff	81	$6,907
Benefits policy, managed care contracting and enrollment support, claims and financial operations support	5	$595
Accounting and financial operations support	2	$166
Eligibility Policy Support	1	$87
Enrollee notices and postage costs		$1,500
Actuarial support for managed care rate setting		$650
Subtotal Business Functions	**92**	**$10,234**
Systems		$2,691
Total Proposal Cost		**$12,925**

Offering this new option will also require changes to DHS IT systems and the Minnesota Eligibility Technology System (METS). The fiscal detail reflects the development costs for the IT work needed to provide this option within the METS eligibility systems and to administer premiums and perform other transactions within DHS IT systems.

This estimate also assumes that, beginning in the second quarter of calendar year 2019 and thereafter, the consumer premiums and premium withhold funds collected under Minnesota Statutes 62V.05 will fund all ongoing costs necessary to manage the program and support ongoing maintenance of IT systems and operational and administrative functions. This includes any costs allocated to support operations related to offering this product in MNsure as a QHP.

IT Related Proposals:

Offering this new option will also require changes to DHS IT systems and the Minnesota Eligibility Technology System (METS). This includes IT development work to provide this option within the METS eligibility systems and to administer premiums and perform other transactions within DHS IT systems.

Results:

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Uninsured rate	8.2%	4.3%	2013, 2015

Statutory Change(s):

Minnesota Statutes 256L.29

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund								
HCAF			12,925		12,925	0	0	0
Federal TANF								
Other Fund								
Total All Funds			12,925		12,925	0	0	0
Fund	**BACT#**	**Description**				**FY 20**	**FY 21**	**FY 20-21**
HCAF	11	Systems	2,691	0	2,691	0	0	0
HCAF	13	HCA Admin (FTE)	8,084	0	8,084	0	0	0
HCAF	13	HCA Admin (Contract)	2,150	0	2,650	0	0	0
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
HCAF	13	HCA Admin	92					

Change Item Title: Compliance with Federal Managed Care and Access to Care Rules (HC-52)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	(724)	(437)	(469)	(492)
Revenues	(6,792)	(6,792)	(6,792)	(6,792)
Other Funds				
Expenditures				
Revenues				
Net Fiscal Impact = (Expenditures – Revenues)	6,068	6,355	6,323	6,300
FTEs	**10**	**13**	**13**	**13**

Recommendation:

The Governor recommends changes to the Medical Assistance (MA) and MinnesotaCare program to comply with new federal requirements for both the managed care and fee-for-service delivery systems.

This proposal has a net impact to the General Fund of $12.4 Million in the FY18-19 biennium and $12.6 million in the FY2020-21 biennium.

Rationale/Background:

The Minnesota Department of Human Services administers the MA and MinnesotaCare programs and contracts with managed care organizations (MCOs) to deliver covered services to enrollees through their provider networks. Roughly 80 percent of the nearly 1.1 million Minnesotans enrolled in the programs are served by MCOs while the remainder are served in a fee-for-service delivery system administered directly by DHS. This proposal addresses new federal requirements for state Medicaid programs to reflect changes in managed care delivery systems and to ensure that recipients served in fee-for-service have access to health care services.

Access Rule

In the Spring of 2016, the Centers for Medicare and Medicaid Service (CMS) finalized a new rule requiring state Medicaid programs to better ensure that fee-for-service payment rates are sufficient so that care and services are available to enrollees at least to the extent that they are available to the general population. The rule requires states to create a data driven process to monitor and review access to services for people enrolled in fee-for-service. To fulfill this requirement, Minnesota must establish and regularly update an access review monitoring plan that tracks trends or changes in provider access by comparing provider availability, payment rates, utilization rates to that of other payers in the market and tracks ongoing beneficiary satisfaction or experience with access. States initially are required to monitor a core set of services prescribed by CMS, but must also include any other service(s) if the state believes there may be an access issue, or when the state changes payment rates. CMS may, as a result of the reports, require states to take corrective actions to address issues that are identified, and report on those actions as well.

Managed Care Regulation

In May 2016, CMS also finalized new regulations to reflect changes in the usage of managed care delivery systems by state Medicaid programs. The final rule aligns many of the rules governing Medicaid managed care with those other major sources of coverage, including coverage through Qualified Health Plans (QHP) and Medicare Advantage plans. The regulation strengthens actuarial soundness requirements to promote the accountability of managed care program rates, promotes the quality of care, strengthens efforts to reform delivery systems that serve Medicaid beneficiaries, ensures appropriate beneficiary protections, and enhances policies related to program integrity. States who fail to comply with the rule are subject to withholding of federal financial participation (FFP).

New developments will include additional support for enrollee health plan selection and screening of all the MCO's network providers. However, the State will still need to review and update its current processes and implement the new requirements as it relates to materials, monitoring, and network adequacy, and quality, continuity of care, program integrity, and payments.

The 2016 process for managed care procurement process also highlighted areas where current state laws are unclear, may conflict with federal regulations, may not represent current best practices, and may not reflect the evolving purchasing strategies the state has been pursuing over the past several years. In addition, the new managed care regulations released by CMS also reiterates the need to ensure the procurement of managed care contracts are competitive and free from conflicts.

To ensure compliance and maintain federal matching funds for the state's health care programs, payments to managed care organizations for the services purchased on behalf of enrollees, changes must be made to ensure all procurements are competitive, clarify the role of the state as the designated single state agency for the MA program, and ensure people in the evaluation are free of conflict.

Proposal:

Access Rule

This proposal requires the commissioner to establish and regularly update an access plan that complies with federal requirements and provides funding for implementation to develop more sophisticated methods to monitor access to services, and compare fee-for-service (FFS) to other rates within the healthcare industry. DHS currently does have sufficient access to data on most metrics to compare MA FFS enrollees to the general population or specifically on MA beneficiary needs and experience. This proposal provides funding for additional analytic support to provide more robust measurement and support ongoing requirements for any changes to the Medicaid state plan and a beneficiary experience survey for FFS enrollees to align with our managed care program.

Managed Care Regulation

This proposal make several changes to the statutes governing managed care procurement to clarify the roles between the commissioner and counties, and to better align with standard practices and evolving purchasing strategies.

Directed and Pass-through Payments. Some payments that are currently made outside of the capitation payments will be discontinued, as they do not conform to the new requirements, such as the enhanced hospital payment and graduate medical education payment, which are both conditioned on an inter-governmental transfer (IGT). The new regulation defines what types of payments a state can direct an MCO pays or can pass-through the rates on behalf of managed care enrollees. This will eliminate managed care payments directed to specific providers.

The managed care rule also restricts federal matching on IGTs which supplement increases to managed care capitation rates and are passed through to specific providers. To comply with this provision, this proposal eliminates two mechanisms described in state law which are used to transfer the nonfederal share of certain hospital payments from a government entity to the state for the purpose of drawing down federal Medicaid share. Specifically, this proposal repeals out the transfer of $6.8 million from Hennepin County to the state and the related supplemental MA payment starting in July 2017. Under current state law, DHS makes a supplemental payment through a health plan serving Hennepin County by the amount of this transfer and generates federal Medicaid funds which are deposited in the state General Fund. Seperately, the impact of this change is a loss of revenue to the General Fund and a reduction in the state share of the MA payment.

In addition to the payment described above, Hennepin and Ramsey county transfer an additional $18 million annually to the state which is used as the nonfederal share of a $36 million MA payment paid through the capitation rates to nonstate owned public hospitals in those two counties. This proposal phases the transfer and related MA payment down by ten percent a year starting in January 2018 until it is eliminated in 2025. While the transfers in and payments out are of equal value, this fiscal detail for this proposal includes a $150,000 annual MA state share cost for the phase out of this payment which is related to the timing of managed care payments.

Rate Setting Standards. A number of new requirements must be performed by the state's contracted actuary as part of the managed care rate development and certification to CMS. New requirements include minimum medical loss ratios, increased information provided to CMS about various components of how the rates were developed, and demonstrating how stays in

institutions for mental disease (IMDs) are calculated. Additional actuarial support is needed to comply with these new requirements and ensure rates can be certified.

Monitoring and Quality. The state must establish and implement ongoing and comprehensive oversight programs to appropriately monitor, evaluate, and take action around a variety of MCO activities such as:

- Monitoring new MCO comprehensive quality assessment and performance improvement plans, including mechanisms to assess quality around LTSS services, if provided by the MCO.
- Establish and monitor performance measures, including those identified by CMS. This will require new data collection and reporting.

The state must develop a Comprehensive Quality Strategy for assessing and improving the quality of health care services furnished by MCOs, including, at a minimum:

- Network adequacy that complies with new federal standards
- Use of evidence-based clinical practice guidelines
- Quality measurement and outcomes
- Annual external independent review of quality outcomes and timeliness of access to services
- Continuity of care policies
- State's plan to identify, evaluate and reduce health disparities
- Measuring quality of life, community integration, etc. of enrollees receiving LTSS
- Provide for public review and comment
- External validation of network adequacy

The state must establish a monitoring system for all MCOs to evaluate the MCO's performance in at least 14 different areas (administration, claims payment, finance, marketing, program integrity, etc.) prescribed by CMS and annually report to CMS and publish results publicly.

The state must also comply with new requirements around limits for IMD stays and in lieu of services that can be included in the managed care capitation rates in order to qualify for federal financial participation (FFP).

Multiple changes to member materials and information are required in order to make information more accessible and understandable.

In addition, the state must comply with new requirements to screen and enroll and periodically revalidate all network providers of MCOs.

Beneficiary support and choice counseling.

The state must establish a comprehensive benefit support system for enrollees to get assistance and information prior to and after enrollment in a MCO. The support must include accessible information and provide neutral choice counseling and assistance to those seeking LTSS. The state plans to expand the existing services available through the Senior and Disability Linkage Lines to create a comprehensive program to fully support the entire spectrum of enrollees (including families and children) and assist them in understanding their choices and the services available to them.
Complying with these new regulations will require additional administrative funding. The specific components involved in meeting these new requirements are as follows:

<u>Managed care rule</u>

- Increased actuarial support to meet new rate-setting requirements
- Additional staff (5 FTEs) to meet additional reporting, monitoring, and quality standards
- Beneficiary support system that include a choice counseling line that will provide conflict-free information and education to enrollees about managed care plan selection
- An inter-agency agreement with the Minnesota Department of Health (MDH) to provide network adequacy review

- Additional staff (5 FTEs) to enroll health care providers serving MA recipients through programs administered by MCOs and who have not already enrolled as fee-for-service MA providers
- Additional staff (.5 FTE) to manage both the mid year change in capitation payments and reconciliation with multiple health plans and the ongoing staff time to process payments and ensure proper MCO rate setting.
- $ 25,000 in actuarial costs for FY2018 to recalculate manged care rates in July 2018 and get rates recertified by CMS.

Access Rule

- Data analytic support to provide more robust metrics and additional data sources for ongoing submission of the state's access monitoring plan. This also includes support when the state is required to update the monitoring plan and evaluate changes each time the state reduces or restructures a provider rate.
- Survey administration to fee-for-service enrollees to assess beneficiary needs and access. The tool is similar to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey the state is required to use for its managed care enrollees.

IT Related Proposals:

This proposal does not require changes to DHS claims payment, eligibility, or other IT systems.

Results:

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Active Primary Care Providers per 1,000 MA FFS Enrollees	N/A	52.5	2014
Quantity	Average Payment Rate for Primary care as a Percentage of Medicare Rates	N/A	83.4%	2014
Results	Total number of active dental providers enrolled in FFS MA	N/A	2,009	2014

Statutory Change(s):

§256B.69 and §256B.692 and other areas of the MA and Minnesota Care statutes.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			6,068	6,355	12,423	6,323	6,300	12,623
HCAF								
Federal TANF								
Other Fund								
Total All Funds			6,068	6,355	12,423	6,323	6,300	12,623
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	13	HCA Admin (contract)	1,290	1,880	3,170	1,880	1,880	3,760
GF	13	HCA Admin (FTEs)	1,097	1,317	2,414	1,317	1,317	2,634
GF	REV1	FFP @ 35%	-836	-1,119	-1,955	-1,119	-1,119	-2,238
GF	13	HCA Admin (state share EQRQ and CAHPS)	51	51	102	51	51	102
GF	33	MA Grants	-2,326	-2,566	-4,892	-2,598	-2,621	-5,219
GF	NDR	Lost Non-Dedicated Revenue from IGT	6,792	6,792	13,584	6,792	6,792	13,584
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
			10	13		13	13	

Change Item Title: Federal Compliance with Asset Verification Requirements (HC-54)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	626	19	(15)	(38)
Revenues				
Other Funds				
Expenditures				
Revenues				
Net Fiscal Impact = (Expenditures – Revenues)	626	19	(15)	(38)
FTEs	**2.25**	**3**	**3**	**3**

Recommendation:

Effective July 1, 2017, the Governor recommends the Department of Human Services (DHS) implement an asset verification system for Medical Assistance (MA) recipients whose basis of eligibility is being blind, over age 65, or having a disability in order to comply with federal Medicaid requirements. This proposal has a net cost to the General Fund of $645,000 in the FY2018-19 biennium and a savings of $53,000 in the FY2020-21 biennium.

Rationale/Background:

Federal legislation enacted in 2008 included a requirement that all state Medicaid programs implement an asset verification system (AVS) to identify unreported liquid assets of people who apply for or are enrolled in Medicaid (Medical Assistance (MA) in Minnesota) and who are age 65 or older, who are blind, or who have a disability. This requirement stemmed from a pilot project implemented by the Social Security Administration (SSA) in 2003 to electronically verify liquid assets of applicants for the Supplemental Security Income (SSI) program in order to identify unreported assets.

In January 2009, the Centers for Medicare & Medicaid Services (CMS) provided guidance to states on the implementation of this law. Each state was required to amend its state plan to implement an AVS using a system that is consistent with the approach taken by SSA in their asset verification pilot project. The Secretary of Health and Human Services was directed to phase in this requirement by requiring states to implement an AVS beginning in federal fiscal year (FFY) 2009 through FFY 2013. Minnesota was scheduled to implement an asset verification system in the fifth phase, i.e. no later than October 1, 2013. CMS has required Minnesota to comply with a corrective action plan to ensure implementation of the AVS as soon as possible. States who fail to comply with the required implementation are subject to withholding of federal financial participation (FFP).

Proposal:

This proposal provides the funding necessary for DHS to issue a request for proposal (RFP) in FY2018 for a vendor to build an AVS for use in eligibility and renewal determinations for people with an aged, blind, or disabled basis of eligibility who are applying or renewing their MA coverage starting in July 2018. This new system would allow DHS to verify liquid assets held in financial institutions who participate in the AVS and would improve program integrity by potentially identifying assets held in financial institutions which a person was unaware of or did not report at the time of application or renewal.

The AVS is envisioned as a web-based tool that county and tribal workers can access to identify and verify financial accounts owned by people age 65 or older, who are blind or who have a disability who apply for or are enrolled in MA. AVS programs implemented in other states have generally required up front development costs and ongoing usage fees. DHS staff would be required to manage the vendor contract, establish associated program policies related to the use of the AVS, develop operational procedures and implement the new AVS, including providing training to county and tribal agencies.

The AVS detailed in this proposal would be managed by an outside contractor with experience establishing these systems with state Medicaid programs. Additional staff resources will be needed for contract management, training for county and tribal human services offices, establishing business requirements, and developing the associate eligibility policy. The anticipated cost

of the vendor contract includes funding for system development costs and ongoing usage fee for verifying assets during application and renewal. The cost for the contractor and the DHS staff are included in the fiscal detail. This proposal purchases a web-based tool for use by eligibility workers and implementation does not require changes to DHS IT systems. There are no systems costs associated with this proposal.

Under this proposal, the AVS would electronically verify assets of recipients with an aged, blind, or disabled basis of eligibility at application and renewal. People with unreported assets over the current limits would have to reduce those assets in order to become eligible or to maintain eligibility. Based on data from states implementing similar systems, this estimate assumes that 0.1 percent or roughly 200 of the projected aged, blind, and disabled recipients on Medical Assistance will have unreported assets which would impact their eligibility for the program, and a portion of this group will have to reduce assets before they are eligible for the program. The fiscal estimate assumes an average impact of 3 months of lost eligibility for those who are affected. The savings for the months of lost eligibility are reflected in the fiscal detail.

IT Related Proposals:

The asset verification system will be accessed by eligibility workers using a web based portal with data stored on vendor systems. Because this system will not interface directly with DHS IT systems, changes to state IT systems are not anticipated at this time.

Results:

Unreported assets is not currently tracked. The instances of unreported assets will be tracked to determine if the AVS results in the estimated program savings.

Statutory Change(s):

None

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			626	19	644	(15)	(38)	(53)
HCAF								
Federal TANF								
Other Fund								
Total All Funds			626	19	644	(15)	(38)	(53)
Fund	**BACT#**	**Description**						
GF	13	HCA Admin (Contract)	1,000	862	1,862	905	950	1,855
GF	13	HCA Admin (FTE)	318	290	608	290	290	580
GF	REV1	FFP % 35%	(461)	(403)	(865)	(418)	(434)	(852)
GF	33	MA Grants	(231)	(730)	(961)	(792)	(844)	(1,636)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	13		2.25	3		3	3	

Change Item Title: Strengthening and Clarifying Provider Enrollment (HC-58)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	45	107	104	44
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	45	107	104	44
FTEs	**1.5**	**3**	**3**	**3**

Recommendation:

Effective July 1, 2017, the Governor recommends updating and clarifying provider enrollment, reenrollment, and revalidation requirements for Minnesota Health Care Program (MHCP – Medical Assistance and MinnesotaCare) providers to support implementation of federal provider screening requirements and to improve the ability to identify and address waste, fraud, and abuse. This proposal has a cost to the General Fund of $152,000 in the FY2018-19 biennium and $148,000 in the FY 2020-21 biennium.

Rationale/Background:

Federal screening requirements

Changes approved by the 2013 legislature allowed the Department of Human Services (DHS) to begin implementing Federal requirements to screen all MHCP providers during initial enrollment, reenrollments, as well as during revalidation, which must occur at least once every 5 years. At the same time, DHS is nearing the implementation of an online tool for providers to complete and submit their enrollment documents through an online portal.

Provider enrollment requirements for in-home services

For certain in-home and community services – Children's Therapeutic Services and Supports (CTSS), Adult Rehabilitation Mental Health Services (ARMHS), Consumer Directed Community Supports (CDCS), Early Intensive Developmental and Behavioral Intervention (EIDBI) services, and Personal Care Assistance (PCA) – currently only licensed/supervising professionals are required to enroll as providers. However, most services are delivered by direct care staff, under the supervision of a licensed professional. In addition, with the exception of PCA services, the billing claims only list the supervising professional, which makes oversight of these services more difficult.

Provider noncompliance identified during enrollment

DHS has authority to impose sanctions and payment withholds, suspensions or terminations when a provider is non-compliant with specific requirements. However, it's unclear if this ability applies to issues that arise during enrollment or reenrollment. This limits DHS' ability to take action.

PCA provider bonds and insurance requirements

PCA agencies are required to have bonds and insurances as a condition of participation in the PCA program and in the future the CFSS program. The surety bond in particular ensures a benefit to the State of Minnesota if the provider fails to comply with program rules. However, not all providers maintain bonds and insurances on a continued basis.

PCA provider review and revalidation

Currently, DHS must perform a review of PCA agencies once every year, known as the "annual review", and must complete a full revalidation for providers at least once every five years. The annual review provision requires PCA agencies to respond to annual review requests within 30 days. Agencies that fail to respond in that time period are subject to suspension or termination of enrollment. Experience shows that few agencies are able to respond within 30 days and suspension or terminations result in

interruptions to service authorizations, which creates conflict for MHCP recipients. Further, annual review is no longer necessary because the provider screening requirements of the Affordable Care Act (ACA) require more stringent screening processes.

Proposal:

Since implementation of the screening requirements and in preparation of having a system with future automation of verifications against databases and credentials, this proposal would make the following updates and clarifications:

1. Clarifies the activities performed during the screening of providers and standardizes the timelines for providers to comply as well as the frequency of ongoing screenings. These changes are technical updates to support implementation of federal screening requirements.
2. Requires providers to enroll and identify on a billing claim direct care staff who provide care through the following MA services: Children's Therapeutic Services and Supports (CTSS), Adult Rehabilitation Mental Health Services (ARMHS), Consumer Directed Community Supports (CDCS), Early Intensive Developmental and Behavioral Intervention (EIDBI) services as well as qualified professionals (QPs) providing PCA services. This will allow DHS to verify the individual providing services has, and continues to maintain, the qualifications to provide those services. This includes ensuring the providers are screened before and on an ongoing basis while providing services. The additional information entered onto the claim helps to: identify who is providing the services, allows DHS to verify the provider is qualified before allowing payment, provides a method to collect data to better monitor the service delivery to MHCP recipients and also helps to add a method of comparison when reviewing provider documentation during audits, screening activities or when identifying trends to locate areas of fraud, waste and abuse.
3. Adds clear legislative authority for the Provider Enrollment area to initiate the collection or stop payments of Medicaid funds, both when it is discovered that a provider becomes or has retroactively been non-compliant or with enrollment, reenrollment or revalidation requirements. This change will allow DHS to take action when issues are first identified during the enrollment process. DHS will use this authority in to plan, build and leverage system automation that will help to proactively stop payments at the time the non-compliance period begins until the provider becomes compliant.
4. Requires PCA agencies to maintain bonds and insurances for each practice location and adds clear statutory authority to deny Medicaid payments during times of non-compliance or to suspend and terminate providers who display patterns of noncompliance with the bond and insurance requirements. These changes are intended to give DHS clearer authority to both stop a provider's ability to receive payment when a bond and insurance has lapsed, to recapture money paid during times required bonds and insurances were or are not in force, as well as terminate enrollment for habitual offenders.
5. Updates the PCA review and revalidation process to allow revalidation at least every five years and as frequently as every three years and eliminates the annual review process. This change is intended to relieve administrative burden for both DHS and PCA provider agencies, while allowing for more frequent in-depth reviews of provider agencies. This proposal will also require PCA provider agencies to submit a written record of grievances and resolution of the grievances that the personal care assistance provider agency has received to DHS upon request. Grievances are currently part of the annual review process and this would allow DHS to continue to review grievances more frequently, as issues arise, without waiting for the next revalidation.

Individually enrolling direct care staff for in-home services (item 2 above) will require additional staff to process enrollment and reenrollments. The department estimates this will require enrolling over 10,000 providers. To enroll this new group and identify the providers onto claims, DHS will need a total of 16 FTEs – 10 provider enrollment, 1 claims processing, 2 provider trainers, 2 call center representatives, and 1 provider communications. DHS currently collects a fee in the amount of $554 per provider for enrollment and reenrollment or revalidation from certain provider types. The amount is set by CMS, and deposits are dedicated to DHS to pay for screening and enrollment activities. DHS can only use the provider enrollment fee revenue to hire provider enrollment staff, so this proposal includes a request for funding to hire 6 FTEs for provider training, call center activities, communications, and claims processing.

Reducing the PCA provider enrollment and revalidation timing period from once every five years to once every three years and requiring each individual PCA provider location will result in additional provider fee revenue. The additional revenue is reflected in the fiscal detail.

This additional provider data may improve the agency ability to identify fraud, waste and abuse among these providers and to recapture claims paid in error or impose additional sanction activities as appropriate. There is also potential savings in stopping

both state and federal dollars from being paid when any provider through any MHCP is noncompliant and even more so when automation allows this to occur on the first date the noncompliance occurs. The SIRS unit and HCA staff do not have information regarding the effect of previous changes in provider enrollment requirements, therefore any potential savings are not reflected in the fiscal detail.

IT Related Proposals:

This proposal has no impact on DHS IT systems.

Results:

These changes are intended to result in increased integrity of the programs, allow the department to establish a baseline measurement for compliance and over time, and implement additional process improvements upon identifying trends and areas of potential fraud waste and abuse.

Statutory Change(s):

256B.04 and 256.0659

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			45	107	152	104	44	148
HCAF								
Federal TANF								
Other Fund								
Total All Funds			45	107	152	104	44	148
Fund	**BACT #**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	11	State Share of MPS Systems Funded Staff (MMIS)	45	107	152	104	44	148
		Requested FTE's						
Fund	**BACT #**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
			1.5	3		3	3	

Change Item Title: Investing in and Modernizing Payments for Safety Net (FQHC) Providers (HC-51)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	0	937	3,938	4,425
Revenues	0	0	0	0
Other Funds				
Expenditures	0	(24)	(49)	(51)
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	913	3,889	4,374
FTEs	**0**	**0**	**0**	**0**

Recommendation:

Effective January 1, 2019, the Governor recommends modernizing the payment methodology for Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) in order to accurately account for and cover the cost of all Medical Assistance (MA) services and reduce administrative burden for both providers and payers.

This proposed change has a net all funds cost of $913,000 in the 2018-19 biennium and $8.3 million in the 2020-2021 biennium.

Rationale/Background:

FQHCs and RHCs are nonprofit community health care providers. They are located in communities identified as having elevated poverty, higher than average infant mortality, and access to fewer practicing physicians. These centers are open to all residents regardless of insurance status or ability to pay and play a critical role as part of the safety net provider community that primarily serve enrollees on state health care programs such as MA and MinnesotaCare. FQHCs and RHCs tailor services to fit the special needs and priorities of their communities and provide services in a linguistically and culturally appropriate manner. There are currently 76 FQHC and 110 RHC delivery sites in Minnesota. FQHCs and RHCs served 175,000 recipients in 2014.

Federal law requires state Medicaid programs to pay FQHC and RHC providers using a perspective payment system (PPS) cost-based rate methodology, which is based on 1999 and 2000 costs/visits and then adjusted for inflation. The basis of a prospective payment is to make a single payment per day to a clinic on any day where there is a face to face encounter involving services. A prospective payment in effect divides the allowable costs of a clinic by the expected number of qualifying encounters to establish the encounter rate. This prospective encounter rate structure provides clinics with a level of stability and predictability with respect to their payments. The prospective encounter rate payment applies to services delivered to MA enrollees in both fee-for-service and managed care delivery systems.

States also have the option to offer alternative payment methodologies (APMs) in place of PPS as long as they pay at least what the center or clinic would receive under PPS. Under current law, Minnesota has three different APMs. DHS is required each year to ensure the APM payments to each provider are equal to or greater than the payments the provider would have received under the PPS methodology. The current APMs, because they generally build off of the original PPS rate, are based on very old costs and apply historical restrictions established by Medicare that can reduce the per encounter payment rate. The historical costs and calculated rates are trended forward annually for inflation. However, costs within FQHCs and RHCs have changed dramatically since the PPS was originally established.

DHS and FQHC and RHC providers agree the current methodologies do not adequately reflect current health care cost trends and results in payment rates that may not accurately reflect a clinic's costs. This causes financial hardship to these provider groups. The current payment system also presents significant operational challenges for providers and DHS. The encounter payments, particularly those for services delivered to manage care enrollees, have been administratively challenging for both DHS and the clinics.

The 2015 Legislature requested recommendations for a new APM for FQHCs and RHCs that cover the cost of all MA services. DHS, in collaboration with FQHC and RHC providers, developed a report which details the recommendations for a new APM rate structure which could be adopted upon enabling legislation.

Proposal:

This proposal replaces the three existing APM options with a single new APM designed to cover the cost of all MA encounter generating services. This new payment methodology will bring greater transparency to the actual costs of and payments made for services provided by FQHC and RHC clinics, modernize and clarify the processes for establishing and updating rates, and promote greater efficiency and accountability for both DHS and providers.

The new rate methodology established by this proposal reflects current health care costs and trends and accounts for increases in the average length of a visit due to more complex care management models. It will allow providers to more easily calculate potential rate changes that result from changes in service and will encourage providers to expand services. In addition, a workgroup will be formed to discuss future performance measurements and reasonable cost containment measures.

The proposal also ends the payment of cost based rates to FQHC providers for MinnesotaCare starting in 2019. The federal requirement to pay cost based rates applies to Medicaid programs and does not apply to MinnesotaCare since its transition from a Medicaid waiver program to a federal Basic Health Plan (BHP) in 2015. Under the federal funding mechanism of the BHP the state receives a fixed payment amount per person instead of a federal Medicaid match. This transition aligns the payment method with the federal funding mechanism of the BHP.

The new rate methodology will be effective for services provided on and after January 1, 2019 and will be rebased every two years beginning in January 2021. MA and MinnesotaCare payments to FQHC and RHC providers reached nearly $94 million in FY2016. Once fully phased in, this proposal will increase total payments to FQHC and RHC providers under MA by roughly 10 percent.

Equity and Inclusion:

Minnesota is among the healthiest states in the nation and enjoys relatively high rates of health insurance coverage. However, when compared with white people in Minnesota, people of color and American Indians residing in the state experience significant disparities in health status and in rates of health insurance coverage. While the majority recipients enrolled in Medical Assistance and MinnesotaCare are white, people of color, especially African Americans and American Indians make up a disproportionate share of total program enrollment. Over 60 percent of African Americans and American Indians residing in the state were enrolled in the programs in July 2014. In 2015, Minnesota boasted the fifth lowest rate of un-insurance in the country at 4.3 percent. However, the rates of un-insurance for African Americans and American Indians residing in the state was roughly double the statewide average, and the rate for Hispanics was about three times the state average. Because Minnesota's health care programs play a significant role in providing health care coverage to racial and ethnic minority populations in the state, DHS has the opportunity to play a larger role in reducing health disparities in the state.

On average, 62% of the people served by FQHCs and RHCs are from communities of color. They provide quality care, reduce disparities and improve patient outcomes. The Institute of Medicine and the Government Accountability Office have recognized health centers as models for screening, diagnosing, and managing chronic conditions such as diabetes, cardiovascular disease, asthma, depression, cancer and HIV. Their efforts have led to improved health outcomes and lowered the cost of treating patients with chronic illness. (http://nachc.org/wp-content/uploads/2016/03/MN16.pdf)

The proposed modernization and simplification of the payment rate methodology ensures these organizations are paid their costs for treating this diverse and often medically complex population while continuing to provide high quality, cost effective care and improving health outcomes.

IT Related Proposals:

Recent legislative action permitting DHS to carve these provider payments out of managed care and back in to fee-for-service established much of the PPS logic in to the claims payment systems. With this work already completed, the new rate methodology detailed in this proposal will require only minor changes to DHS claims payment systems. The cost of making these changes is included in the fiscal detail section.

Results:

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Results	Ratio of MA Payments to Costs	NA	NA	

Statutory Change(s):
256B.0625, subdivision 30

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund				937	937	3,938	4,425	8,363
HCAF				(24)	(24)	(49)	(51)	(100)
Federal TANF								
Other Fund								
Total All Funds				913	913	3,889	4,374	8,563
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	33	MA Grants		927	927	3,935	4,422	8,357
GF	12	Systems (MMIS)		10	10	3	3	6
HCAF	31	MinnesotaCare Grants		(24)	(24)	(49)	(51)	(100)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
				0	0		0	0

Change Item Title: Provider Payment Modernization (HC-40)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	227	0	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	227	0	0	0
FTEs	**0**	**0**	**0**	**0**

Recommendation:

The Governor recommends adjustments to hospital reimbursement methods under the Medical Assistance (MA) program to continue recent efforts to modernize and streamline payment rates. The Governor also recommends an analysis of the fee-for-service MA payment rate methodology for outpatient services to improve consistency. This proposal has a one-time net cost to the General Fund of $227,000 in FY2018.

Rationale/Background:

This proposal is part of a multi-year project to streamline and simplify fee-for-service payments to hospitals. The overall goal is to construct and implement a payment methodology that is simple to update and better reflects changes in the scope of services delivered at each hospital over time while also being transparent to providers and consumers. Much of the work was accomplished in the 2014 and 2015 legislative sessions. This proposal brings another group of hospitals into the new payment system and ensures that DHS will continue to have the authority needed to update certain payment adjusters that are built into the methodology. The payment adjusters were implemented with the new payment methodology to ease the transition from the old payment methodology to the new payment methodology. The adjuster impact both payments to specific hospitals as well as payments for types of services such as mental health, obstetric, trauma, transplant or pediatric services.

Under current law, MA fee-for-service hospital payment rates are rebased every two years. Hospital rebasing modernizes the rate structure, recognizing factors that affect the use of hospital resources over time. These factors can include changes to patient case mixes, hospital treatment patterns and the use of medical technology. These updates to hospital payment methodology also ensure that MA hospital reimbursement is updatable and transparent to providers.

A similar effort is needed to address inconsistencies in how outpatient fee-for-service MA rates are calculated. Payment rates for many professional services are adjusted annually based on the Resource Based Relative Value Scale or RBRVS. The RBRVS was created to provide a standard system of pricing physicians' services that weights payment rates according to the resources used in delivering the service. Currently, those procedures that do not have relative values are priced utilizing the Consumer Price Index (CPI). The CPI is not always appropriate to the service provided because reimbursement is based on the CPI percent of billed charges. This results in inconsistent reimbursement for the same service.

The payments for physicians and other health care professionals are especially outdated and DHS has no authority to adjust for changes in inflation, wages, or other health care market forces. Essentially, the current professional fee schedules are based on payments and provider charges that range from 9-27 years old. A number of provider groups including physicians, mental health professionals, chiropractors, therapists, and medical specialists have expressed great concern about the current levels of fee for services payment rates. A comprehensive approach is to maintain the integrity and soundness of the current rate methods.

Proposal:

Hospital Rebasing

This proposal addresses several aspects of the hospital payment system:

1. Updates payment methodology for rehabilitation hospitals. Rehabilitation hospitals treat high need patients and typically have longer lengths of stay than acute care hospitals. These are the last of the hospital types to be transitioned from the older payment methodology to the new rates system based on the 3M APR-DRG grouper. A grouper assigns the services delivered by hospitals into categories or "groups" based on diagnoses and the types of services delivered to a patient. The groups are then ranked relative to each other with groups that include more services or more intense services ranked higher. The relative difference between the rankings is one of the factors used to set payment rates. Because it is better at handling services delivered to pregnant women, children and younger adults, the 3M APR-DRG grouper is more suited to the services delivered to Medical Assistance enrollees than the Medicare grouper used in the old payment methodology.
2. Addresses the changes needed to move the payment rate methodology for prospective payment system hospitals from the "transition" phase into the on-going full implementation phase. Inpatient hospitals rates had not been updated for a decade and the shift from the old methodology to the new methodology was dramatic for the prospective payment system hospitals. In order to mitigate the disruption that would have been caused by a sudden shift, time limited transition factors were built into the initial implementation phase for each hospital to smooth the change at the hospital level. DHS was also given time-limited authority to implement policy adjustment factors to smooth the transition between the two rate methodologies and ensure that certain types of services that are important to Medical Assistance enrollees such as obstetrics, mental health and pediatric services continue to receive payments at levels historically supported by the legislature. In continuing the implementation of the new methodology, DHS is seeking to extend the expiring authority to use payment adjusters so that the policy and transition adjustment factors, as well as updates to the disproportionate share hospital payment factors can be updated as the implementation of the new methodology continues. All of these factors interact with each other within the new payment methodology and must be addressed simultaneously. Given the significance of the changes from the old payment methods to the new, the legislature provided only time limited authority to use the payment and policy adjusters. Prior to the legislative session, DHS will submit a report to the legislature (due January, 2017). The report will summarize the effects on hospital payments if the adjusters are eliminated, are retained with their current values or updated to new values. The report will also make a recommendation to the legislature as to which scenario DHS believes is the best.
3. Changes the payment methodology for hospital stays that are over 180 days to align with the new payment methodology. The change moves payment for these longer stays into the cost outlier pool which is a portion of payment funds that is reserved to supplement payment for high cost cases.
4. Specifies the methodology used to compute the payment rate for fee-for-service outpatient hospital services delivered by critical access hospitals. Prior to July 1, 2015, DHS paid for these services at an interim rate that was then settled to the actual cost of the services. As of July 1, 2015, DHS was given authority to use a rate this is based on each hospital's cost of providing the outpatient services but that is not settled to the actual cost of the service. DHS will compute the outpatient payment rates using the cost and charge data from the "as filed" Medicare Cost Report that is two years prior to the rate year that is being set. The rate will be completely transparent to each hospital prior to each rate year and will allow the hospitals to more accurately predict payments for planning and budgeting purposes.
5. Updates the medical necessity standard used to determine the appropriateness of inpatient hospital admissions. Current rules require DHS to use a standard that is outdated and no longer complies with the community standard of care.

Total fee-for-service payments for inpatient hospital services in the Medical Assistance program reached about $599 million in FY2015. The hospital rebasing is in current law and any net change in hospital payments is included in the current forecast.

Outpatient Rates Analysis

This proposal would provide funding for DHS to contract with a vendor who has expertise in physician and professional payment rates to provide options to make the necessary changes to the existing fee schedule that utilizes the Resource Based Relative Value System (RBRVS) and alternate payment methodologies for outpatient services that do not have relative values. This will allow DHS to improve consistency across fee for service MA rates. The RBRVS system is the industry standard, however, it does assume adjustment of conversion factors over time to account for inflation or other market factors. The current conversion factors have been, with few exceptions, left unchanged since they were first implemented. Moreover, the lack of updates to

conversion factors has resulted in a series of add-ons that favor and disfavor certain providers that have not been analyzed thoughtfully or thoroughly. A comprehensive review can simplify the payment structures so that they are more transparent, understandable, and simple to support over time. Evaluating the outpatient fee-for-service MA rate structure will require support from an actuarial or health care consulting firm with expertise studying physician and professional payment rates.

IT Related Proposals:

The IT work needed for this project was completed as part of the 2015 rebasing. There are no additional systems costs related to the 2017 rebasing.

Results:

This proposal will result in a payment methodology for hospitals that is simple to update and better reflects changes in the scope of services delivered at each hospital over time while also being transparent to providers and consumers. A typical measure that will be used to monitor the sufficiency of the rates and payments will be the ratio of cost to payment. This can be measured as a statewide average across each hospital type (DRG hospital, critical access hospital (CAH), long term hospital, and rehab hospital).

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Results	Ratio of MA Payments to Hospital Costs	NA	NA	

Statutory Change(s):

256.9686; 256.969; 256B.0625; 256B.75

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			227	0	227	0	0	0
HCAF								
Federal TANF								
Other Fund								
Total All Funds								
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	13	HCA Admin (Contract)	350	0	250	0	0	0
GF	REV1	FFP @ 35%	(123)	0	(123)	0	0	0
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**

Change Item Title: Updates to the Medical Assistance Asset Reduction Policy (HC-46)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	0	101	140	145
Revenues	0	0	0	0
Other Funds				
Expenditures				
Revenues				
Net Fiscal Impact = (Expenditures – Revenues)	0	101	140	145
FTEs	**0**	**0**	**0**	**0**

Recommendation:

Effective July 1, 2017, the Governor recommends separating Medical Assistance (MA) eligibility rules in state law for people who are age 65 and older from those for people who are blind or who have a disability. The Governor also recommends, effective July 1, 2018, amending state law enacted in 2008 which limits the way a person could reduce their assets to achieve MA eligibility so that the policy applies only to people over age 65.

This proposal has a cost to the General Fund of $101,000 the FY2018-19 biennium and $285,000 in the FY2020-21 biennium.

Rationale/Background:

In Minnesota, the same set of MA eligibility rules currently apply to people who are age 65 and over, blind or have a disability. The state demographer estimates that MA enrollment will experience an 85% growth in program enrollees receiving assistance for their long-term care (LTC) needs over the 25-year period ending in 20401. These groups account for 40% of the state's MA expenditures, and the needs and financial situation of people who are age 65 and older differ from the needs and financial situation of people who are under age 65 and who are blind or have a disability. Looking at these groups of people separately will help the state better plan for meeting the needs of this growing population.

In 2008, the legislature passed a cost savings measure that would limit the way a person could reduce their assets to achieve MA eligibility to pay for medical bills incurred in the month of application or the three months prior to the month of application in which the person is requesting coverage. MA eligibility would begin with the next dollar of medical assistance covered health services incurred in the applicable month. The effective date of this provision was postponed twice, once to January 1, 2011, and then to January 1, 2014, in accordance with federal maintenance of effort (MOE) rules that are now expired.

Since this law passed in 2008, the elimination of the asset test for parents and relative caretakers and other law changes related to MA asset eligibility, including the increase in the community spouse asset allowance, the ability for people to convert assets into an income stream for a community spouse pursuant to the 8th Circuit Court of Appeals Decision, commonly referred to as the Geston Decision, and an increase in the use of special needs and pooled trusts, will reduce the impact of the asset reduction requirements in state law.

MA eligibility rules for people age 65 and older must be separated from the MA eligibility rules for people who are blind or who have a disability in order to apply a separate set of rules regarding how people are able to reduce excess assets.

[1] Minnesota State Demographic Center (2016). *Demographic Considerations for Long-Range & Strategic Planning for the State of Minnesota's Executive and Legislative Leaders.* http://mn.gov/bms-stat/assets/demographic-considerations-planning-for-mn-leaders-msdc-march2016.pdf

Proposal:

This proposal separates statutory eligibility requiremenst for people who are age 65 and older to be evaluated separately from those of people who are blind or who have a disability.

This proposal also strikes the state law limitation established in 2008 that a person can only reduce assets to achieve MA eligibility by paying medical bills incurred in the month of application or the three months prior to the month of application in which the person is requesting coverage for people who are blind or have a disability. This law is scheduled to be implemented in July 2018. Once implemented, some applicants will have a delay in their MA eligibility. Since 2008, a number of policies have been enacted that reduce the impact of this law by providing MA applicants additional means to protect assets without changing program eligibility.

The reduction of MA eligibility results in savings to the state budget. The primary fiscal impact is expected to come from long term care applicants. Program data suggests that on average less than 1 percent of long term care applicants on MA are private pay and become eligible for MA after spending down some assets. Based on this data. It is assumed that by implementing the 2008 asset reduction policy, 0.2 percent of long term care applicants under 65 would have their eligibility reduced by one month.

The fiscal detail table reflects the cost of repealing the 2008 asset reduction policy effective July 2018 for those with a blind or disabled basis of eligibility. Separating eligibility rules in statute for people who are age 65 and older from those for people who are blind or have a disability does not have a fiscal impact other than that associated with the change to the asset reduction policy in this proposal.

IT Related Proposals:

Changes to DHS eligibility systems are needed to apply the asset reduction policy to reflect current law and this change is in the existing MN.IT IT project plan. This proposal would limit the application of the asset reduction policy to those age 65 and over. No additional resources are needed to make this change.

Results:

Type of Measure	*Name of Measure*
Quantity	Persons under age 65 eligible for MA-LTC

Statutory Change(s):

Minn. Stat. 256B.055; Minn. Stat. 256B.056

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			0	101	101	140	145	285
HCAF								
Federal TANF								
Other Fund								
Total All Funds			0	101	101	140	145	285
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	33-ED	MA Grants	0	101	101	140	145	285
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**

Change Item Title: Updates to the MinnesotaCare Program and Medical Assistance Rate Cleanup (HC 56)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	5	1	1	1
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	5	1	1	1
FTEs	**0**	**0**	**0**	**0**

Recommendation:
The Governor recommends updating the MinnesotaCare program to better align its coverage with the federal funding model now that it has transitioned to a Basic Health Plan. The Governor also recommends updating and refining Medical Assistance and MinnesotaCare statute to reflect federal requirements and current practice as well as making clarifications to statutory language governing payment rates. This proposal has a state General Fund cost of $6,000 in the FY 2018-19 biennium and $2,000 in the 2020-21 biennium.

Rationale/Background:
Starting in 2014, MinnesotaCare became Minnesota's Basic Health Plan (BHP). A BHP is intended to be a bridge program for individuals between Medical Assistance and advanced premium tax credits. When MinnesotaCare became a BHP it changed the federal funding structure for the program. Rather than receiving a match similar to Medicaid, Minnesota now receives a set amount per individual served by MinnesotaCare. As a result, there are now services in the MinnesotaCare program that do not align with the BHP funding methodology and this proposal aims to bring alignment between the services and the funding structure.

Statutory language related to payments to Indian Health Services (IHS) for cross over claims and MinnesotaCare cost sharing do not align with the legislative intent and need to be refined. There is also a need for a number of technical for updates to Medical Assistance and MinnesotaCare statutes to reflect current practice and provide greater clarity.

Statutory language for two new children's mental health benefits currently being implemented – service plan development and psychiatric residential treatment facilities (PRTFs) – needs technical revisions as well. Service plan development pays for the time a provider spends developing an individual treatment plan for a child in need of mental health care. However, Minnesota Rule requires services to be billed in accordance with a treatment plan and this creates an unintended conflict for this service. The 2015 legislature established PRTFs as a new service in Minnesota, directed DHS to implement a payment methodology, and provided the necessary funding. However, statute needs to be updated to reflect the payment methodology that will be reflected in the state plan and aligns with the funding provided by the legislature.

The 21st Century Cures Act recently passed by Congress and signed into law by President Obama contains a provision which will require changes to state law. It allows a person with a disability to establish their own special needs trust, rather than relying on a court, grandparent or parent. This change was effective upon enactment of the federal legislation and a technical change to state law is needed to update align.

Lastly, the United States Health and Human Services Department issued a new final rule on Nondiscrimination in Health Programs and Activities in May 2016. The new federal rule requires state Medicaid agencies and other payers to remove categorical exclusions for care of transgender individuals and specific procedures used for gender confirmation effective January 1, 2016. Current state law excludes coverage for gender conformation surgeries in both MA and MinnesotaCare.

Proposal:
This proposal will conform MinnesotaCare statute to federal requirements and current practice through the following changes:

- Replace a reference to Medicaid cost sharing regulation that exempts American Indians from cost sharing to the Basic Health Plan regulation that exempts American Indians who are members of federally recognized tribes from cost sharing.
- Remove coverage of Individualized Education Program (IEP) services from MinnesotaCare. Under the Medicaid program, federal Individuals with Disabilities Education Act (IDEA) funds are used to draw down a federal Medicaid match for IEP services provided in schools. The schools only receive Medicaid payment of the federal funds which they match with IDEA funds. Under the MinnesotaCare BHP, there is no longer a mechanism to draw down matching federal Medicaid dollars for IEP services. Medically necessary services provided in schools that meet all MinnesotaCare program requirements for coverage would still be eligible for coverage and could be paid with BHP funding.
- Exclude coverage under the EPSDT program in Minnesota Care. This clarifies that the obligations for coverage of services beyond what is in the state plan for the MA program and for administrative outreach that apply to a Medicaid program do not apply to a Basic Health Plan. This does not change the general coverage of well-child visits, screenings, and diagnostic or treatment services that are covered under the BHP.
- Only individuals through age 18 would be considered children for the purpose of covered services provided by MinnesotaCare. 19 and 20 year old individuals in MinnesotaCare would receive the same covered benefits as individuals 21 and older. Adults in MinnesotaCare receive the adult dental benefit set and do not have nonemergency transportation benefits. People ages 19 and 20 would retain the exemptions from cost-sharing and monthly premiums. Currently about 5,800 19 and 20 year olds are enrolled in the MinnesotaCare program. Under this proposal, 19 and 20 year olds will receive the adult benefit set which excludes coverage for non-emergency medical transportation, personal care assistance, home care nursing, and certain dental services. Claims data show very low or no utilization of these services among 19 and 20 year olds in MinnesotaCare and there is no fiscal impact anticipated for these changes.

The changes outlined above result in small reductions to MinnesotaCare spending. However, as of the November 2016 forecast, coverage for MinnesotaCare enrollees who are eligible for federal basic health plan (BHP) funding does not have a state budget impact. As a result, the small savings attributed to the changes outlined above accrue to the BHP trust fund and are not reflected in the fiscal detail below.

The proposal will also make a number of conforming changes in MinnesotaCare statute to align with legislative intent and current practice:

- Remove references to cost sharing in place prior to the 2015 legislation requiring changes to the cost sharing structure.
- Expand the definition of cost sharing to include co-insurance and deductibles. This change will allow the department flexibility in program design to accomplish the 94% actuarial value required in law while simultaneously using the flexibility in program design to drive for better outcomes.
- Replace the premium table in statute to reflect legislative changes enacted in 2015.

In addition, this proposal will make several technical changes to Medical Assistance cost sharing and rates including:

- Exclude cost sharing on part B cross over claims paid to Indian Health Services to align with how these same types of claims are treated with Federally Qualified Health Centers and Rural Health Centers.
- Clarify in statute that Early Intensive Developmental and Behavioral Intervention (EIDBI) services are exempt from ratable reductions found in Minnesota Statutes 256.

Finally, this proposal will make several changes to update Medical Assistance statute to reflect current policy and practice or to comply with federal law:

- Eliminate an obsolete asset requirement for adults with bank accounts that contain both business and personal funds. Adults no longer have an asset limit for Medical Assistance, except for parents who qualify for MA with a spenddown. Additionally, in 2011 the Centers for Medicare and Medicaid Services (CMS) declined DHS' request for authority to implement this change.
- Codify the good cause requirements for nonpayment of Medical Assistance for Employed Persons with Disabilities (MA-EPD) premiums in statute to replace the reference to a now obsolete MinnesotaCare rule. This change will not alter the current requirements.
- Clarify that the rate increase passed for Gillette in 2015 did not include laboratory services consistent with federal law.
- Clarify that children's mental health service plan development, which pays for the development of an individual treatment plan, can be provided before the treatment plan is complete, given that the service is to develop said plan. Also clarifies that payment for this service is contingent on an individual treatment plan being completed.
- Codify the rate methodology for PRTFs to align with the proposed state plan and the funding provided by the 2015 legislature for this new service.
- Delete statutory language related to the decision support system that was previously used for prior authorization of diagnostic imaging services. This language is no longer needed since the decision support system is no longer available.
- Clarify which portion of the NEMT statute applies to managed care organizations serving MHCP recipients.
- Codify current practice related to spousal impoverishment to provide clarity for applicants.
- Align state statute with federal law to allow a person with a disability to establish a special needs trust.
- Update the recently modified state statute governing estate recoveries to align with the state plan amendment approved by CMS.
- Strike the coverage exclusion from state law to align with the federal rule. There is no cost for this change included in this proposal. The MA and MinnesotaCare programs currently cover medically necessary gender confirmation surgeries pursuant to the federal requirement, and the cost for this change was included in the November 2016 forecast.

There is no fiscal impact for updates to reflect current policy and practice as these changes align the statute with the current funding assumptions.

IT Related Proposals:
Eliminating coverage for IEP services and moving the 19-20 year olds to the adult benefit set requires some changes to DHS claims payment systems. The cost for these changes is reflected in the fiscal detail.

Results:
This proposal is comprised of numerous initiatives that clean up current statute to reflect practice as well as changes to create alignment amongst the various insurance affordability programs. The result is accurately updated statute and smoother transitions for individuals as they move amongst the different insurance affordability programs.

Statutory Change(s):
256L.03, 256B.76, 256B.0949; 256B.0625;

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			5	1	6	1	1	2
HCAF								
Federal TANF								
Other Fund								
Total All Funds			5	1	6	1	1	2
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	11	Systems (MMIS @ .29)	5	1	7	1	1	2
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**

Change Item Title: Improving Medical Assistance Benefit Recoveries and Special Needs Trust Guidance (HC-59)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	130	97	0	0
Revenues	86	118	66	67
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	44	(21)	(66)	(67)
FTEs	**0**	**0**	**0**	**0**

Recommendation:

Effective July 1, 2017, the Governor recommends allowing the Department of Public Safety (DPS) to transmit Social Security Data to the Department of Human Services for the purpose of recovering additional Medical Assistance (MA) benefits paid for recipients injured in motor vehicle accidents. This proposal would use the state budget savings in the first biennium to create a trust guide for medical assistance recoveries and make recommendations for future statutory changes to improve and clarify trust law in Minnesota.

This proposal has a net cost to the General Fund of $23,000 in FY2018-19 biennium and a savings of $133,000 in the FY2020-21 biennium.

Rationale/Background:

Per federal law, the Medicaid program, known as Medical Assistance (MA) in Minnesota, serves as the payer of last resort. This means that if another insurer or program has the responsibility to pay for medical costs incurred by a MA enrollee, that entity is required to pay its share of the cost prior to MA making any payment. This is known as "third party liability" or TPL.

States are required to take steps to ensure that the provider bills the third party first before requesting payment from the Medicaid program. This is known as "cost avoidance." Whenever a State has paid claims and subsequently discovers the existence of a liable third party, it must attempt to recover the money from the liable third party. This is known as "pay and chase." States are required to cost-avoid claims, with a few specific exceptions which are identified in regulation.

A common example of this occurs when an MA enrollee is involved in an auto-accident that involves an insurance settlement to cover related health care costs for an enrollee. Data sharing is useful for identifying potential new recovery cases proactively and efficiently when there is an accident. Federal Medicaid regulations provide for and require an exchange of data for the purpose of determining the legal liability of third parties for health care costs, particularly from State Motor Vehicle Accident Report files.[i]

State law authorizes DPS to share motor vehicle accident data with DHS for the purposes of complying with federal Medicaid rules regarding third party liability, but this law does not explicitly authorize DPS to share Social Security data with DHS.[ii] In 2009, DPS began sharing motor vehicle accident data for this purpose, but the data shared included a large volume of duplicate names and birth dates. Accurate data matches are not possible without a unique personal identifier.

Trust Guide and Recommendations Proposal:

State law requires trustees to file special needs trusts with DHS at the time of the beneficiary's application for Medical Assistance benefits. It also requires trustees to submit an annual filing that includes itemized distributions from the trust during the accounting period, an inventory of trust assets, the value of those assets at the end of the accounting period, and changes to the trust instrument during the accounting period. The statute does not direct the DHS to do anything with these trust filings and establishes no clear standard for use of trust assets other than "for the benefit of the individual."

Proposal:

This proposal recommends that DPS share accident data including social security numbers with DHS to improve MA tort recovery from motor vehicle accidents. These savings offset the cost of a contract of outside legal counsel to assist with development of a trust guide for MA recovery and make recommendations for future statutory changes to improve and clarify trust law in Minnesota.

Data Matching:
In October 2015, the Tort Recovery Unit with DHS began dividing the recovery numbers to identify how much was recovered for no-fault/auto/personal injury protection cases. From October 2015 to the end of the fiscal year, the Tort Recovery Unit recovered approximately $775,000 of MA payments for health care claims resulting from motor vehicle accidents. Permitting DHS access to personal identifiers within motor vehicle accident data will accelerate tort recoveries and allow DHS to participate in more settlements.

This proposal will permit a data exchange to improve recoveries for the existing tort recovery program. This change will allow DHS to efficiently obtain matches of accident data to determine whether there might be third-party liability or a potential recovery of health care costs paid under the MA program.

The proposal will allow DPS to exchange motor vehicle accident data with individuals' Social Security numbers through an existing secure web portal on a biweekly basis through a secure transfer. DPS has a secure web portal where the information is made available to DHS. DHS would match the claims against the MA recipient eligibility data and once the match is complete, DHS will destroy the data received from DPS. It could also be possible to conduct these transfers using only the last four digits of the Social Security number, so that complete Social Security data was not being transferred.

Allowing DPS to include the Social Security numbers in motor vehicle accident information transmitted to DHS will improve Medical Assistance recoveries where auto insurers are liable for medical coverage. Obtaining motor vehicle crash information will reduce the time it takes DHS to recognize some situations where a third party may have liability for claims paid by Medical Assistance.

DHS currently identifies these cases primarily through required legal notification once an attorney has been retained by the injured party, or after a Medical Service Questionnaire (MSQ) is triggered in MMIS by a trauma code and the injured party responds. These processes can take months after the initial date of injury and medical treatment, and by then the medical payment and no fault funds may have been exhausted by other sources.

Providers have a year to bill Medical Assistance from the date of service. This time lag in claims submission and payment may mean that settlement discussions are occurring before we're aware of the injury or before the client responds to the MSQ. Obtaining this information more quickly increases the opportunity for the state to join in legal settlements before they are final and before medical payment and no fault funds are distributed. Improving the timeliness of motor vehicle accident information will result in some additional revenue to the state. DHS proposes using this additional revenue in the first biennium only for an outside consultant to develop guidance for trust recovery and special needs trust reporting and use.

Trust Guidance Component:
DHS receives regular reports from special needs trusts, most spent carefully, but some with questionable spending. Under this proposal, DHS in cooperation with the Minnesota Elder Bar and other interested parties will develop straightforward guidance for estate planning and consistent treatment of special needs trust assets by the Special Recovery Unit (SRU) in DHS' Benefit Recovery Section (BRS), and provide a report to the legislature containing recommendations to clarify special needs trusts reporting laws.

DHS would use an attorney with trust expertise to assist with the development of a special needs trust guide that would a) direct the state medical assistance program's trust recovery process and lay out clear guidelines for the public on what the state will and will not recover from; and b) will inform the public of trust reporting duties and fiduciary responsibilities related to spending of trust assets for the sole benefit of the trust beneficiary.

The goal is to establish clear and straightforward guidance for estate planning, consistent treatment of special needs trust assets by DHS, and clarity in special needs trusts reporting laws. This is a new initiative to clarify existing law for MA enrollees. Therefore, DHS would ultimately make proposals to improve existing legal requirements for enrollees. The consultant will assist

DHS in developing a proposed guide to MA recovery from trusts and recommendations for clarification of existing trust law in Minnesota, including proposed guidance regarding trust accounting to DHS and the proper use of special needs trust funds.

The intended result of this change item is:

- clear state policy on the collection of trust funds by the MA program,
- improved guidance for the program and the public on acceptable expenditures for special needs trusts, and
- more clarity regarding trust formation laws.

This proposal will develop consistency in the way the state treats trust recovery and monitors spending on special needs trusts. It will clarify trust creation, trust spending, trust dissolution, the impact of MA recovery on trusts, and in the end make estate planning clearer and easier for Minnesotans.

This proposal would use the state budget savings in the first biennium to offset costs of creating a trust guide for medical assistance recoveries and making recommendations for future statutory changes to improve and clarify trust law in Minnesota. The estimated additional revenue and anticipated cost of the trust consultant are reflected in the fiscal detail. To implement this proposal DHS will issue a request for proposal (RFP) and contract with a consultant in 2017.

IT Related Proposals:

This proposal does not require any changes to DHS IT systems. DPS currently provides DHS with a file containing motor vehicle accident information. This proposal will allow for the exchange of a personal identifier within the motor vehicle data which can be added to the existing DPS file.

Results:

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	MA Recoveries from Motor Vehicle Accident Settlements	NA	NA	

Statutory Change(s):

Minnesota Statute § 13.69, subdivision 1

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			44	(21)	23	(66)	(67)	(133)
HCAF								
Federal TANF								
Other Fund								
Total All Funds								
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	REV2	MA Recoveries	86	118	204	66	67	133
GF	13	HCA Admin	200	150	350			
GF	REV1	FFP @ 35%	(70)	(53)	(123)			
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**

[i] 42 CFR 433.138(d)(4)(ii).
[ii] Minn. Stat. § 256.015, subd. 7

Change Item Title: MA and MinnesotaCare Rate Increase for Preventive Medical Care and Outpatient Mental Health Services (HC-63)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	4,057	5,633	6,075	6,553
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	4,057	5,633	6,075	6,553
FTEs	**0**	**0**	**0**	**0**

Recommendation:

Effective July 1, 2017, the Governor recommends a 5 percent rate increase for preventive medical care and outpatient mental health services in the Medical Assistance(MA) fee-for-service program. This proposal has a net cost to the General Fund of $9.7 million in the FY2018-19 biennium and $12.8 million in the FY 2020-21 biennium.

Rationale/Background:

This proposal increases the payment rate paid for preventive medical visits providing an incentive for medical practitioners to provide comprehensive preventive medical services to Medical Assistance and MinnesotaCare recipients. Maintaining a robust preventative care network is critical to ensuring recipients receive appropriate and necessary care.

Recent developments (such as the closure of key critical mental health facilities) underscore the fragility of the mental health system. Mental health providers operate with small financial margins that leave them vulnerable. In some cases, reimbursement rates for some mental health services do not cover the costs of providing those services.

Proposal:

This proposal increases provider payment rates for preventive medical care and outpatient mental health services in MA fee-for-service by 5 percent effective July 1, 2017. Services where the primary reason for the service is preventive care when provided by physicians, advance practice registered nurses, and physician assistants would receive the increase. All outpatient mental health services, for both children and adults, which do not have a cost-based or negotiated rate are included in this rate increase. This includes, but is not limited to, Adult Rehabilitative Mental Health Services (ARMHS), Children's Therapeutic Services and Supports (CTSS), day treatment, psychiatry, neuropsychological services, mobile crisis services, certified peer specialist services, psychotherapy, and diagnostic assessments, but does not include case management.

Results:

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Number of MA Enrollees Receiving Outpatient Behavioral Health Services	199,967	TBD	2015

Statutory Change(s):

256B.761, 256B.76

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			4,057	5,633	9,690	6,132	6,669	12,801
HCAF								
Federal TANF								
Other Fund								
Total All Funds			4,057	5,633	9,690	6,132	6,669	12,801
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	33	MA Grants	4,057	5,633	9,690	6,132	6,669	12,801
HCAF	31	MinnesotaCare Grants						
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**

Change Item Title: Higher Medical Assistance Reimbursement for Evidence-Based Family Home Visiting (HC-60)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	160	451	535	626
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	160	451	535	626
FTEs	**.5**	**1**	**1**	**1**

Recommendation:

Effective January 1, 2018, the Governor recommends increasing Medical Assistance (MA) reimbursement for public health family home visiting for mothers and young children delivered by providers using an evidence-based model. This proposal has a net cost to the General Fund of $611,000 in the FY2018-19 biennium and $1.2 million in the FY2020-21 biennium.

Rationale/Background:

Family home visiting is a voluntary service for pregnant women and child caregivers which links pregnant women with prenatal care, ensures that a very young child develops in a safe and healthy environment, imparts parenting skills and supports that decrease the risk of child abuse, and supports parents early in their role as a child's first teacher. MA currently covers family home visiting services when they are provided by public health nurses or registered nurses supervised by a public health nurse, including postpartum follow-up home visits for at risk mothers and infants.

Some public health agencies in Minnesota use evidence-based home visiting models recognized by the United States Health Resources and Services Administration (HRSA). Evidence-based home visiting models have been shown to improve prenatal health, reduce child injuries, prevent subsequent unplanned pregnancies, and improve school readiness. However, evidence-based home visiting services contain additional elements and require more resources relative to other home visiting services. There are concerns that the current MA payment rate for public health home visiting may not be adequate to cover the cost of service when delivered by a public health nurse using an evidence-based model.

This proposal is a component of Governor Dayton's vision to improve early childhood outcomes for high-risk families in Minnesota. Increased MA reimbursement complements the Department of Health's budget proposal to expand home visiting for high-risk families by encouraging counties to seek MA reimbursement for these services when possible.

Proposal:

The Governor proposes increasing the MA reimbursement rate for certain public health home visiting services provided to mothers and young children under four years of age. The enhanced rate for these services is paid to providers using evidence-based home visiting models recognized by the United States Health Resources and Services Administration and identified by the Minnesota Commissioner of Health as eligible services under the Maternal, Infant and Early Childhood Home visiting program. This proposal accounts for and supports expected growth in home visiting services resulting from the Governor's recommendation to expand these services to an additional 3,659 pregnant and parenting teens per year once phased in over three years. A portion of current home visits and of the additional home visits proposed by the Governor would qualify for the increased MA reimbursement rate. Specifically, the enhanced MA reimbursement rate is for family home visiting services delivered by public health nurses or registered nurses supervised by a public health nurse using an evidence-based model.

This proposal provides up to a $140 payment rate for public health nurse visits in the home by providers meeting certain evidence-based criteria. In FY2016, there were about 43,000 public health nurse visits to pregnant women and children under

four enrolled in MA with an average payment per visit of $63. About 7,900 or 18 percent of these visits are from providers meeting the evidence-based criteria that would qualify for an average increase of $77 (to a total of $140) under this proposal. The total number of visits is trended forward based on the current MA forecast for families and children. With the Governor's proposed expansion of evidence-based family home visiting through the Minnesota Department of Health, this estimate assumes that additional public health agencies will begin using evidence-based models delivered by public health nurses or registered nurses supervised by a public health nurse for home visiting services and that the new rate will apply to about one third of all visits by FY2021.

Identifying the providers and services receiving the higher rate, collecting attestations from providers of evidence-based services, developing and administering new payment policies, and training providers on new billing procedures requires administrative resources. This proposal includes the cost for one new full time employee to facilitate enrollment of the evidence-based providers and be available for training on billing and enrollment.

Equity and Inclusion:

Minnesota is among the healthiest states in the nation and enjoys relatively high rates of health insurance coverage. However, when compared with white people in Minnesota, people of color and American Indians residing in the state experience significant disparities in health status and in rates of health insurance coverage. While the majority recipients enrolled in Medical Assistance and MinnesotaCare are white, people of color, especially African Americans and American Indians make up a disproportionate share of total program enrollment. In fact, over 60 percent of African Americans and American Indians residing in the state were enrolled in the programs in July 2014. In 2015, Minnesota boasted the fifth lowest rate of un-insurance in the country at 4.3 percent. However, the rates of un-insurance for African Americans and American Indians residing in the state was roughly double the statewide average, and the rate for Hispanics was about three times the state average. Minnesota's health care programs play a significant role in providing health care coverage to racial and ethnic minority populations in the state, and to the extent that these programs can affect the health status of recipients may also play a large role in reducing health disparities.

IT Related Proposals:

Implementing this proposal will require some changes to the DHS claims payment systems. New provider indicators or new modifiers may be necessary and the MMIS will need to be coded to pay differently for the evidence based visits than other visits.

Results:

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Total number of public health nurse home visits	N/A	42,583	
Quality	Percentage of home visits which are evidence-based	N/A	18%	
Results	Number of claims for child injuries and ED visits for young children on Medical Assistance	N/A	N/A	

Statutory Change(s):

256B.0625

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			160	451	611	535	626	1,161
HCAF								
Federal TANF								
Other Fund								
Total All Funds								
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	33	MA Grants	100	384	484	468	559	1,027
GF	13	HCA Admin	88	101	198	101	101	202
GF	REV1	FFP @ 35%	(34)	(35)	(69)	(35)	(35)	(70)
GF	11	Systems (MMIS)	6	1	7	1	1	2
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
			.5	1		1	1	

Change Item Title: Repeal Provider Tax Sunset

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	0	0	11,501	30,736
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	60	147
Revenues	0	0	239,359	747,630
Net Fiscal Impact = (Expenditures – Revenues)	0	0	(227,798)	(717,747)
FTEs	**0**	**0**	**0**	**0**

Recommendation:
The Governor recommends repealing the sunset on the two percent taxes on hospitals, ambulatory surgical centers, providers and wholesale drug distributors contained in Minnesota Statutes Chapter 295.52. This proposal increases General Fund expenditures by $42 million and has a net impact to the Health Care Access Fund by $987 million in the FY2020-21 biennium. This proposal raises $239 million and $748 million of revenue in fiscal years 2020 and 2021 respectively.

Rationale/Background:
Minnesota levies a two percent tax on revenue from patient services at hospitals, surgical centers and health care providers. This two percent tax also applies to the revenue of wholesale drug distributers as well as on amounts paid for resale prescription drugs in the state purchased from sources other than a wholesale drug distributer. Provider tax revenue is deposited into the Health Care Access Fund and which funds health care coverage through the MinnesotaCare and MA programs support public health activities administered by the Minnesota Department of Health. The provider tax represents approximately 80 percent of revenue in the Health Care Access Fund in FY 2018-19. Under current law, the provider taxes sunset on December 31, 2019. Repealing the sunset of the provider tax provides greater funding stability for the state's initiatives to promote access to health care, improve the quality of care, and contain health care costs.

In 2003, the state legislature removed an exemption on taxing health care provider revenue for services provided to recipients of MA and MinnesotaCare and increased provider payment rates by two percent for services subject to this tax. The November 2016 MA and MinnesotaCare forecast accounted for the provider tax sunset by removing the value of the two percent rate increase effective Januray 1, 2020. Repealing the provider tax sunset reinstates the two percent rate increase in MA and MinnesotaCare, resulting in a net cost to the state of just over $42 million in FY2020-21.

The current tax rate is 2%, although each year the rate must be reduced if the Commissioner of Management and Budget determines that projected revenue to the Health Care Access Fund is greater than 125% of expenditures and transfers, and the cash balance in the fund is adequate.

Proposal:
This proposal repeals the sunset of the two percent provider taxes contained in Minnesota Statutes Chapter 295.52

Change Item Title: Refinance Medical Assistance to Health Care Access Fund

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	(358,000)	(358,000)	(573,500)	(573,500)
Revenues	0	0	0	0
Other Funds				
Expenditures	358,000	358,000	573,500	573,500
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	0	0	0
FTEs	**0**	**0**	**0**	**0**

Recommendation:
The Governor recommends investing $358 million per year in FY 2018-19 and $573.5 million per year in FY 2020-21 from the Health Care Access Fund to finance the Medical Assistance (MA) program. This results in a reduction of an equal amount to General Fund spending for MA.

Rationale/Background:
Total biennial state MA expenditures are expected to increase 18.5 percent from FY 2016-17 to FY 2018-19, which amounts to an increase of approximately $1.77 billion. These increases are placing a significant burden on the state General Fund. Meanwhile the Health Care Access Fund is projected to have a surplus of $1.38 billion at the end of FY 2019, with annual revenues exceeding expenditures by more than $300 million per year.

Proposal:
This proposal would finance $716 million in MA expenditures from the Health Care Access Fund in FY 2018-19, which will result in a General Fund savings of $716 million over the biennium. In FY 2020-21, the proposal finances $1.147 billion in MA expenditures from the Health Care Access Fund which reduces General Fund spending by $1.147 billion.

Statutory Change(s):
N/A

Fiscal:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			(358,000)	(358,000)	(716,000)	(537,500)	(537,500)	(1,147,000)
HCAF			358,000	358,000	716,000	537,500	537,500	1,147,000
Other Fund								
Total All Funds			0	0	0	0	0	0
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	33	Medical Assistance	(358,000)	(358,000)	(716,000)	(582,000)	(582,000)	(1,164,000)
HCAF	33	Medical Assistance	358,000	358,000	716,000	582,000	582,000	1,164,000
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**

Change Item Title: Minnesota Security Hospital Staffing for Improved Client Care & Staff Safety

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	10,349	15,049	18,206	21,076
Revenues	1,035	1,505	1,821	2,108
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	9,314	13,544	16,385	18,968
FTEs	**90.52**	**124.52**	**146.52**	**168.52**

Recommendation:

Effective July 1, 2017, the Governor recommends increasing the base funding for Direct Care & Treatment (DCT) Forensics Services to increase clinical direction and support to direct care staff treating and managing clients with clinical complexities, some of whom engage in aggressive behaviors. Additional funding is also requested to enhance the current staffing model to achieve a safe, secure and therapeutic treatment environment that provides the appropriate level of care to the individuals served.

In 2015, Governor Dayton requested the Bureau of Mediation Services (BMS) facilitate a process to develop solutions for issues of patient care, staff safety, and labor-management relations to create an effective communication and structure for on-going collaborative problem solving. During this collaborative process, small work groups focused on Resident Appropriateness, Application of Person-Centered Principles & Safety, Staffing, Communication, and Organizational Wellness. These groups identified and made recommendations for needed policy and legislative changes, and an independent evaluation of current staffing resources. This group also provided recommendations to help meet the clinical needs for patients ensuring a safe working environment for the patients and staff. This proposal is based on the collaborative recommendations of the full (e.g. labor and management partners) BMS group. Beginning this spring the staff from the Bureau began to work with Forensic Leadership, which includes labor leaders, and developed a Joint Labor/Management Committee to continue the work started in 2015.

Proposal:

This proposal requests funding for significant and sustained investments in clinical resources, tools for building a skilled workforce, meeting statutory requirements, and supervision and training of new skills and techniques related to incidents and safety within Forensic Services. This proposal is crucial in addressing chronic underfunding and remedying staffing imbalance.

Specifically, funding is needed to address the following areas:

1. Provide on-going base funding to maintain approximately 30 positions that are currently being supported with one-time funds;
2. Increase staffing levels to enhance safety, evaluation, and treatment. In particular, to expand programming beyond the Monday through Friday business model;
3. Increase the number of mental health practitioners and medical staff to achieve a staff to patient ratio that is consistent with forensic psychiatric facilities across the nation;
4. Increase the utility pool to allow flexibility to meet dynamic staffing needs in order to reduce overtime and to increase resources where acuity is reflecting a need;
5. Establish a positive behavior support expert team to provide clinical direction to treatment teams in providing care and treatment to behaviorally challenging individuals;

6. Ensure compliance with the statutory mandate requiring individuals committed as mentally ill and dangerous to be reviewed by the Special Review Board every three years, and to comply with the mandated MN Rule to use Positive Support strategies with developmentally disabled individuals;
7. Hire administrative leadership necessary to guide and support staff and to lead quality and performance improvement, and provide clinical direction;
8. Establish an occupational health presence on campus.
9. Increase support staff on campus to help maintain the facilities and campus and to provide for the dietary requirement of patients.
10. Hire HR support personnel on campus to assist with recruitment, retention, and overall employee relations;
11. Reduce amount of non-clinical work done by nursing and other clinicians in order to meet mandates and licensing regulations, including but not limited to documentation and notifications for compliance purposes;
12. Develop recruitment and retention incentives to be more competitive with industry standards, including but not limited to: continuing medical education, loan and tuition reimbursement and hiring bonuses;
13. Provide additional resources to maintain the campus facilities and grounds; and
14. Establish a training fund to enhance safety and regulation compliance

Rationale/Background:

The requested funding is essential and without these investments, we can expect to see the following challenges continue:

- Inability to reduce staff workplace injuries to an acceptable level;
- Continued high rates of overtime;
- Continued staff burn out, turnover;
- Inability to retain qualified personnel with competitive salaries;
- Inability to recruit qualified personnel with standard recruitment and retention incentives;
- Inability to meet the demands of the legislative mandates, such as Positive Support Rule and mandated Special Review Board three year review;
- Falling short of our commitment to the State of Minnesota to provide treatment services to our patients; and
- Continued citations from licensors and regulators.

Description of Services

Forensic Services provides evidenced-based treatment for individuals with complicated diagnoses who have typically been involved in the criminal justice system. Many of the individuals served have experienced multiple treatment failures and/or can no longer be accepted for treatment in less restrictive settings. Forensic Services provides treatment in a secure setting to assist patients in recovery with the ultimate goal of a community placement and a meaningful life. Forensic services goal is to provide start of the art evidenced-based treatment that is recognized across the country.

The complexity of patients' mental health, and associated illness such as chemical dependency, cognitive disabilities, personality disorders, and often multiple medical health issues, requires a professionally trained staff from a variety of clinical backgrounds. Provision of therapeutic treatment has to be driven from clinical staff who understand complicated co-morbid conditions. The best clinical practices to serve patients with illnesses of this acuity strongly suggests that in order for treatment to be effective, it must be individualized and comprehensive.

Staff who provide the 24/7 direct care must constantly enhance their skills while working with complex individuals. There is a high need for on-going and just-in-time training to build proficiency in de-escalation, intervention, and engagement that leads to treatment recovery.

Comparison to Like-Facilities

When Forensic Services is compared nationally, Minnesota falls short on resources dedicated to serving individuals in comparison to other Forensic facilities.

Organization	Licensed Beds	Total Staff	Staff to Patient Ratio
Oregon State Hospital	540	1,800	3.3 staff for every 1 patient
Fulton State Hospital	401	1,345	3.3 staff for every 1 patient
Forensics (Current)	395	886.83	2.2 staff for every 1 patient
Forensics (Proposed – over 5 years)	395	1,064.35	2.7 staff to every 1 patient

Current and Historical Funding

The table below provides an overview of base funding compared to actual expenditures for the past three biennium. Forensic Services was able to balance the FY12-13 biennium within available base funding. However, during the FY14-15 biennium Forensic Services was placed under a conditional license. Forensic Services had to hire additional staff and incur additional expense related to the conditional license requirements and other legislative mandates which resulted in overspending. The 2015 Legislature did approve $10.4 million in deficit funding; however, this was not enough to balance the biennium. An additional $7 million was transferred from other areas of DHS (due to underspending) to balance Forensic Services for the FY14-15 biennium. The 2016 Legislature did approve cost of living increases for FY16 and FY17; however, no funding was approved for additional positions.

Fiscal Year	Base Funding	Actual Expenditures	Budgeted FTEs	Paid FTEs	Overtime FTEs
2012	$69,582,000	$67,575,361	750.15	727.43	22.96
2013	$69,582,000	$70,483,427	754.09	727.36	26.76
2014	$69,582,000	$77,560,997	792.41	775.82	27.57
2015	$74,402,000	$83,089,310	754.09	773.21	39.88
2016	$84,021,000	$83,748,528	796.66	775.38	36.95
2017	$86,535,000	$90,701,400	873.80	831.13	34.91

NOTE: Paid FTEs and Overtime FTEs calculated based on total hours paid for the time period divided by total hours available during that time period (typically 2088 hours for a fiscal year). FY2017 Expenditures is the Forecasted Balance as of 10/31/2016.

Forensics has spent, on average, $2.2 million annually for overtime over the past three fiscal years (or approximately 4.5% of total personnel costs). The goal is for overtime to average 2.5% or less of total personnel cost. There have been measures put in place to work towards reducing overtime hours, however, it is unlikely a reasonable overtime expense allocation will be achieved until there is an increase in the staffing complement.

The below table represents year to date overtime dollars and FTE for FY17.

Overtime	July	August	September	October
FTE	39.10	42.75	36.97	32.43
Dollars	$142,572	$298,378	$430,074	$222,577

Recruitment and Retention Considerations:

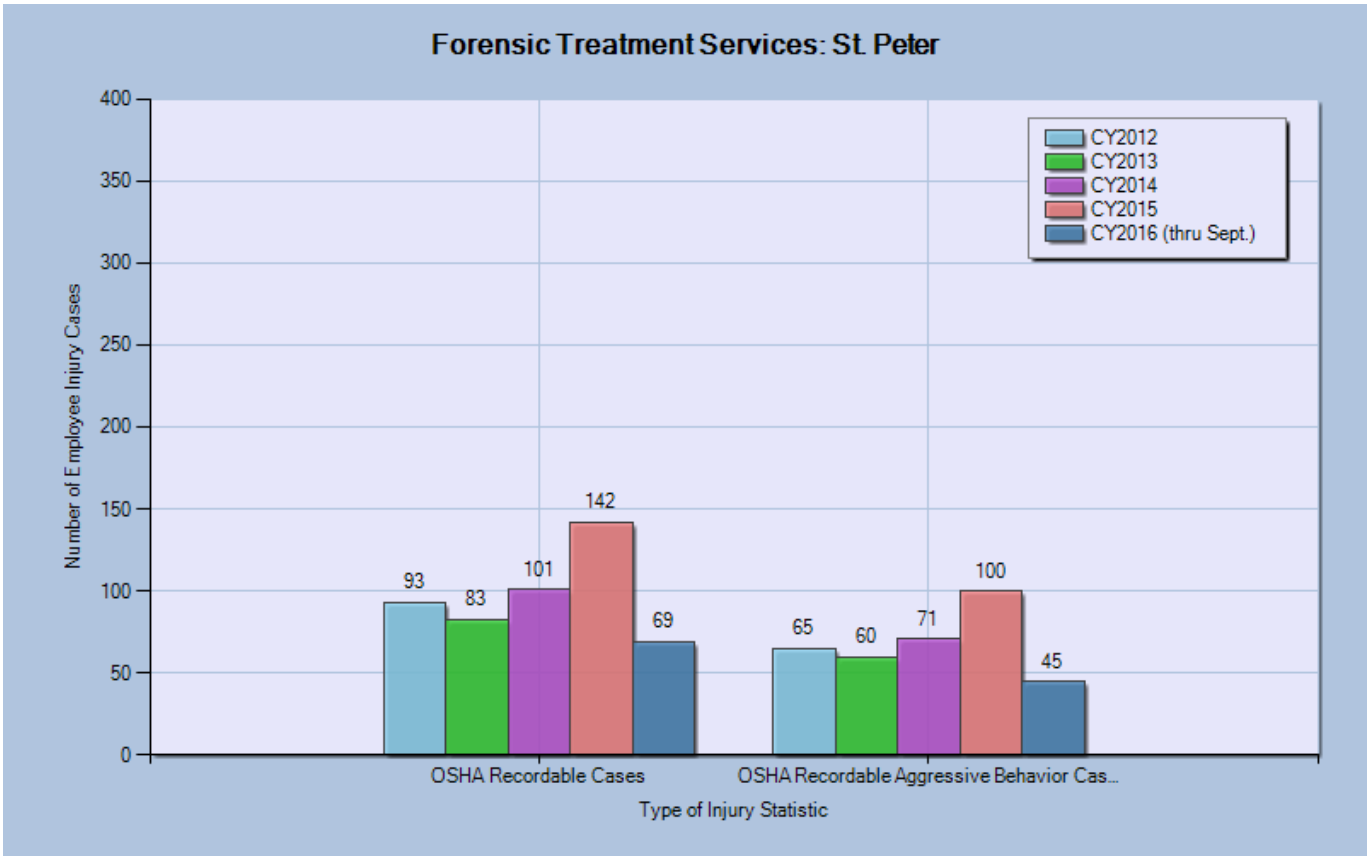
It is becoming increasingly difficult to both recruit and retain staff. Issues contributing to poor retention include the amount of overtime, especially forced overtime, non-competitive with other health care organizations, and continued additional responsibilities to meet legislative mandates without additional staffing resources. These factors as well as the difficult work contribute to an overall staff burnout, negatively impacting retention.

Recruitment has been a challenge and there are a variety of positions that are increasingly difficult to fill. Examples of these include nurses (registered nurses and licensed practical nurses), recreational program assistants, key experienced leadership positions and mental health professionals including psychiatric practitioners and psychologists.

In order to recruit and retain staff, Forensics must offer competitive incentives such as hiring bonuses, loan and tuition reimbursement, and dollars towards continuing education. Currently, Forensics is unable to compete with recruitment and retention efforts of other health care or secure treatment providers. This results in a chronic challenge in attracting and retaining qualified candidates, even when positions are funded. It is crucial that both the needed positions are funded but that the state also make investments in the tools needed to build and sustain a skilled workforce.

Results:

One measure of safety is the number of recordable injuries or illnesses reported to the federal Occupational Safety Health Administration (OSHA). As you can see from the chart below, the number of recordable incidents had increased significantly in calendar year 2015. Many efforts have taken place to lower the number of incidents resulting in a reduction of OSHA recordable injuries within Forensic services. These efforts need to continue, but will only go so far. Programming evenings and weekends, providing behavioral expertise by clinicians to direct care treatment staff and having enough staff to minimize overtime is critical to see an even greater reduction in staff injuries.



OSHA Recordable Cases: An injury or illness is considered to be OSHA Recordable if it results in any of the following:

- Death, days away from work, restricted work or transfer to another job, medical treatment beyond first aid (see below for first aid definition), or loss of consciousness.
- A significant injury or illness diagnosed by a physician or other licensed health care professional, even if it does not result in death, days away from work, restricted work or job transfer, medical treatment beyond first aid, or loss of consciousness.
- Injuries include cases such as, but not limited to, a cut, fracture, sprain, or amputation.
- Illnesses include both acute and chronic illnesses, such as, but not limited to, a skin disease (i.e. contact dermatitis), respiratory disorder (i.e. occupational asthma, pneumoconiosis), or poisoning (i.e. lead poisoning, solvent intoxication).
- OSHA's definition of work-related injuries, illnesses and fatalities are those in which an event or exposure in the work environment either caused or contributed to the condition. In addition, if an event or exposure in the work environment significantly aggravated a pre-existing injury or illness, this is also considered work-related.

Aggressive Behavior: A disabling injury stemming from the aggressive and/or intentional and overt act of a person, or which is incurred while attempting to apprehend or take into custody such person.

Statutory Change(s):

N/A

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			9,314	13,544	22,858	16,385	18,968	35,353
HCAF								
Federal TANF								
Other Fund								
Total All Funds			9,314	13,544	22,858	16,385	18,968	35,353
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
1000	63	Forensic Services	8,567	12,702	21,269	15,572	18,181	33,753
1000	64	MSOP	444	452	896	452	452	904
1000	65	DCT Operations	1,338	1,895	3,233	2,182	2,443	4,625
		Total Expense	10,349	15,049	25,398	18,206	21,076	39,282
1000	Rev1	Cost of Care Recoveries	(1,035)	(1,505)	(2,540)	(1,821)	(2,108)	(3,929)
		Net GF Impact	9,314	13,544	22,858	16,385	18,968	35,353
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
1000	63	Forensic Services	82.52	115.52		137.52	159.52	
1000	64	MSOP	6.00	6.00		6.00	6.00	
1000	65	DCT Operations	2.00	3.00		3.00	3.00	
		Total	90.52	124.52		146.52	168.52	

Change Item Title: Minnesota State Operated Community Services Sustainability

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	7,697	2,588	2,588	1,000
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	7,697	2,588	2,588	1,000
FTEs Maintained	**91.1**	**21.6**	**21.6**	**0.0**

Recommendation:

Effective July 1, 2017, the Governor recommends appropriating $10.2 million for the FY2018-2019 Biennium from the General Fund to the Direct Care and Treatment (DCT) Minnesota State Operated Community Services (MSOCS) program to ensure sufficient operating funds to continue to provide services to approximately 1,100 individuals in residential and vocational sites throughout the state. The request fills a gap of approximately 2.6% between the cost of operations and the revenue generated by the program for the FY18-19 biennium. This request includes appropriating $1.0 million each year from the General Fund to Direct Care and Treatment to fund start-up expenses to open up to 10 new MSOCS homes per year.

Proposal:

The 2016 Legislature appropriated $14 million to the MSOCS program in FY2017 as one-time funding to maintain operations while the department redesigned the program. Since that time, the deparment has developed a plan to mitigates operating losses and provides sustainability though program redesign. This includes:

1. Increasing Crisis Residential Rates to cover the cost of providing services
2. Converting existing 6-bed Intermediate Care Facilities (ICFs) to 4-bed Adult Foster Care (AFC) residences
3. Consolidating residential homes that have had long-term vacancies to allow for more effective use of the resources available.
4. Working with counties to fill vacancies within other MSOCS residential homes.
5. Consolidating vocational services sites to reduce the number and size of the sites as more individuals are seeking community jobs so less day treatment space is required.
6. Begin targeted discharges of individuals that have banded rates that are substantially lower than the cost to serve them.

Although these steps will help mitigate current operating losses, an appropriation is required to maintain services until at least 2021 when the Rates Management System will be open to individuals currently under banded rates.

Rationale/Background:

Minnesota State Operated Community Services (MSOCS), which is part of Community Based Services (CBS) within Direct Care and Treatment, provides residential and vocational support services for people with disabilities. Services include:

- **Adult Foster Care** with a current average daily census of 357
- Five **Crisis Residential** sites with a capacity of 4 beds per site;
- Fifteen **Intermediate Care Facilities** for individuals with Developmental Disabilities with a current average daily census of 75
- **Vocational Services** currently serving 648 individuals in 18 sites and in the community

The role of MSOCS as a service provider has been evolving over the past few years to increase the focus on people requiring a higher level of service that is currently unavailable in the community. As individuals who do not require this level of care or supervision leave the programs operated by MSOCS, the focus has been to only admit individuals that do require a service level not available with another provider. This transition has increased the number of vacancies causing revenues to fall more quickly than expenses. This has contributed to a financial loss to the program currently projected at $14 million for fiscal year 2017.

Below are factors that have converged to create a need for a more focused vision for MSOCS.

- A 2013 Legislative Auditor's Report recommended that DHS focus state-operated programs on "safety net" supports for those individuals whose needs could not be met by existing community resources.
- The "48-Hour Rule" requires that individuals who are in jail and are committed to the Commissioner of DHS be admitted to an appropriate treatment or residential setting suitable to meet their needs within 48 hours.
- The federally required implementation of the Rate Management System (RMS) resulted in rate reductions over a 5-year period. While rates were cut, MSOCS' costs of operating the residential programs increased due primarily to increased staffing costs.
- The increase in the need for placement of individuals with higher levels of aggression and behavioral needs.

Results:

- This proposal will increase MSOCS' ability to serve more challenging individuals with disabilities and reduce inappropriate admissions to state or community hospitals or jails . This will be measured by 1) reducing the number of admissions to Anoka Metro Regional Treatment Center (AMRTC) of individuals who do not need hospital level of care at the time of admission; and 2) reducing the length of stay for those indivdiuals admitted to AMRTC who no longer need hospital level of care.
- The proposal will also improve the financial stability of the program, which can be measured by the outcomes obtained from implementing the six loss mitigation strategies identified above. Specific metrics will include:
  - Monitoring the financial sustainability of the Crisis Residential programs
  - Progress on the number of ICFs converted to AFC residences
  - Total vacancies at residential homes
  - The number and percentage of individuals supported by Vocational programs who have community jobs
  - The number of individuals whose rates do not cover the cost of service
  - The amount by which rates do not cover the cost of service

Statutory Change(s):

Minnesota Statutes Section 246.014 and Rider

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			7,697	2,588	10,285	2,588	1,000	3,588
HCAF								
Federal TANF								
Other Fund								
Total All Funds			7,697	2,588	10,285	2,588	1,000	3,588
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
1000	62	Community Based Svcs – Start-up Capital	1,000	1,000	2,000	1,000	1,000	2,000
1000	62	Community Based Svcs – Operational Deficit Coverage	6,697	1,588	8,285	1,588	0	1,588
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	62	FTE's Maintained	91.1	21.6		21.6	0.0	

Change Item Title: Direct Care and Treatment System Modernization

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	1,000	1,000	1,000	1,000
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	1,000	1,000	1,000	1,000
FTEs	**0**	**0**	**0**	**0**

Recommendation:

Effective July 1, 2017, the Governor recommends increasing the base appropriation for Direct Care and Treatment Operations by $1 million per year for the FY2018-2019 biennium. This funding will support the development of a legally compliant electronic health records and operations system for Direct Care and Treatment (DCT) programs, serving over 12,000 clients annually.

Rationale/Background:

Currently, approximately 20% of DCT client health records are supported within electronic data systems and 80% are still maintained via paper mechanisms. As a result the legal client health record is considered to be our paper files, therefore, all electronic health data is printed to be included in the official health record. This impacts our ability to provide safe environment and quality health care to the individuals who are civilly committed to receive our medical services.

The following provides examples of how patient care processes are impacted by the current records system:

- **Process for prescribing medication:** a medical provider will request a certain medication by writing a paper prescription, this paper prescription is then converted to a legible document that is faxed to a pharmacy, the medication is sent to the facility, and the medication is mechanically written on an administration document that is used for physically handing out medications.
- **Processing lab orders:** a lab will be ordered by paper, this lab along with relevant medical information will be sent with the individual to the physical location where the lab is performed, the lab results will be faxed back to the facility, and printed. In order for a provider to evaluate the lab results they need to physically go to the facility or have the lab results read to them by a member of the nursing staff. In order to compare previous results the provider will need to physically go through the previous results, manually compare results, and determine appropriate treatment.
- **Process for obtaining medical treatment external to our facility:** a paper copy of the medical record is made and physically sent with the individual. The external provider will provided written documentation of the visit. The results of the visit will be physically evaluated by the provider or read to the provider over the phone. At that time the provider would make the appropriate medical treatment decisions, which will be manually entered into the paper file.

Electronic health records technology, data analytics/metrics, and up-to-date systems are critical to the operation of a 24/7 health care system located in multiple sites throughout Minnesota. This proposal will support development, implementation, on-going operations, and equipment to move all aspects of DCT client heath care information into electronic paperless records, allowing DCT providers to share patient information electronically with other health care providers, record medical treatments and archive all the historical paper client records.

These medical records not only record aspects of treatment for clinical purposes, but it also provides state and federal courts with key treatment, results, and discharge planning information. This information is critical for anyone wanting to be released from a secure civil commitment environment and directly impacting clients/patients civil liberties.

Proposal:

This proposal is to continue to develop and expand our present health records and operational systems located in Avatar and Phoenix, the two main computer systems utilized in DCT. The funding will be used by DCT for external contractors. Funding will support the following activities:

- Ensure DCT is providing the industry standard level of safe environment and quality care to the individuals civilly committed to our programs.
- Ensure documents meet state and federal court requirements to have all aspects of the clients' treatment record to be informed on civil committed individuals as they progress through treatment in order to be discharged in a timely and effective manner.
- Ensure DCT billing and fiscal activities are supported by data obtained via the patient's electronic health record.
- Obtain technical and business support to implement a scheduled release cycle for new functionality and ongoing enhancements to the current Avatar and Phoenix systems, so that ongoing progress is made toward a fully compliant electronic health record.

The current annual operating budget for Direct Care and Treatment is over $300 million. Of that amount approximately only about $3.0 million is spent on IT related activities that support the ongoing operations of the Avatar and Phoenix systems, the major technology systems that support the client care activities of DCT. This request is specifically to support the expansion of the Avatar and Phoenix systems to initiate the development of an electronic health records system. Funds received through this proposal will be used to develop, implement and support the operations associated with an electronic health records system. The funding will expand contracted services with our current vendors.

IT Related Proposals:

This proposal provides funding for the development of an electronic health records system for over 12,000 clients served by DCT programs. Funding will be used for contracted services and (resources permitting) equipment to support the use of the system by care providers. Ongoing funding is necessary to support the continued development, implementation and ongoing operations of an electronic health records system.

Results:

Electronic Health Records:

- DCT will continue to develop and expand the electronic health record in order to provide a safe environment and quality care, meet state and federal court mandates, comply with federal billing requirements, adhere to Minnesota electronic record laws, comply with federal regulation requirements, and meet MNIT system standards.
- Health Care System metrics will be available for DCT leadership, fiscal management, and staff to inform and improve services to clients and patients served through DCT.

An annual assessment will be made on the increase in the % of health record data supported through the electronic health records systems.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	% of health records meeting laws, requirements and standards	NA	<20%	2016

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			1,000	1,000	2,000	1,000	1,000	2,000
Total All Funds			1,000	1,000	2,000	1,000	1,000	2,000
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
1000	65	DCT Operations for EHR	1,000	1,000	2,000	1,000	1,000	2,000

Change Item Title: Child & Adolescent Behavioral Health Services

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	405	491	5,630	5,630
Revenues	0	0	2,510	6,057
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	405	491	3,120	(427)
FTEs	**0.00**	**0.00**	**52.88**	**52.88**

Recommendation:

Effective July 1, 2017, the Governor recommends increasing the General Fund appropriation for the Child & Adolescent Behavioral Health Services (CABHS) program by $896 thousand for the FY18-19 biennium. This request is needed to continue to operate the CABHS program in the current location until a new building can be secured. Funding for the new building is included in the Governor's capital budget recommendations. Once the new building is available, the General Fund appropriation would increase by $11.3 million for the FY20-21 biennium.

Proposal:

This proposal requests funding to continue to lease the current facility to operate the CABHS program until a more appropriate facility can be built. The current program would continue to operate as an 8-bed program with a one to one staff to client ratio serving children & adolescents with complex behavioral health needs. The new facility, once available, would operate as a 16-bed program serving the same clients as at the existing site.

Rationale/Background:

CABHS, located in Willmar, is a 16-bed psychiatric hospital providing services to children and adolescents with complex mental health conditions. The target population for the hospital includes children with the highest unmet treatment needs including those with autism spectrum disorder, reactive attachment disorders, Post-Traumatic Stress Disorder (PTSD), co-occurring mental health and developmental disability, borderline personality disorder, schizophrenia, fetal alcohol spectrum disorder, brain injuries, and complex medical issues.

The current facility has serious physical plant limitations which impede accepting more than 6-8 children at one time. This is an inefficient use of scarce mental health resources and results in long waiting lists with some children needing to go out of state to receive treatment. Related to the ill-fitting design of the units, and depending on demographics and treatment needs, children may need to be placed alone on an entire unit with a full unit complement of staff.

The current lease for CABHS expires on June 30, 2017. The building which houses the program will move to a new owner on July 1, 2016 who has agreed to lease the building to the state for two years but at a rate higher than the current rate paid by the state.

IT Related Proposals:

N/A

Results:

- Increase number of children/adolescents served with complex needs

Statutory Change(s):
N/A

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			405	491	896	3,120	(427)	2,693
HCAF								
Federal TANF								
Other Fund								
Total All Funds			405	491	896	3,120	(427)	2,693
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
1000	61	MHSATS	405	491	896	5,630	5,630	11,260
1000	Rev1	Cost of Care Recoveries	0	0	0	(2,510)	(6,057)	(8,567)
		Net GF Impact	405	491	896	3,120	(427)	2,693
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
1000	61	MHSATS	0.00	0.00		52.88	52.88	

Change Item Title: Direct Care and Treatment Security System and Electronic Monitoring Upgrade

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	2,500	2,500	2,500	2,500
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	2,500	2,500	2,500	2,500
FTEs	**1.0**	**1.0**	**1.0**	**1.0**

Recommendation:

Effective July 1, 2017, the Governor recommends increasing the Direct Care and Treatment Operations base budget by $2.5 million per year for the FY2018-2019 biennium to fund upgrades to security systems and electronic monitoring tools at Direct Care and Treatment (DCT) facilities. The upgrade will establish a regular and routine replacement and maintenance program for essential security systems and electronic monitoring tools to enhance the safety and security of our staff and patients.

DCT currently does not have dedicated funding for the replacement costs associated with all security and communication systems and monitoring tools. Without funding allocated to replace and upgrade our security system as these tools and systems fail due to aging technology, funding is taken from clinical, treatment, and program operations to cover these costs.

Rationale/Background:

DCT security systems and electronic monitoring tools are critical to safely operating a secure health care system, 24/7, 365 days/year. The needs of the population served within DCT require a variety of electronic systems and equipment to ensure the safety and security of the facilities, the clients/patients, the staff and the public.

These electronic systems and equipment include both software operating systems and the equipment those systems operate on. Many of the systems also require hardware operating equipment to function appropriately; and many of our facilities existing security system have failed, and continue to fail because of outdated systems or systems that are no longer supported.

There is no current mechanism to upgrade these systems without dramatically impacting the facilities operating budget. DCT's security systems are in need of regular system maintenance and physical upgrades. In addition, several DCT sites and facilities need to be modified and fitted with modern security measures.

Proposal:

This proposal includes funding to upgrade current security access, communications, and monitoring systems at DCT facilities. This effort will establish a regular and routine replacement and maintenance program for essential security systems for the following areas:

- **Communications:** Standardized security communication technology replacement, including 800 MHz Radios, with central coordination.
- **Monitoring & Surveillance Equipment:** Enhance security surveillance with 1,700 new cameras and on-going replacement of over 2,000 standardized security cameras and associated monitoring systems

The proposal also funds two (2) additional staff – one (1) DCT and one (1) MN.IT. Currently, MN.IT does not support security systems. This leaves approximately 200 DCT sites to try and manage their own sites. This creates many issues with outdated security systems and provided no guidance and consistency across DCT. The DCT staff would proactively review, monitor and

manage DCT security systems. The MN.IT staff would consult on all reviews, RFPs, purchases and installations on all technical aspects of security systems.

Since the safety of our patients, staff, and communities are important to DHS, this is a significant request that is warranted for both a one-time and ongoing investment in IT funding for the Direct Care and Treatment programs at DHS which have not previously received dedicated funding for these activities.

This request provides funding for salary and benefit expense for 1.0 FTEs within DCT as well as non-salary expense for equipment, software and installation for security, communication and monitoring systems for DCT. Funding for the MN.IT staff will be handled through a service level agreement between DCT and MN.IT.

Results:

- DCT Security, monitoring systems, and equipment will be replaced within industry standards, maximizing their useful life.
- Centralized security and monitoring systems at Minnesota Security Hospital
- Secure treatment environments at DCT's CBHH and CARE facilities.

Statutory Change(s):

N/A

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			2,500	2,500	5,000	2,500	2,500	5,000
HCAF								
Federal TANF								
Other Fund								
Total All Funds			2,500	2,500	5,000	2,500	2,500	5,000
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
1000	65	DCT Supports – Equipment & Other Operating Costs	2,375	2,375	4,750	2,375	2,375	4,750
1000	65	DCT Supports – 1 FTE	125	125	250	125	125	125
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
1000	**65**	**DCT Supports**	**1.0**	**1.0**		**1.0**	**1.0**	

Change Item Title: Transfer of Funding Responsibility for Judicial Appeal Panel Expenses from DHS to MJB

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
DHS				
General Fund				
Expenditures	(450)	(450)	(450)	(450)
Revenues	0	0	0	0
Supreme Court				
General Fund				
Expenditures	1,653	1,653	1,653	1,653
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	1,203	1,203	1,203	1,203
FTEs	**0**	**0**	**0**	**0**
DHS				
Courts				

Recommendation:

The Governor recommends $3.306 million to the Minnesota Judicial Branch (through the District Courts) to cover the Judicial Appeal Panel expenses for reduction in custody hearings by Minnesota Sex Offender Program clients. Funding for the Department of Human Services would be reduced by the current base amount of $900,000. The difference, $2.406 million, is an increase in total funding based on expected expenses for the Panel.

Proposal:

This proposal will shift the financial burden for Judicial Appeal Panel (also known as Supreme Court Appeal Panel (SCAP)) expenses from the Department of Human Services (DHS) to the Minnesota Judicial Branch (MJB). The Panel hears and decides reduction in custody petitions for clients civilly committed as Sexually Dangerous Persons or as Sexual Psychopathic Personalities. Currently, DHS is responsible to pay for all compensation and expenses of the judges appointed to the appeal panel as well as allowable costs and fees for the committed person's court-appointed attorney and any court-appointed examiners, court reporters, courtroom security and transportation. Except for transportation of committed persons, all appeal panel expenses will now be the responsibility of the MJB.

Rationale/Background:

Petitions for Appeal Panel hearings have been increasing significantly over the past few years. The increase has resulted in significantly more hearings and their associated costs. While the Panel used to be able to manage its caseload by holding hearings once a week by a single three-judge panel, it has had to increase the frequency of hearings such that now three three-judge panels meet each week.

The judicial branch has reached out to DHS to pay for the increased costs; however, these increased costs cannot be absorbed by DHS. Both DHS and MJB agree that DHS should not be responsible to pay the Appeal Panel expenses; however, both agree that the "base" funding should be shifted from DHS to MJB. The MJB has requested that these funds be placed in the District Courts budget.

Results:

This change will provide a more efficient process for paying Appeal Panel expenses.

Statutory Change(s):

253B.19 Subdivision 1

Change Item Title: Direct Care and Treatment – Oversight Response Teams

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	500	500	1,000	1,000
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	500	500	1,000	1,000
FTEs	**5.0**	**5.0**	**10.0**	**10.0**

Recommendation:

Effective July 1, 2017, the Governor recommends increasing the Direct Care and Treatment (DCT) Operations base budget by $1.0 million for the FY2018-2019 biennium to fund activities that respond to numerous citations and Department of Human Services (DHS) Licensing, Minnesota Department of Health Licensing, Centers for Medicare and Medicaid Services (CMS), the Joint Commission, and state and federal court settlements for the four DCT program divisions serving over 12,000 clients annually.

Rationale/Background:

DCT programs and facilities are regulated by many different federal, state, and oversight entities; including Federal and State Court Litigation, The Joint Commission, CMS, Commission on Accreditation of Rehabilitation Facilities (CARF), Department of Health Licensing, Department of Human Services Licensing, Fire Marshall's Office, Office of the Legislative Auditor, and many others. DCT needs to enhance internal monitoring, detection of risk areas, and process improvement efforts. In addition, DCT needs to be more proactive to ensure all programs meet or exceed current or emerging oversight standards. These supporting functions include regulatory compliance monitoring, staff training, safety inspections and enhancements, health care continual assessments and program improvements, and infection control monitoring. This system ultimately drives high-quality care and services and reduces organizational risk.

Proposal:

Due to budget pressures and funding constraints, DCT has focused resources on providing direct client care and has had to reduce the number of staff supporting the daily operations of DCT's four program divisions. With the increase in direct care staff and the increase in oversight of regulatory issues, this has created gaps in coverage for training, quality improvement, health information management, physical plant, and regulatory/compliance staff to cover court mandates, licensing responses, and licensing citations. DCT is in need of a critical core group of staff to meet the growing oversight requirements, which directly impact client/patient safety and services. The following areas will be addressed by this request:

- Training Staff (2.0 FTEs): There is an increased need for trainers for DCT programs/services to schedule, conduct and document regulatory training and increase on-the-job learning for over 4,500 employees to meet oversight requirements. This training provides staff competencies with program safety, evidence-based practices, and person-centered training to increase employee learning effectiveness and create a culture of mutual respect with staff and clients.
- Quality Staff (2.0 FTEs): Additional staff are needed to respond and follow up with safety and program incidents involving staff and clients. Positions are needed within the areas of safety, compliance, utilization management, and infection control. These functions interact directly with regulatory entities to ensure programs are maintaining proper levels of treatment and facilities are safe and secure.

- Physical Plant Staff (1.0 FTEs): DCT owns more than 3 million square feet of facility space throughout Minnesota. In order to address the growing legislative requirements and aging facilities, additional staff is needed to identify, manage, and report deteriorating buildings and meet the growing local, state and federal agencies requirements.
- Health Information Management (3.0 FTEs): Every year, DCT gets thousands of requests for data and patient/client case reviews. Records management staff are needed to manage over 30,000 active patient/client records and over 70,000 historical records. These staff will be utilized to coordinate and conduct the required review of client records to ensure client diagnosis are recorded correctly and ensure records are meeting licensing/oversight entity requirements. Additional staff are also needed to ensure we can provide records with the very quick turnaround times required by oversight entity auditors.
- Oversight Mandated Reports (2.0 FTEs): DCT continually responds to court, legislative, and regulatory requests, directions and mandates. These result in a need for staff to adequately review situations, provide best alternatives, and manage projects to completion. This results in better treatment, higher quality of care for clients, and better documentation to meet these mandates

Funding includes salary and benefits cost for 5.0 FTEs for the FY2018-2019 biennium and 10.0 FTEs for the FY2020-2021 biennium. Funding also includes additional non-salary expense to support these staff, e.g., occupancy cost, travel expense, supplies, etc.

Results:

The result of these efforts will reduce the number of CMS and Joint Commission citations, and provide a better quality of care for DCT clients/patients.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Number of CMS/TJC Citations	NA	NA	

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			500	500	1,000	1,000	1,000	2,000
HCAF								
Federal TANF								
Other Fund								
Total All Funds			500	500	1,000	1,000	1,000	2,000
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
1000	65	DCT Support Svcs - Salary	445	445	890	945	945	1,890
1000	65	DCT Support Svcs – Non-Salary	55	55	110	55	55	110
			500	500	1,000	1,000	1,000	2,000
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
1000	65	DCT Support Svcs	5.0	5.0		10.0	10.0	

Change Item Title: Minnesota Sex Offender Program Reform

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	2,592	2,592	2,592	2,592
Revenues	558	726	895	1064
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	2,034	1,866	1,697	1,528
FTEs	**26.0**	**26.0**	**26.0**	**26.0**

Recommendation:

Effective July 1, 2017, the Governor recommends increasing appropriations to the Direct Care and Treatment (DCT) Minnesota Sex Offender Program (MSOP) by $5.2 million for the FY2018-19 biennium. These new resources will 1) provide Community Preparation Services (CPS) and reintegration services to the increased population of clients who have been transferred to a less secure setting or provisionally discharged into the community by the Judicial Appeals Panel (aka SCAP); 2) charge counties 25% for the cost of care for clients that are provisionally discharged from the MSOP, and 3) shift the funding from the Minnesota State Industries Program from an Enterprise Fund to a Special Revenue Fund.

Rationale/Background:

The Minnesota Sex Offender Program (MSOP) is currently the subject of a class action lawsuit brought by individuals who are civilly committed as SDP and/or SPP. These individuals assert numerous claims, including but not limited to claims regarding the constitutionality of the civil commitment process and the adequacy of the treatment provided by MSOP. Although the 8th Circuit Court of Appeals issued their ruling deeming the statute constitutional, it is still uncertain as to the outcome of the remaining claims. In connection with this lawsuit, the Sex Offender Civil Commitment Advisory Task Force issued recommendations for statutory changes in 2013. Also, a panel of court-appointed experts submitted a report containing recommendations for MSOP and civil commitment reform.

Under current law, MSOP is required to provide sex offender treatment for individuals under civil commitment as a sexual psychopathic personality and/or a sexually dangerous person. Since August 1, 2011, counties have been responsible for 25 percent of the cost of care at the facility for clients civilly committed to MSOP. For clients committed prior to August 1, 2011, counties remain responsible for the past statutory requirement of 10% of the cost of care.

When an individual is provisionally discharged from MSOP, the program is required to provide supervision, treatment aftercare, housing, and case management services. MSOP must also act as the designated agency to assist with establishing client eligibility for public welfare benefits and provide those services that are currently available exclusively through county government. In current statute, there is no county share specified for the cost of these services. The statute only addresses county responsibility for cost for the time the client spends inside the facility.

Proposal:

Effective July 1, 2017, this proposal provides funding for 26 positions for community preparation services and reintegration services due to the recent increase in client population to 89 at CPS with the opening of 30 new beds (MSOP Phase 1 Bonding project). With the increase of court-ordered transfers to this less restrictive alternative setting, there is expansion outside the secure perimeter on the lower campus of St. Peter. The expansion of CPS requires appropriate staffing levels to provide the necessary reintegration programming, continued sex offender treatment, security, medical care, and supportive services in a less secure setting. Increased funding for approximately 26 positions covering security, healthcare, physical plant, vocational/rehabilitation programming, reintegration programming and supervision, and facility support services. Success will be measured by maintaining safety and security for the lower campus and assure successful reintegration into the community.

Effective July 1, 2017, this proposal clarifies counties are responsible for 25 percent of the cost of care regardless of if a MSOP client, for which they have financial responsibility, is within a DHS facility or on provisional discharge. Current statute is silent on provisional discharge.

This proposal also requests a shift of the funding sources for the Minnesota State Industries program from an Enterprise Services to a dedicated revenue service.

IT Related Proposals:

N/A

Results:

Due to the court-ordered transfers of clients outside the secure perimeter, CPS needs to continue to expand both physically and operationally. Clients participate in work, recreate, education, recreation, health services, and daily living in a separate setting from the secure facilities which requires additional resources and staff to accomplish this. Following and adhering to these court orders are mandatory and therefore providing services, programming, and preparation for community reintegration is the end result.

Statutory Change(s):

Provisions in M.S. chapters 246B, 246B.06

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			2,034	1,866	3,900	1,697	1,528	3,225
HCAF								
Federal TANF								
Other Fund								
Total All Funds			2,034	1,866	3,900	1,697	1,528	3,225
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
1000	64	MN Sex Offender Program	2,592	2,592	5,184	2,592	2,592	5,184
1000	REV2	MSOP Cost Recoveries	(558)	(726)	(1,284)	(895)	(1,064)	(1,959)
		Net GF Impact	2,034	1,866	3,900	1,697	1,528	3,225
4503	DED	MN State Industries Program	(1,800)	(1,800)	(3,600)	(1,800)	(1,800)	(3,600)
4503	64	MN State Industries Program	(1,800)	(1,800)	(3,600)	(1,800)	(1,800)	(3,600)
2000	DED	MN State Industries Program	1,800	1,800	3,600	1,800	1,800	3,600
2000	64	MN State Industries Program	1,800	1,800	3,600	1,800	1,800	3,600
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
1000	64	MN Sex Offender Program	26.0	26.0		26.0	26.0	

Change Item Title: Child Care Assistance Program Improvements (CF47)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	12,159	45,729	49,021	50,003
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	12,159	45,729	49,021	50,003
FTEs	**0**	**0**	**0**	**0**

Recommendation:

Effective beginning in fiscal year 2018, the Governor recommends investments of $57.9 million in FY2018-19 and $99 million in FY2020-21 to improve the Child Care Assistance Program (CCAP). These investments support family stability and improve the safety and school readiness of children served in child care settings across the state. These investments also comply with new federal requirements.

Rationale/Background:

The Child Care Assistance Program (CCAP) helps families pay for child care so that parents can work or go to school. It also helps ensure that children are well cared for and prepared to enter school ready to learn. CCAP serves approximately 16,000 families and 30,000 children each month. Over 60 percent of the children served are ages 5 or younger. Over 60 percent of all children served are children of color or American Indian children. Approximately 4,100 providers are paid each month for serving children receiving CCAP. CCAP is administered by county and tribal agencies.

This proposal will impact all children and families served by CCAP and improve their experiences with the program. The changes help improve school readiness, make it easier for families to receive assistance, encourage parents to pursue career advancement, make child care available to more families who are homeless, update the rates paid to child care providers, and help ensure that children are safe.

Many of the changes are required under the federal Child Care Development Block Grant (CCDBG). In Federal Fiscal Year 2016, Minnesota received $90.1 million from the CCDBG. These funds help pay for initiatives to improve the quality of child care and for the Child Care Assistance Program, which includes Basic Sliding Fee child care and Minnesota Family Investment Program child care. Most changes to CCAP were federally required to be implemented by Sept. 30, 2016. Minnesota was not able to comply with this timeline since legislative proposals were not passed in 2016. As a result, the federal Office of Child Care approved a time-limited waiver for Minnesota, in effect until Sept. 30, 2017. If Minnesota is not in compliance by this date, it is possible that Minnesota will face penalties, including a reduction of CCDBG funds.

Proposal:

This proposal includes three sections:

1. Improvements to the Child Care Assistance Program
2. Update Maximum Rates Paid Under the Child Care Assistance Program
3. Health and safety Improvements.

Improvements to the Child Care Assistance Program (Federal requirements excluding rates: $27.1M in FY2018-19, $46.6M in FY2020-21; non-federally required proposals: $4.6M in FY2018-19, $8.5M in FY2020-21)

These changes will improve the experiences that all children and families have with the Child Care Assistance Program (CCAP). All of these changes support the goals of new federal requirements. Most of these changes must be implemented to comply with federal requirements. Changes that are not specifically required are identified.

A central component of the new federal requirements is a 12-month eligibility period. During the 12-month period, the amount of benefits that an individual family or child receives should not be reduced, except in limited situations. This helps parents maintain stable employment and improve school readiness by giving children consistent access to child care. Many of the proposals below are needed to implement the federal direction regarding the 12-month eligibility period.

Improves school readiness by keeping children in child care with fewer disruptions and more consistent schedules by:

- Keeping the same amount of care authorized during the entire 12-month eligibility period unless certain things change or the child needs more care.
- Allowing child care assistance to continue during the 12-month eligibility period when a family temporarily stops working or attending school, or when their work hours fall below the 20 hour per week average currently required.
- Extending eligibility with the same amount of care for three months after a family's work or school activity ends permanently.
- Eliminating barriers to continued assistance: Families who received Minnesota Family Investment Program/Diversionary Work Program (MFIP/DWP) for at least one of the last six months will qualify for Transition Year child care. Education is added as an authorized activity for Transition Year child care and Transition Year Extension child care. The six month limit on Portability Pool is eliminated for families who move between counties.

Makes it easier for families to receive assistance and simplifies the program by:

- Re-determining eligibility every 12 months instead of every six months.
- Eliminating requirements to report most changes in income and parent's work or school schedule.
- Limiting verification of a parent's work or school schedule and instead tying authorized hours to the number of hours care is needed for a child, not the specific days and times of the parent's schedule. This is not a federal requirement.
- Eliminating overpayments caused solely by agency error; overpayments that occurred more than one year prior to discovery, and overpayments under $500, unless due to fraud or loss of an appeal. This is not a federal requirement.
- Aligning the self-employment income definition with other public assistance programs. This is not a federal requirement.

Encourages parents to pursue increased income and career advancement by:

- Allowing continued eligibility during the 12-month eligibility period when there are changes in income, but income remains below the federal exit level (85 percent SMI).
- Eliminating increases in copayments during a family's 12-month eligibility period. This is not a federal requirement for all families. This is a federal requirement for families whose income is at or below 47 percent SMI and for families in their first year of eligibility.
- Allowing parents to search for a job for up to 30 hours per week for three months at initial application, and up to five hours per week during the 12-month eligibility period. Minnesota's current job search policies do not comply with federal requirements. Job search at initial application must either be eliminated or changed to allow at least three months of assistance. Job search during the 12-month eligibility period must either be eliminated or changed to allow job search throughout the period by removing the cap on allowed hours.

Makes child care available to more homeless children by:

- Creating an expedited five business-day application process for families who are experiencing homelessness. Proof of eligibility would be required within three months (but not prior to approval) or assistance would end.

- Exempting homeless families from activity requirements during the three month period following application. Care would be approved for up to 30 hours per week. This is not a federal requirement.

Additional proposals that meet federal requirements include:

- Establishing a $1 million asset limit. Families will be required to certify on the application and redetermination that their assets are not more than $1 million. Currently there is no asset limit.
- Updating provider payment policies to pay bills within 21 days.
- Allowing families to receive assistance until the next redetermination following when a child turns 13 years old, or a child with a disability turns 15.

Update Maximum Rates Paid Under the Child Care Assistance Program ($25.6 M in FY2018-19, $43.7M in FY2020-21)

States are required to update payment rates on an ongoing basis to align with the results of the most recent market rate survey. States have some discretion in setting the percentile benchmark for the maximum rates. The Governor recommends updating the maximum rates paid to child care providers in February 2018, based on the 2016 market rate survey. Maximum rates would be set at the greater of the 25th percentile of the 2016 market rate survey or the rates in effect at the time of the update. Many maximum rates would increase, some rates would stay the same and no rates would decrease under this proposal. Preliminary analysis by the department indicates that approximately 66% of maximum rates outside the seven-county metro area and 60% of maximum rates in the metropolitan area would increase if this proposal becomes law.

Health and Safety Improvements

This proposal will help ensure that children are cared for in safe, nurturing environments by:

- Requiring that non-relative legal non-licensed providers who care for children receiving CCAP meet basic health and safety standards, including annual monitoring visits, and training on health and safety topics.
- Eliminating the option to pay legal non-licensed providers before a background study has been completed. No counties currently use this option.
- Requiring that out-of-state providers meet federal health and safety requirements in order to receive Minnesota CCAP payments.

Equity and Inclusion:

Over 60 percent of the children served by CCAP are children of color or American Indian children. According to the Minnesota Child Care Assistance Program Family Profile for SFY15, children in CCAP belong to the following racial and ethnic communities:

Race / Ethnicity	African-American	American Indian	Asian/ Pacific Islander	Hispanic / Latino	Multiple Races	White	Unknown
SFY 15	44.3%	1.7%	2.3%	6.1%	6.9%	34.7%	4.1%
SFY 14	40.7%	1.9%	2.7%	6.4%	7.3%	37.6%	3.4%
SFY 13	38.9%	2.2%	2.9%	7.1%	8.0%	40.8%	2.7%
SFY 12	36.1%	2.7%	3.3%	7.6%	8.2%	42.1%	2.4%

Compliance with the federal Child Care and Development Block Grant is key to protecting funding for CCAP, which helps make child care affordable for income-eligible families. If the state does not achieve compliance to the satisfaction of the federal government it risks penalties to federal funding for CCAP, which would disproportionately affect communities of color based on the children that are part of the Child Care Assistance Program in Minnesota.

IT Related Proposals:

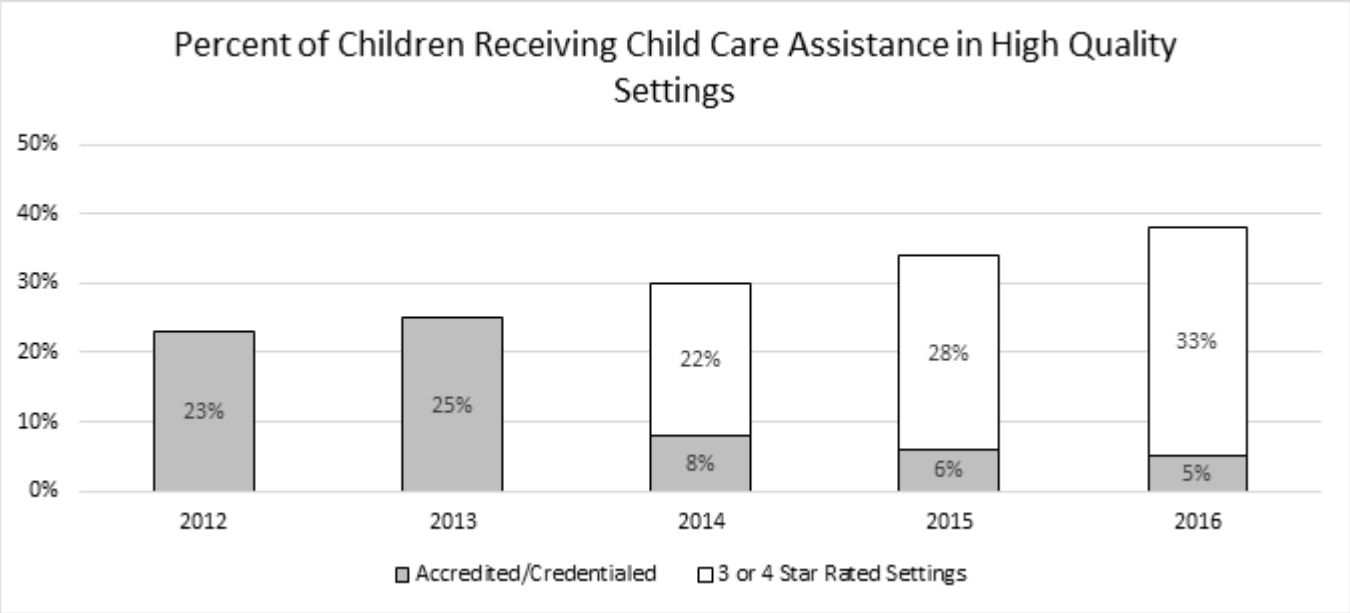
The Minnesota Electronic Child Care Systems, or MEC2, the automated case management computer system that supports the Child Care Assistance Program will need to make changes to implement most of the proposals. Costs include $591,000 in 2018-19 and $201,000 in 2020-21.

Results:

Increase in the use of High Quality Care

Children who participate in high quality early care and education are more likely to experience school success and positive life-long outcomes. This measure shows that the percent of all children receiving child care assistance through providers eligible for the higher rates for quality has increased from 23 percent in quarter four of 2012 to 38 percent in quarter three of 2016. This represents a 65 percent increase over the four-year period.

The policies in this proposal that simplify the program and keep children in child care fewer disruptions and more consistent schedules will allow more families to choose high quality care and encourage high quality providers to serve more children receiving child care assistance. This will help increase the percent of children receiving child care assistance in high quality settings.



In 2014 a statute change allowed providers to qualify for the higher maximum subsidy rate through receiving a Parent Aware rating of Three- or Four- Stars. Previously only providers holding certain accreditations and family child care providers meeting certain education standards were eligible. In this figure, child care settings were categorized according to the quality standard they meet to be eligible for the CCAP quality differential.

In 2012-13 settings meeting quality standards though accreditations/credentials may also have been highly rated by Parent Aware. In 2014-15 settings that hold both a Three- or Four- Star Parent Aware Rating and an accreditation or educational credential are included in the Parent Aware Rated category.

Statutory Change(s):

Minnesota Statutes, Chapter 119B will require extensive changes. Minnesota Statutes, Chapter 256P will require changes.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			12,159	45,729	57,888	49,021	50,003	99,024
HCAF								
Federal TANF								
Other Fund								
Total All Funds			12,159	45,729	57,888	49,021	50,003	99,024
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	22	MFIP Child Care Assistance Grants	7,725	30,735	38,460	33,379	34,322	67,701
GF	42	BSF Child Care Assistance Grants	3,945	14,891	18,836	15,539	15,583	31,122
GF	11	Operations (MEC2)	489	103	591	103	98	201
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**

Change Item Title: Child Care Assistance Program Integrity Changes (CF50)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	(1,142)	(15,057)	(15,311)	(15,383)
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	(1,142)	(15,057)	(15,311)	(15,383)
FTEs	**2**	**2**	**2**	**2**

Recommendation:

Effective beginning in SFY 2018, the Governor recommends changes to the Child Care Assistance Program (CCAP) that will improve program integrity and help ensure that existing resources go to eligible families.

Rationale/Background:

The Child Care Assistance Program (CCAP) helps families pay for child care so that parents can work or go to school. It also helps ensure that children are well cared for and prepared to enter school ready to learn. CCAP serves 16,000 families and 30,000 children each month. Over 60 percent of the children served are ages 5 or younger. Over 60 percent of all children served are children of color or American Indian children. Approximately 4,100 child care providers are paid each month for serving children receiving CCAP. CCAP is administered by county and tribal agencies.

These changes are intended to address program integrity concerns including recipient potential fraud and misuse, provider fraud, and administrative errors.

While all of these proposals relate to program integrity, the reasons for the proposals vary:

- Due Process: This proposal creates due process rights required under the federal reauthorization of the Child Care Development Block Grant and shifts the burden of appealing adverse actions taken against providers away from families. Portions of this proposal are modeled after due process policies for health care providers.
- Multiple Providers Use: This proposal limits the amount of care allowed a secondary provider. There has been a large increase in the number of children using multiple providers, particularly children using two licensed centers. In many situations, the parent is employed by at least one of the centers. Therefore, the provider is able to set the parent's schedule, in a way that allows the provider to maximize CCAP payment for that parent's children.
- Children of Center Employees: This proposal reduces the complexity of enforcing current law that restricts CCAP payments for center employees. It shifts implementation from a percent to a number. It reduces burden for agency staff and decreases the number of factors that providers need to track and report. In some cases this will allow payment for fewer children.
- Administrative Penalties: This proposal strengthens consequences for providers who commit fraud and discourages violating program rules.
- Attendance Record Keeping Overpayments: This proposal reduces administrative burden for county and tribal agencies and promotes statewide consistency in how agencies calculate this type of overpayment.

Proposal:

This proposal helps ensure that CCAP funds are used appropriately by:

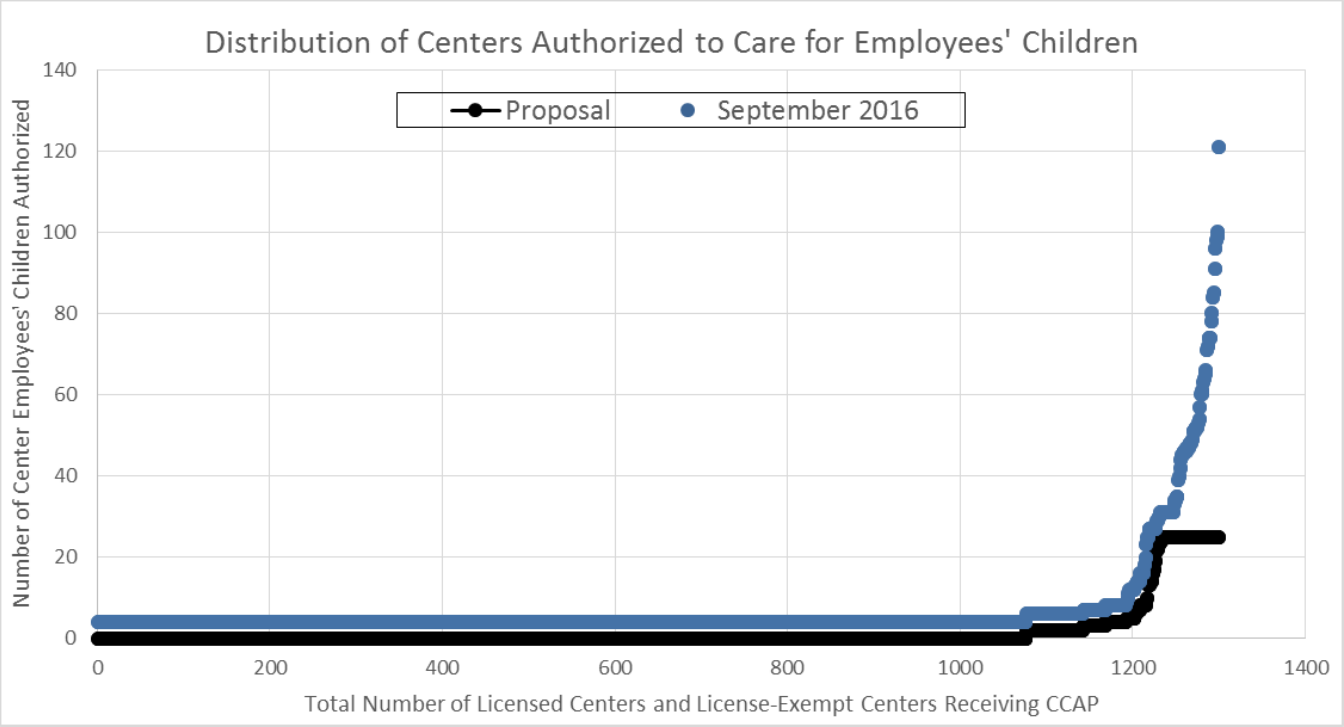
- Expanding due process rights for providers. Due process will be provided for all adverse actions against providers with either a fair hearing, an administrative review, or a hearing that is consolidated with licensing. Currently, providers' appeal rights are limited to a few specific reasons.
- Limiting the amount of care when a child has more than one provider. Care with the secondary provider will be limited to 20 hours or payment of two daily rates in a biweekly period. This proposal does not apply to children using legal nonlicensed providers (sometimes referred to as family, friend and neighbor providers) as their secondary provider.
- Restricting payments to children of center employees. Centers will be authorized to care for 25 or fewer children of center employees. Currently, CCAP cannot pay for children to attend a child care center where their parents work, if more than 50% of the children attending the center receive CCAP and are children of center employees. If a center is authorized for more than 25 employees' children when the new law takes effect (a) authorizations for employees' children will not close, but b) new authorizations for employees' children cannot start until the number of employees' children authorized at the center drops below 25.
- Increasing the administrative penalties for child care providers who commit fraud. Will increase the penalties to 2 years (1st offense) and permanently (2nd offense). Currently, the penalties are 1 year (1st offense), 2 years (2nd offense), and permanently (3rd offense).
- Clarifying overpayment policies when providers violate attendance record keeping requirements. Current policy requires providers to keep attendance records and defines when overpayments occur, but does not direct how to calculate the overpayment.

It is estimated that changes in this proposal that impact provider due process will result in an increase in appeals. Two staff positions are included to cover the increase. The savings estimated in this proposal assume interactions with the Child Care Assistance Program Improvements proposal. Savings would be lower if all provisions are not included.

IT Related Proposals:

IT changes will be required to implement some of these changes.

Results:



Statutory Change(s):
119B

Fiscal Detail: NOTE: PROPOSAL INCLUDES INTERACTION WITH CCDF REAUTH REQUIREMENTS

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			(1,142)	(15,057)	(16,199)	(15,311)	(15,383)	(30,694)
HCAF								
Federal TANF								
Other Fund								
Total All Funds			(1,142)	(15,057)	(16,199)	(15,311)	(15,383)	(30,694)
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	22	MFIP Child Care Assistance	(1,088)	(11,071)	(12,159)	(11,397)	(11,550)	(22,947)
GF	42	BSF Child Care Assistance	(437)	(4,173)	(4,611)	(4,101)	(4,020)	(8,121)
GF	11	Operations (MEC2)	234	47	281	47	47	94
GF	11	Operations (FTEs 2,2,2,2) Due Process Appeals	229	215	444	215	215	430
GF	REV1	FFP35%	(80)	(75)	(155)	(75)	(75)	(150)
GF	11	Operations Due Process Appeals	2	2		2	2	

Change Item Title: CCDBG Licensing and Background Study Compliance

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	6,001	5,151	5,151	5,151
Revenues - FFP				
Other Funds				
Expenditures – Special Revenue	2,367	2,023	201	201
Revenues – Special Revenue	(2,367)	(2,023)	(201)	(201)
Net Fiscal Impact = (Expenditures – Revenues)	6,001	5,151	5,151	5,151
FTEs	48.0	48.0	44.0	44.0

Request:

The Governor recommends changes to child care health, safety, and licensing requirements necessary to meet the federal requirements set forth by the 2014 federal Child Care and Development Block Grant (CCDBG) Act. Federal funding to support Minnesota's Child Care Assistance Program (CCAP) is partially contingent on implementing these proposed changes. On June 15, the Department received conditional approval for Minnesota's State Child Care and Development Plan – a plan required by the federal government to document how Minnesota plans to implement CCDBG requirements. Final approval of the plan and full federal funding requires that many of the following changes be implemented. In addition, these changes represent positive changes to the way that child care centers (CCC), family child care homes (FCC), and license exempt centers (LEC) are regulated and move closer to ensuring the health, safety, and integrity of all child care programs.

Rationale/Background:

The federal Child Care Development Block Grant (CCDBG) provides funding to states to help increase the availability, affordability and quality of child care for families with low income. Two purposes of the fund are: 1. to promote families' economic self-sufficiency by making child care more affordable; and 2. to assist States in implementing the health, safety, licensing, and registration standards. In Federal Fiscal Year 2016, Minnesota received approximately $90 million from the CCDBG. Minnesota uses these funds to help pay for child care through the Child Care Assistance Program (CCAP), Minnesota Family Investment Program child care, and initiatives to improve the quality of child care services.

Health, safety and licensing changes are now needed to meet new federal requirements and provide safer, higher quality and accessible child care. These new requirements are expected to improve the safety of all children served by Minnesota's 10,674 licensed providers and more than 680 license exempt centers. The proposed changes will increase of the safety of child care programs and increase the number of caregivers having fingerprint-based FBI checks before providing direct contact.

There are several factors that this proposal seeks to address:

1. New federal regulations will require that all CCCs be reviewed on an annual basis to determine compliance with health and safety standards. In FY16, DHS reviewed 551 CCC's – only 33% of its providers. By performing reviews of all CCCs on an annual basis, not only will DHS come into compliance with federal requirements, it will also be better equipped to monitor CCC for compliance with standards that ensure the health, safety, and integrity of CCC programs.

2. One of the largest contributors to the number of reviews performed is the number of cases per licensor – or the licensor's caseload. By decreasing this through hiring more FTEs, DHS will be able to reduce the caseload per licensor and ensure the ability to achieve an annual licensing review schedule.

3. Negative actions are taken against child care providers when providers fail to comply with existing licensing requirements. The level of the action depends on the nature, severity, and chronicity (time period during which the violation has occurred) of the violation. The new health and safety components of the above proposal will be enforced and, with increased technical assistance and improved standards across child care, will eventually result in fewer negative actions against CCC and FCC.

Proposal:

This proposal will:

1. Implement federal requirements for health, safety, integrity and licensing of child care– including staff necessary to achieve federal compliance;
2. Issue grants to counties to comply with new licensing inspection requirements set forth in the CCDBG

Implementing federal requirements for health, safety, integrity, and licensing of child care – including staff necessary to achieve federal compliance ($4.32 million in 2017, $9.86 million in 2018 and $8.90 million in 2019)

The goal of this section of the proposal is twofold: First, the changes below are intended to provide safer, higher quality, and accessible child care across the state. Second, the changes below are intended to meet federal regulations and new requirements under the CCDBG. These proposals will impact over 10,000 family and center-based child care providers throughout the state who have the capacity to care for over 225,000 children. Approximately 63% percent of child care providers and child care capacity are located in greater Minnesota.

The proposed changes include:

- Annual inspections of CCCs – including adequate DHS Licensing Division staffing to perform the licensing reviews, to train licensors, and to provide support in order to meet the new requirement that providers receiving CCAP funds be inspected annually (20.5 FTEs)
- Reducing CCC licensor caseloads to 1:75 from the current 1:175 for FY16 by hiring additional licensors within the DHS Licensing Division to ensure that inspections can occur annually as required by federal law. With current staffing, DHS licensors are unable to complete even the current standard of biennial inspections.
- Providing technical assistance for county annual inspections of FCCs and improving oversight of county licensing activities, including improving training for FCC providers and FCC licensors (11.5 FTEs)
- Web content, legal, data and policy analysis, and human support to meet the posting requirements of the CCDBG, process requests for reconsiderations, utilize new data to improve licensing activity for CCC and FCC, and hire new DHS Licensing Division staff (8 FTE in FY18, decreasing to 7 FTE in FY19 ongoing.)
- Requiring that the more than 680 LECs in Minnesota registered to receive CCAP meet basic health and safety standards, including annual monitoring reviews.
- Conducting comprehensive background studies for CCCs, FCCs and legal nonlicensed providers, including fingerprint based Federal Bureau of Investigation checks, federal sex offender registry checks, and criminal history, sex offender registry, and child abuse and neglect registry checks in Minnesota and any state a provider/staff resided in the past five years. The Department also proposes to create a new background study requirement for current LECs that will be certified. This proposal is funded through state special revenue fund, using a $40 fee collected from providers/staff. DHS will need to complete about 100,000 studies of current CCC and current legal nonlicensed, LEC, and FCC providers and new providers/staff during fiscal years 2018, 2019 and 2020. It is estimated that approximately 8,000 will require out of state checks. (8 FTEs in FY18, 9 FTE in FY19 and decreasing to 5 ongoing starting in FY20-21)
- Update health and safety requirements related to emergency preparedness, handling of bio-contaminants, allergies, administration of medication with parental consent and reinforce these with updated training requirements.
- Mandate training and qualification standards for licensors/inspectors of licensed FCC, licensed CCC, and LECs.
- Require certification of LECs that receive CCAP funds to ensure the health and safety of children under the care of these programs
- Posting on a public website of annual monitoring and inspection reports for all providers, and aggregate data on the number of deaths, serious injuries and substantiated maltreatment that occurred among all providers. This proposal also recommends $250,000 in one-time funding for modifying the Department's licensing websites to

feature more information on child care providers important to families, and finalizing the ongoing development of an electronic monitoring tool for Department of Human Service's and county licensors.

Annual Grants to Counties for Licensing Activities

Counties will continue to be responsible for licensing FCC providers but, due to the CCDBG, will now be required to conduct annual inspections, instead of once every two years. In addition, counties will be required to transmit correction orders and inspection reports relating to serious injuries, substantiated maltreatment, and deaths in licensed family child care homes. Minnesota counties license more than 9,000 FCC providers with the capacity to serve more than 105,000 children. In order to help counties meet this expanded monitoring responsibility, this proposal includes $2.4 million in ongoing annual grants to counties to help defray the cost to counties of conducting annual inspections for FCC providers.

This proposal has fiscal implications in three areas: DHS Licensing Division activities, County Licensing Grants, and DHS Background Study Division activities. The DHS Licensing Division impacts can be separated into two parts program operations and systems costs. Licensing program operations is requesting an investment of $5.19 million in FY18 and $4.23 million in FY18 ($3.37 and 4.23 million respectively after Federal Financial Participation (FFP) of 35%). Additionally, the proposal requires a $250 thousand investment in FY18-19 for Licensing Division system modifications. The proposal requests a $4.8 million investment in FY18-19 for County Grants to support annual inspections for FCC providers. The proposal also requests a $3.291 FY18-19 investment from the Special Revenue fund for Background Studies which will be offset by a $40 fee collected from providers/staff resulting in a net $0 change in the Special Revenue fund.

IT Related Proposals:

This proposal requires posting on a public website of annual monitoring and inspection reports for all providers, and aggregate data on the number of deaths, serious injuries and substantiated maltreatment that occurred among all providers. This proposal also recommends $250,000 in one-time funding for modifying the Department's licensing websites to feature more information on child care providers important to families and finalizing the ongoing development of an electronic monitoring tool for Department of Human Service's and county licensors.

Results:

The following performance measures would be used to assess the effectiveness of health, safety and licensing changes:

Name of Measure	***FY14***	***FY15***	***FY16***	***Anticipated Outcome of Proposal***
CCC providers reviewed each year	734	820	551	All CCC (1,669 as of 6/30/16)
Percentage of CCC providers reviewed each year	45%	50%	33%	Approximately 100%
Caseload per CCC licensor	171	171	175	75
CCC Licensing complaint reports	524	706	768	Fewer over time due to increased access to technical assistance
Negative actions against CCC	109	191	163	Fewer over time due to increased access to technical assistance
Negative actions against FCC	458	420	371	Fewer over time due to increased access to technical assistance
Percentage of FCC reviewed each year	Approx. 50%	Approx. 50%	Approx. 50%	Approximately 100%
LECs reviewed each year	0	0	0	All LEC (681 as of 6/30/16)

Statutory Change(s):

Minnesota Statutes, Chapters 245A and 245C will require extensive changes to implement changes to child care licensing requirements and background study requirements.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			6,001	5,151	11,152	5,151	5,151	10,302
HCAF								
Federal TANF								
Other Fund – Special Revenue			0	0	0	0	0	0
Total All Funds			6,001	5,151	11,152	5,151	5,151	10,302
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
40	11	Operations (Licensing)	5,155	4,232	9,387	4,232	4,232	8,464
GF	REV1	FFP @35% (Licensing)	(1,804)	(1,481)	(3,285)	(1,481)	(1,481)	(2,962)
GF	47	County Licensing Grants	2,400	2,400	4,800	2,400	2,400	4,800
GF	11	Systems (Licensing)	250	0	250	0	0	0
DED	EXP	Special Revenue (Background Study expenditures)	2,367	2,023	4,390	201	201	402
DED	REV	Special Revenue (Background Study revenues)	(2,367)	(2,023)	(4,390)	(201)	(201)	(402)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	11	Operations –Licensing FTEs	40	39		39	39	
DED	11	Operations – Background Study	8	9		5	5	
		Total FTEs	48	48		44	44	

Change Item Title: Improvements to Child Protection and Foster Care, and Permanency (CF40)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	3,991	15,674	22,917	26,247
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	3,991	15,674	22,917	26,247
FTEs	**7**	**7**	**13**	**13**

Recommendation:

Beginning July 1, 2017, the Governor recommends investing $19.7 million in FY2018-19 and $49.2 million in FY2020-21 to develop, implement, and monitor policy and practice to improve child protection, foster care and timely permanency outcomes for children who are not reunified with their legal guardians; to increase Northstar Care for Children benefits for children under age six; to make improvements to the federally required State Automated Child Welfare Information System (SACWIS); and to support a pilot to establish a response system to meet the specific needs of older minor youth who are homeless and without parental support.

Rationale

The Minnesota Department of Human Services supervises county-administered and tribal-administered child welfare services. Best practice standards in child protection serve as the foundation for training, technical assistance, and ultimately accountability. The Legislature made significant new investments in the child protection system in 2015 based on recommendations of the Governor's Task Force on the Protection of Children. This proposal builds on these investments by focusing on practice standards, which in Minnesota are currently minimal and fragmented. As a result, a child's experiences with child welfare, foster care or a path to permanency may be determined predominately by where they live.

A child's trajectory toward permanency begins at the point of initial removal from their home. This proposal creates the framework for a continuum of sequential activities that must occur within that placement process to safely move children toward reunification and other permanency outcomes within established timelines. It also provides the department with the capacity to monitor and meet established outcomes.

An analysis of findings from federal Child and Family Service Reviews indicate that frequent, quality caseworker visits are associated with strong performance in assessing risk and managing safety, establishing appropriate permanency goals for children, meeting children's educational, physical and mental health needs, engaging families in case planning, and achieving permanency.

For children in out-of-home placement, state statute requires monthly face-to-face caseworker visits with children with the majority occurring in children's homes. Minnesota has received fiscal sanctions for failing to meet the monthly caseworker visit requirement each year since federal requirements were implemented.

For children receiving child protection case management services while residing in their family home, Minnesota statute is currently silent on the frequency of caseworker visits with children who receive services while residing in their home. Administrative rule requires monthly contact with the family, not necessarily the children, once per month or monthly contact with a service provider who sees the family at least monthly. There is insufficient guidance for ensuring ongoing assessment of safety and overall needs of children.

For the transfer of permanent legal and physical custody, cases are routinely closed upon a transfer of permanent legal and physical custody of children to relatives. In some cases, maintaining an open case to assist relatives in accessing needed services for children would help ensure children's stability and permanency. In Minnesota more than 150 children achieve legal permanency through a transfer of custody to a relative each year. Early initiation of Concurrent Permanency Planning efforts is required to improve timeliness to permanency when reunification is ruled out.

Children who are adopted have often experienced significant abuse and neglect. While adoption addresses children's needs for permanency, there are other needs they may have as a result of the abuse and neglect. Children often require ongoing mental health or other services after adoption. Adoptive parents may not know how to access services or which services would be most appropriate to deal with children's needs.

Currently, under Northstar Care for Children, MN Section 256N, children in foster care under the age of six who move to permanency through adoption or transfer of permanent legal and physical custody to a relative experience a 50 percent decrease in benefits when they leave foster care. In 2015 there were 300 children under the age of six who experienced legal permanency under Northstar Care for Children. The majority of these children presented with extraordinary needs. The reduced permanency benefit required the families moving forward to incur out-of-pocket expenses to cover services provided in foster care. The goal of Northstar Care for Children was to equalize benefits for children in foster care and in permanency.

Included in the proposal is a pilot to provide intervention for homeless youth. On any given night in Minnesota, about one hundred young people under age 18 experience homelessness on their own, without a parent or guardian. Minors face homelessness for a variety of reasons. In most cases, there are three primary factors: Home is not safe, home is not supportive, or home does not exist. Too often, these situations involve youth facing risky and dangerous situations in securing shelter for the night, whether that means staying outdoors, sleeping in a vehicle or other place not meant for shelter, or accepting shelter from someone who may be exploiting them. With research on the critical developmental journey of adolescence, experiencing homelessness during this period can be one of life's most significant developmental challenges. Youth homelessness requires an urgent and effective response to mitigate and eliminate the harm that homelessness creates for unaccompanied minors. As Minnesota's child welfare system is undergoing reform, there is a timely need to design a distinct path, where currently there is none, for addressing the homeless youth population and how that population can best interface with the child welfare system.

Proposal

There are five distinct pieces to this proposal: 1) Improve child safety assessment, foster care and permanency practice standards; 2) Expand to full Northstar Care for Children permanency benefits for children under age six, effective February 21, 2018; 3) Increase the department's capacity to provide monitoring oversight to local county and tribal child welfare agencies in support of improved outcomes; 4) Provide funding to conform with new Federal information system requirements; and 5) Provide funding in support of a pilot initiative designed to eliminate youth homelessness in Minnesota.

1. <u>This proposal will improve child safety, case management practice, foster care, and permanency practice standards throughout Minnesota.</u> In the August 2016 the Federal Child and Family Services Review, Minnesota was required to develop a program improvement plan for 18 standards given the failure to meet federal benchmarks. Minnesota continues to fail to meet federal benchmarks related to monthly caseworker visits and foster care re-entry.

   Under the current system, the department has no capacity to offer resources to the local level, program redesign, or other measures to support improved outcomes and meet state and federal benchmarks. Federal guidance suggests these are essential services required to support continued improvement.

   Funding under this proposal will be used to hire six department program staff charged with monitoring local agency practice related to child safety assessments and adherence to state and federal guidance on practice standards when children are in foster care or when they require supports for alternative permanency through kinship or adoption. The staff will provide the monitoring and follow up when standards are not met.

   The department will develop standards with input from county and tribal partners as well as other child welfare system stakeholders. Hiring department staff would begin in July 2017 to build the department's capacity to engage in the development and implementation of practice standards. Currently, the department has three staff for foster care and one staff for adoption and kinship policy. This is insufficient to provide the needed technical assistance and monitoring

to ensure required equitable outcomes for children. This proposal also makes changes to the child protection grant allocation performance requirements.

2. Effective February 21, 2018, expand full Northstar Care for Children benefits to children under age 6 who achieve permanency through adoption or guardianship to eliminate a reduction of benefits.

3. This proposal will increase the capacity for the department to provide oversight to local, county and tribal child welfare agencies and more timely review and response when statute policy and guidance are not followed. The department currently has insufficient staff to provide monitoring for meaningful oversight of child welfare practice at the county or tribal agency level, with capacity for direct involvement when required.

   The additional six staff (in SFY 2020) will provide continuous improvement supports to local agencies following child and family service reviews, or at the request of an agency at the local level. Providing this resource where the local agency desires to improve performance, or, in keeping with state oversight, supports improved outcomes at the local level and the state overall.

4. Meet federal guidance for the development of a Comprehensive Child Welfare Information System (CCWIS). This proposal provides the resources to analyze how the current system can meet the requirements to promote data sharing with other agencies, specifically with the Minnesota Department of Education and Minnesota State Court, and provide for data exchanges to help coordinate services, eliminate redundancies, improve client outcomes, and improve data quality.

   In Minnesota, the SACWIS approved system is the Social Service Information System (SSIS). The Administration of Children and Families (ACF) has issued new guidance for states to move to a new Comprehensive Child Welfare Information System (CCWIS). Funding will be used to analyze and plan how the department can conform to federal guidance. This will support improved monitoring of children in foster care meeting statutory guidelines related to mandated progress in review hearings, timeliness to permanency, education performance, special education service needs, and monitoring whether those crucial education services are met.

5. Pilot Initiative Serving Homeless Youth. Through a partnership among state government, county and tribal human services, child welfare agencies, and nonprofit agencies serving youth, this proposal will pilot a coordinated response system for older minor homeless youth. The current array of service options lacks the capacity or the tools sufficient to meet the youth's needs. Under this proposal funding will be used to hire one person to provide oversight of the program at the department, and one to provide the navigator services at the local level when contacted by a local social service agency concerning a need for youth homeless services. The navigator is a broker of services to reunify youth with parents, provide arrangements for temporary housing services, and coordinate other services designed to stabilize youth. The navigator of services approach is similar to the use of a navigator in the Safe Harbor initiative in place since 2014. While the difference is that the Safe Harbor initiative provides services specifically to youth who are or at risk of being sexually exploited, this proposal serves the broader homeless youth population that is not currently served.

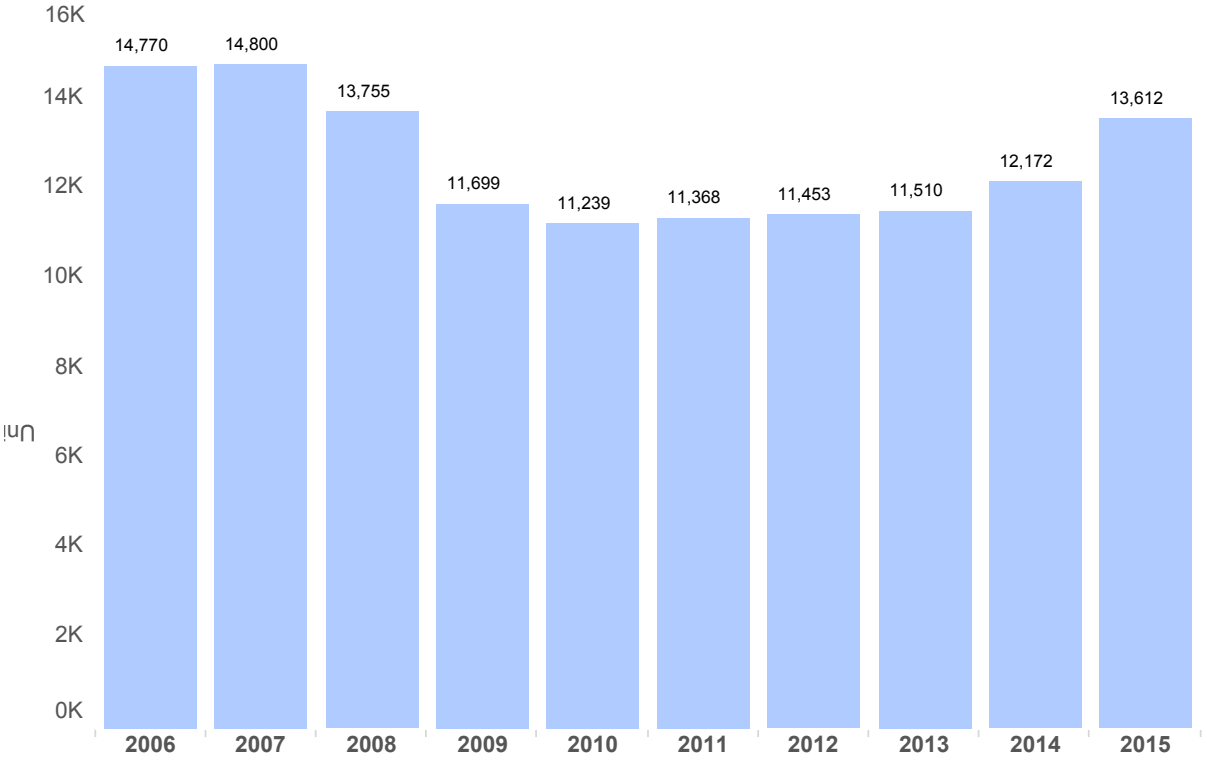
   This pilot proposal would provide resources to participating county or tribal child welfare agencies to ensure that when a young person whose situation does not trigger a formal child protective response, but whose homelessness creates the potential for significant harm and risk to the young person, the child welfare agency can offer a specific response attuned to the needs of older homeless minors. A navigator serves as a broker of services available to homeless youth with the goal of stabilizing them. These services minimally include an individualized assessment of the youth's needs, efforts to connect and reunify the youth with parents, and housing options and connections with services designed to stabilize them. Under this program reports involving homeless youth that do not meet criteria for formal child protective services are forwarded to a navigator who will engage homeless youth in an array of services designed to stabilize and support them in transition to adulthood. Efforts to locate parents or legal caregivers to support reunification is made as a first step. There is much support at the federal level for states to develop practice approaches for this population, and this proposal is based in the initiative brought forth by the Minnesota Interagency Council on Homelessness to prevent and end homelessness for all Minnesotans through 2017.

This proposal is aligned with Opening Doors, a federal strategic plan to prevent and end homelessness with the goal of ending homelessness among all youth by 2020. It also aligns with the MN Interagency Council on Homelessness which seeks to end homelessness for all Minnesotans.

Relevant Statistics:

- In 2015, 13,612 children spent time in out-of-home care
- 41 percent of children in care were age 12 or older
- 18 percent of placement episodes ending in 2015 were one week or less, and 31 percent lasted more than one year
- 72 percent of primary reasons offered for entry into care in 2015 were related to children's parents
- On average, children who entered care in 2015 experienced 4.1 moves per 1,000 days in care. This meets the federal performance standard for the new placement stability measure.
- About 68 percent of children discharged from care in 2015 involved children returning to the caregivers with whom they resided prior to placement; another 13 percent were adopted.
- Using the federal performance measure for re-entry, in 2015, about 19 percent of all children re-entered foster care.
- American Indian children continue to have the most disparate out-of-home placement rates and are about 17 times more likely to experience out-of-home care than white children. Children who are African-American or identify as two or more races were about 3 and 5 times more likely to experience care than White children, respectively.

Children in out-of-home care, 2006-2015:



Equity and Inclusion:

Child welfare professionals and researchers have documented a pattern of disparities in the experiences and outcomes for American Indian children and families of color. For example, African-American and American Indian children are more likely than their counterparts to have an accepted report of maltreatment, be removed from their families and placed in foster care. They remain in care longer, and are less likely to exit foster care through reunification or other forms of permanency. The department remains committed to ensure American Indian children and families, and children and families of color, achieve equitable opportunities, experiences and outcomes.

In Minnesota, American Indian, African-American/Black, and children with two or more races were more likely than those of other races to be involved with the child protection system. They were 5.5, 3 and 3 times more likely than white children to be

subjects of an allegation of maltreatment, respectively. Similarly, American Indian, African-American/Black, and children of two or more races were about 17, 3 and 5 times more likely than White children to experience out-of-home care, respectively.

American Indian children were 4.3 times more likely to enter state guardianship than white children. Children of two or more races and African-American/Black children were 4.6 and 2.8 times more likely to enter guardianship than white children.

This data shows a clear disparity for children of color, and its prevalence across the continuum of child welfare in Minnesota. With the funds requested in this proposal the department will monitor, in real time, the circumstances and conditions children face as they move through the continuum of services and programs. This will include monitoring whether parents are provided with case plans in keeping with statutory guidance; whether children are properly assessed for physical and or mental health needs; whether identified needs are addressed; whether permanency planning services occur timely; and whether required court hearings are in compliance with state statute.

The department will assess whether children and their parents receive equitable services to decrease risk and safety concerns in support of reunification. Similarly the department will assess equity in the provision of services in support of alternative legal permanency. The department will establish and maintain the required level of oversight when statute, policy, or guidance is not followed in casework practice.

Expanding full Northstar Care for Children benefits to those willing to adopt or enter into kinship care for children under the age of six will support improved permanency outcomes for American Indian and children of color when the adults who would otherwise lack the financial means to provide care are entitled to the full benefit.

Funding to improve our information system in keeping with new federal requirements allows the department to monitor school performance through the connection established with the Department of Education's information system. The department will also receive improved understanding of the state's courts concerning the timeliness of required hearings and judicial dispositional determinations. This will be accomplished through the connection established with the state court information system.

The department monitors performance at the local agency level as one means to evaluate performance improvement with disparities. The current monitoring system does not allow for evaluation and follow up at the individual case level. This level of system monitoring will provide the department with a better lens to understand the dynamics associated with disparities in the child welfare system and what supports promote the best outcomes to impact this phenomenon.

Results:

Type of Measure	Name of Measure	2014	2015	Performance
Quantity: How much did we do?	• Number of victims in accepted reports	25,972 [1]	31,634 [2]	--
	• Number of children experiencing out-of-home care during period	12,172 [1]	13,612 [3]	--
Quality: How well did we do it?	• Overall timeliness to initial contact	75.7% [4]	77.5% [4]	Below Std.
	• Caseworker monthly visit percentage (increase)*	76.9% [4]	77.3% [4]	Below Std.
Results: Is anyone better off?	**Federal Performance Measures**			
	• Maltreatment recurrence (decrease)	5.1% [5]	4.9% [5]	At/Above Std.
	• Permanency rates (increase)*			
	○ Permanency: 12 months	51.5% [5]	50.5% [5]	At/Above Std.
	○ Permanency: 12-23 months	44.6% [5]	39.7% [5]	Below Std.
	○ Permanency: > 24 months	16.3% [5]	22.0% [5]	Below Std.
	• Foster care re-entry rate (decrease)**	18.0% [5]	18.6% [5]	Below Std.

Sources

1. Minnesota's Annual Child Welfare Report, 2014
2. Minnesota's Annual Child Maltreatment Report, 2015
3. Minnesota's Annual Out-of-Home Care report, 2015
4. Public Child Welfare Data Dashboard

5. Internal Child Safety and Permanency Data

Statutory Change(s):

256M.41, 256N

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			3,991	15,674	19,664	22,917	26,247	49,164
HCAF								
Federal TANF								
Other Fund								
Total All Funds			3,991	15,674	19,664	22,917	26,247	49,164
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	11	Operations (SSIS) SACWIS Changes	76	0	76	0	0	0
GF	11	Operations (SSIS) Northstar <Age 6	272	54	326	54	54	108
GF	12	Children & Families (FTEs, 7,7,13,13)	1,004	917	1,921	1,715	1,628	3,343
GF	12	Children & Families (P/T contract)	73	88	161	88	88	176
GF	REV1	FFP@35%	(377)	(352)	(729)	(631)	(601)	(1,232)
GF	26	Northstar Full Benefits < Age 6	2,943	14,967	17,909	21,691	25,078	46,769
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	12	Children & Families FTEs	7	7		13	13	

Change Item Title: Child Welfare Services for Sexually Exploited Youth (CF44)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	81	71	71	71
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	81	71	71	71
FTEs	**1**	**1**	**1**	**1**

Recommendation:

Effective July 1, 2017, the Governor recommends administrative funds to support full implementation of federal Public Law 114-22, the Justice for Victims of Trafficking Act of 2015. The net cost of this recommendation is $152,000 in fiscal years 2018-19 and $142,000 in fiscal years 2020-21.

Rationale/Background:

Public Law 114-22, the Justice for Victims of Trafficking Act of 2015, requires changes to the Child Abuse Prevention and Treatment (CAPTA) grant, including changes to the definition of sexual abuse to include all victims of sex trafficking. To comply, the definition of sexual abuse under Minnesota Statute 626.556, subdivision 2(n) was modified in the 2016 legislative session. As of May 29, 2017 a report of a sex trafficked child or youth, regardless of relationship to the offender, will be classified as a child maltreatment report of sexual abuse by local social services agencies.

The Child Safety and Permanency division staff immediately brought this information to the Screening Guidelines Work Group, a group of the Governor's Task Force for the Protection of Children. The work group developed a list of professional requirements for a sub work group to consider the new population to be added to child welfare. Individuals were identified and invited to be members of the sub-work group. The group first met in November 2015. The group ended in February 2016 after seven meetings. In the subsequent work plan, the work group strongly recommended hiring 11 staff with a background in sex trafficking, youth development, adolescent development and youth work to assist counties as they began work with this new population. The work group also strongly recommended that several staff begin work on creating an infrastructure to connect the child welfare and homeless and runaway youth systems and to develop a new service model for working with sex trafficked children and youth in child welfare. Sex trafficked children and youth tend to avoid the child welfare system due to worker inexperience and lack of knowledge regarding sex trafficking. They may approach the child welfare system in times of extreme crisis, (i.e. pregnancy), but if they do not receive the type of service they need, they return to being trafficked as a system they understand and in which they are not judged. Workers need both information and system support to take this work on.

This is the first opportunity to request legislative support for this work.

The activities funded to comply with the requirements in Public Law (P.L.) 114-22, amendments to CAPTA include the following state requirements:

1. To assure and describe in the CAPTA state plan, provisions and procedures:
   - Regarding identifying and assessing all reports involving known or suspected child sex trafficking victims (as defined in section 103(10) of the Trafficking Victims Protection Act of 2000 (TVPA) (22 U.S.C. 7102))
   - For training child protection workers about identifying, assessing and providing comprehensive services to children who are sex trafficking victims, including efforts to coordinate with state law enforcement, juvenile justice, and social service agencies such as runaway and homeless youth shelters.

2. Collecting and reporting, to the maximum extent practicable, on the number of children who are victims of sex trafficking as part of the National Child Abuse and Neglect Data System (NCANDS).
3. Consideration of any child who is identified by a state as a victim of sex trafficking or severe forms of trafficking (as defined in sections 103(9)(A) and (10) of the TVPA) as a victim of child abuse and neglect and sexual abuse. A state may, at state option, apply the trafficking portion of the definition to a person who has not attained age 24.

Recently, services for sex trafficked children and youth, not necessarily in child protection, were made available through the Safe Harbor program. In 2011 the state passed Safe Harbor legislation decriminalizing sex trafficking for children and youth under age 18. The 2016-17 legislation increased the age of decriminalization to 24 years of age. Funding for implementation of Safe Harbor services was passed in 2014 and again in 2016-17. The Safe Harbor program now offers services from 10 regional navigators and 45 shelter beds for victims of sex trafficking statewide. These locations offer specific services necessary for all sex trafficked children and youth.

Data is currently unavailable regarding the number and needs of sex trafficked children and youth in the state. Safe Harbor has completed and reported on one year of data collection. A data collection screen has been recently added in quarter three of CY 2016 to begin collecting information on children and youth that have been sexually exploited. This was completed to comply with federal legislation.

County and tribal agencies have identified and worked with sex trafficked children and youth in the past, especially in some metropolitan areas of the state, often using federal homeless and runaway youth funding. In rural Minnesota, many workers in the child welfare system have not been aware of the scope of the problem. Experts believe that sex trafficking is occurring in all areas of the state. As child welfare workers are trained in how to recognize sex trafficked children and youth, we expect to see an increase in data on the number of children and youth impacted.

Proposal:

This proposal increases the department's capacity to develop and provide guidance, oversight and coordination of a new service model for victims of sex trafficking in the child protection system, as required under new federal legislation, Public Law 114-22, effective May 29, 2017. The changes will result in a new population of sex trafficked children and youth receiving services from child protection instead of the juvenile justice system. This will require local social service agencies to open a child protection investigation, some involving non-caregiver, non-custodial cases, which is a new responsibility under this CAPTA requirement. This population of children and youth tends to be older, more independent, very vulnerable and highly traumatized. It will require a set of specialized services and an infrastructure that links the child protection system, the homeless and runaway youth system, law enforcement, county attorneys, mental health, community based agencies and Safe Harbor services.

One staff position is needed to lead the new development, implementation and maintenance of this new system of response, care, and services for children and youth who are known or suspected of being trafficked. The position will be responsible for the following activities:

- Development and implementation of a new service model for victims of sex trafficking in the child protection system
- Development of policy guidance to provide to local social service agencies, including the potential use of Title IV-E dollars
- Identification of training needs for local services agency workers and foster parents, and coordination with the Minnesota Child Welfare Training System to develop
- Construction of an infrastructure to allow child protection to link to the system of specialized services established statewide by the Safe Harbor program
- Establishment of partnerships and linkages with law enforcement, children's mental health, community based agencies, homeless and runaway youth service providers and county attorneys
- Identify and collaborate with MN.IT staff to implement necessary changes to the Social Services Information System (SSIS).

The department conducted a sex trafficking work group which consisted of diverse professionals, service providers and past victims of sex trafficking in the winter of 2015-16 to collaborate and develop a plan to respond to the new federal requirement. Department staff also led a follow-up focus group with sex trafficked youth at the Link, a non-profit organization. The new staff position would support the work defined by this workgroup.

This will result in a new response and service system for sex trafficked children and youth that provides consistent, effective services and support. Public Law 122-14 requires that this response and services begin May 29, 2017.

IT Related Proposals:

None

Results:

Identifying children and youth who are victims of sex trafficking, instead of criminalizing these youth, and providing a mix of trauma-informed, culturally relevant services to sex trafficked children and youth will allow them to heal from the trauma they have experienced. Along with a safe environment, youth development activities and experiences (including the main protective factor, a long term relationship with a caring adult) will hopefully allow children and youth to succeed long-term.

This population is new to child protection. A carefully crafted service model will need to address the unique needs of this population who is at high risk of running away and returning to sex trafficking. The workgroup formed to address this new legislation informs us that developing a new service model, including a new investigative path, is essential.

This is a new program; the program performance measures to be used are below. This reflects the collection of baseline data.

Key data components will also include increasing awareness of agency staff around recognition of sex trafficked children and youth, which will add to data accuracy. Worker skills with this population are expected to increase each year and add to the delivery of services specific to sex trafficked children and youth.

Type of Measure	***Name of Measure***
Quantity	Begin the collection of data regarding: • Number of children and youth who are sex trafficked in the state per year • Number of youth sex trafficked by non-custodial adults versus parent or other household member • Number of children and youth sex trafficked while in out-of-home placement • Number of children and youth sex trafficked before entering out-of-home placement • Number of children and youth sex trafficked after leaving out-of-home placement.
Quality	• Number of children and youth entering out-of-home placement as a result of being sex trafficked • Number of children and youth receiving appropriate level of trauma based services • Number of children and youth receiving youth development related services which help develop protective factors and lead to the critical protective factor, a long term connection with a caring, prosocial adult • Number of children and youth reunited with biological family members after being in care as a result of being sex trafficked • Number of children and youth achieving other types of permanency after being sex trafficked and receiving services.
Results	Children and youth who are sex trafficked or at risk of being sex trafficked will receive appropriate services and support that provide safety, permanency and well-being for them and their children.

Performance data will be collected in SSIS and information on these outcomes will be included in annual reporting to the legislature.

Statutory Change(s):

Changes to Minnesota Statute 626.556, subdivision 2(n) to comply with the requirements in P.L. 114-22 were made in the 2015-16 legislative session. No further statutory changes have been identified.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			81	71	152	71	71	142
HCAF								
Federal TANF								
Other Fund								
Total All Funds			81	71	152	71	71	142
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	12	Children & Families Operations	125	110	235	110	110	220
GF	REV1	FFP@35%	(44)	(39)	(83)	(39)	(39)	(78)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	12	Children & Families Operations	1	1	1	1	1	1

Change Item Title: Family Foster Care Liability Insurance (CF57)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	0	0	0	0
Revenues	(150)	(150)	(150)	(150)
Other Funds				
Expenditures	150	150	150	150
Revenues	150	150	150	150
Net Fiscal Impact = (Expenditures – Revenues)	(150)	(150)	(150)	(150)
FTEs	**0**	**0**	**0**	**0**

Recommendation:
Effective July 1, 2017, the Governor recommends that Title IV-E federal funds earned on expenditures for foster parent liability insurance be used to offset cost increases in the family foster care liability program.

Rationale/Background:
There has been an increase in the number of children removed from their homes due to abuse and neglect. Additional family foster care providers are needed to support these children in family home settings. State law (M.S 245.814) enacted in 1977 requires the Department of Human Services, within the limits of the appropriation, to purchase and provide insurance to individuals licensed as foster home providers. The original appropriation for this purpose was $122,000. The Minnesota Department of Commerce and Minnesota Joint Underwriters Association recently updated their review of past claims and determined an increase in premiums was justified. Insurance premiums for this purpose increased by over $500,000 per year.

Under current law, federal reimbursement received on these expenditures goes back to the General Fund. It is estimated that federal funds are about $150,000 per year.

Proposal:
Under this proposal, federal funds earned through Title IV-E for expenditures made by the state for premiums paid for foster parent liability insurance would be retained to offset state costs and future increases in premiums. Currently, these federal funds go back to the General Fund.

IT Related Proposals:
None

Results:
If funding is not appropriated to cover increased premiums, some families may not choose to serve as family foster care providers and take on the risk associated with serving older children and children with significant needs.

Statutory Change(s):
MS stat. 245.814: add subdivision permitting federal Title IV-E administrative funds to offset costs of premiums.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			(150)	(150)	(300)	(150)	(150)	(300)
HCAF								
Federal TANF								
Other Fund								
Total All Funds								
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	REV2	Family Foster Care Liability Insurance (Dedicate Federal Reimbursement to Insurance)	(150)	(150)	(300)	(150)	(150)	(300)
DED	REV	Dedicated Foster Care Revenue	(150)	(150)	(300)	(150)	(150)	(300)
DED	EXP	Dedicated Foster Care Expenditures	150	150	300	150	150	300
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**

Change Item Title: Child Support Paternity Adjudications to Birth Registry (CF54)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	68	83	83	83
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	68	83	83	83
FTEs	**0**	**0**	**0**	**0**

Recommendation:

The Governor recommends an investment of $68,000 in FY 2018 and $83,000 per year beginning in FY 2019 to create an automated process for reporting paternity adjudications to Minnesota's birth registry, by requiring district courts to file Certificates of Adjudication with the Minnesota Office of Vital Statistics.

Rationale/Background:

When a court determines who the father of a child is, the paternity adjudication order includes an instruction that the child's birth record be updated to include the father's name and, in some cases, the child's new last name. Currently, there is no statutory guidance on who is responsible for filing the paternity order with the Minnesota Department of Health's Office of Vital Statistics.

A small number of county child support agencies file the order with the Minnesota Department of Health and pay the $40 filing fee to update the birth record. However, most counties lack the financial resources to pay the fee, so do not file the paternity order. Some counties instruct the parents to file the order and pay the fee themselves, but not all parents receive this instruction and others fail to follow it. For parents with low incomes the filing fee may be a financial barrier.

Problems caused by the lack of a standardized process and form for updating the birth registry include:

- Inaccurate birth records, potentially creating difficulties for a child when obtaining a job, driver's license or passport. Inaccurate information regarding parentage also causes problems for courts and families when administering estates.
- Administrative time spent by Minnesota Department of Heath staff reviewing entire court orders to extract information needed to update the birth record.
- Rejection of paternity adjudication orders by the Department of Health because they do not include all information required to update the birth registry.

Child support services that are provided by the state and county child support offices are referred to as IV-D services, in reference to the title under the Social Security Act. The state oversees the federal child support program and counties provide the services.

A pilot program for filing Certificates of Adjudication in all paternity actions brought by the county child support agencies began on March 1, 2015 with Dakota, Ramsey, Stearns, Douglas, Koochiching, Beltrami, and Mille Lacs counties and all of Minnesota's tribal child support programs as participating agencies. A Certificate of Adjudication form was created that provides clear instructions and contains only the information the Department of Health needs to update birth records. It is initiated and partially completed by the county child support officer, finalized and certified by the court administrator, and filed with the Office of Vital Statistics to update the birth record to include the adjudicated father. Between March of 2015 November of 2016, 1,053 Certificates of Adjudication were accepted by the Department of Health for filing.

Feedback on the pilot project from counties and the Department of Health has been positive, and additional counties have asked to start participating.

It is important that this proposal be pursued in 2017 because:

1. The pilot project is voluntary, so not all counties are participating. The result is some families obtain updated birth records, while others do not, based entirely on which county provides the child support services.
2. Without a statute requiring that the Certificates of Adjudication be filed, the courts could decide not to file them, or the Department of Health could decide not to accept them as adequate for purposes of replacing a birth record.
3. If the court moves forward with a plan to file Certificates of Adjudication in all cases, birth records may not always be updated by the Department of Health because the filing fee may not be paid. Families and counties may assume the court's filing resulted in an update to the child's birth record when it wasn't because no fee was paid.

This proposal will impact both those cases that are served by the state child support program and those that are not. Cases not served by the state program will be covered under this proposal and paying the filing fees will be covered by DHS through a $40,000 per year appropriation. The Minnesota Department of Human Services will pay the fee to the Department of Health for each changed birth record. The majority of paternity adjudications are brought by the state child support program, so updating birth records for these cases will significantly improve the number of adjudications that result in a changed birth records. Payment of these fees is eligible for 66 percent federal financial participation.

Proposal:

Effective Jan. 1, 2018, district courts will be required to certify and file a Certificate of Adjudication with the Minnesota Department of Health's Office of Vital Records for every paternity adjudication brought by the state child support program. This requirement will help ensure that paternity adjudication cases under the state program result in an updated birth record. The Department of Health charges a $40 filing fee for replacement birth records. The Department of Human Services would pay the fee, up to the appropriation available. Cases served through the child support program are eligible for 66 percent federal financial participation. The courts would be required to create a Certificate of Adjudication that contains all information necessary to obtain a replacement birth record, and identify a case as serviced under the state program.

The intent of this proposal is to:

- Better ensure an accurate birth registry
- Provide a consistent and streamlined process for district courts to use when filing paternity adjudications with the Department of Health.

Impact on the Department of Human Services. Department staff will update policy and training documents, any informational/educational materials available to parents and work with MN.IT staff to plan for changes to PRISM. Department staff will also need to work with the Department of Health to determine how payment of the filing fees will be handled between agencies and ensure the Certificate of Adjudication form provides all necessary information.

Impact on the Department of Health. Staff at the Department of Health will likely have more adjudications to file, however, the Certificates of Adjudication will include only the information necessary to update the birth record, simplifying the review process.

Impact on the counties. County child support workers would perform the tasks required to ensure Certificates of Adjudication are properly submitted to and signed by the court in state paternity adjudication matters.

Impact on the court. The proposal requires district courts to sign and certify Certificates of Adjudication, then file them with the Department of Health.

This proposal will have a fiscal impact of $14,979 (state share) in FY 2018 and $2,996 ongoing for the changes required to PRISM. The proposal requires a general fund investment of $27,000 in FY 2018 and $54,000 per year beginning in FY 2019 to fund replacement birth record fees the department would pay each year. This is based on an estimate of an average of 3,956 IV-D paternity adjudication filings per year at a cost of $40 per filing. These expenses are eligible for 66 percent Federal Financial Participation. A general fund appropriation of $40,000 would cover costs of filing fees for cases with a paternity adjudication that are not served through the child support program.

IT Related Proposals:
This proposal will require changes to PRISM.

Results:
By creating a standardized process for filing a Certificate of Adjudication with the Department of Health to update birth records, this proposal will ensure a more accurate birth registry, eliminate the time Department of Health staff spends reading paternity orders and substantially reduce, if not eliminate, the need to reject a significant number of incorrect or incomplete paternity adjudications. The number of birth records not changed following a IV-D paternity adjudication are shown in the chart below.

Year	IV-D paternity adjudications	Birth records changed per IV-D request after paternity adjudication	IV-D paternity adjudications w/o changed birth record	Percent of paternity adjudications that did not change birth record
2013	4,678	1,940	2,738	59%
2014	3,989	1,976	2,013	50%
2015	3,200	1,759	1,441	45%
TOTAL	**11,867**	**5,675**	**6,192**	**52%**
Note: It is likely that the 2015 increase in the number of IV-D paternity adjudications that resulted in a changed birth record was due to the pilot project that began in March 2015.				

Applying the equity of the equity and inclusion data provided above to this chart indicates that of the 6,192 records that were not properly changed following a paternity adjudication, approximately 4,334 (70 percent) of those records were for a child who is from an ethnically diverse community.

The department will know this proposal has been successful when the number of birth records changed following a IV-D paternity adjudication are the same or nearly the same.

It is important to note sometimes birth records are changed by parents or their attorneys after a IV-D or non-IV-D paternity adjudication. The data above does not count those requests. The department lacks data on the annual number of non-IV cases that involve a paternity adjudication (i.e. dissolution, custody/parenting time). However the department does have data on the overall total number of birth records changed each year due to paternity adjudications.

- 2013 – 2,089
- 2014 – 2,441
- 2015 – 1,941
- **Total – 6,471**

In each of these years, there are significantly fewer total changed birth records due to paternity adjudications than there are IV-D paternity adjudications. If the courts are required to file non-IV-D paternity adjudications, the annual number of changed birth records due to adjudications will certainly exceed the total annual number of IV-D paternity cases.

Statutory Change(s):
This will require a statutory changes to Minn. Stat. §§ 144.218, 144.226, and 257.73.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			68	83	151	83	83	166
HCAF								
Federal TANF								
Other Fund								
Total All Funds			68	83	151	83	83	166
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	11	Operations (PRISM System)	15	3	18	3	3	6
GF	11	Operations (PRISM Program)	27	54	81	54	54	108
GF	12	Children & Families Operations (non-IVD MDH Fees)	40	40	80	40	40	80
GF	Rev1	FFP@35%	(14)	(14)	(28)	(14)	(14)	(28)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**

Change Item Title: Child Care Child Support Emancipation (CF55)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	55	0	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	55	0	0	0
FTEs	**0**	**0**	**0**	**0**

Recommendation:

Effective July 1, 2018, the Governor recommends that child care support obligations be automatically terminated when the youngest child to a support order turns 13 years old, unless child care assistance continues to be paid for the child, or it is otherwise specified in a court order.

Rationale/Background:

Minn. Stat. § 518A.40, subd. 4 provides that a county child support office can suspend child care support collection at the request of either party without the need for a court order. Not all parents know about the option to suspend the obligation without a court order, and the option to suspend the collection is not available to those parents who do not receive county child support services. This is problematic because:

- Many child support payers continue to pay child care support unnecessarily
- The Department does not meet its goal for right-sized orders
- It results in overpayments
- Families not receiving county child support services do not have an administrative tool to end child care support
- It creates a time consuming, complicated process for parents, child support offices, and the courts.

Unnecessary child support payments. This proposal will help eliminate unnecessary child care support payments.

By age 13, most children are no longer in need of child care. Minnesota Statute § 518A.30, subd. 7 provides child care support must be based upon actual child care expenses. This means that when child care expenses are no longer incurred, no child care support is owed. A parent who continues to pay child care support when no expenses are incurred pays more child support than appropriate for the circumstances of the case. County child support offices are currently collecting child care support from 664 payers whose youngest child is age 13 or older.

The department has no way to determine the number of cases not serviced by county child support offices in which child support payers continue to pay child care support that is not owed.

There will be cases when child care expenses should continue to be paid after a child has turned 13 years old. For example, families with special needs children or that continue to receive child care assistance, and parents who travel for work or work at night when the other parent is unavailable to provide care. Those families will need to provide for longer-term child care support in their divorce decrees, or custody and parenting time orders. In some cases, they will need to return to court to obtain a court order extending child care support. Department administrative data indicates those cases are rare.

Right-sized child support. This proposal will help ensure that child care support obligations reflect the circumstances of a case, furthering the department's goal for right-sized child support orders.

Child support ordered in an amount that falls within the payer's ability to pay and reflects the current circumstances of a case is a right-sized order. The department has a long-standing goal of encouraging policies that result in right-sized child support orders. A child support obligation is not right-sized if child care support continues to be paid when no child care costs are incurred.

Orders that are not right-sized frequently result in:

- Payment non-compliance
- Accrual of uncollectible arrears
- Inadequate support in both parental homes;
- Conflict between parents that is harmful to children.

In turn, county child support enforcement offices are unable to focus effort on cases in which collection of unpaid child support is more likely to succeed.

Child support overpayments. This proposal will reduce overpayments incurred due to unnecessary payment of child care support.

An overpayment to the child support recipient results from payment of child care support that is not owed. An overpayment is a debt that the child support recipient owes to the child support payer. Because child care support is based on actual expenses incurred, Minnesota Statute § 518A.30 allows the court to modify child care support as of the date when child care expenses were reduced or eliminated. Overpayments are problematic for child support payers, child support recipients and their children for a number of reasons.

- Overpayments can accumulate for months or years before they are discovered, creating significant debt owed by the child support recipient to the child support payer.
- Minnesota Statute § 518A.52 allows the public authority to withhold 20 percent of a child support payment and return it to the child support payer as reimbursement for any child support overpayment. The 20 percent reduction in support continues until the overpayment is paid in full, the court orders a different payback amount or method, or the child support order ends. For many families, a 20 percent reduction in child support limits the ability of the parent receiving the support to provide for basic necessities in the child's home.
- Child support overpayments and child support arrears are enforced differently, which has led to frustration for some child support payers owed money by the recipient. For example:
    - Overpayments owed to the child support payer are not charged interest, but arrears owed to the child support recipient are subject to interest
    - The ability of a county child support office to return a portion of child support payments to the payer as reimbursement for any overpayment ends when the support order ends, and the child support payer must find another method for collecting the debt owed by the recipient. In contrast, arrears owed to the child support recipient can be collected by a county child support office for many years after the child has emancipated.

Currently, there are 1,918 IV-D child support cases with overpayments owed by child support recipients to child support payers. The total amount of overpayments owed is $1,516,294. Not all of the overpayments are due to payment of child care support paid when not owed. However, the department anticipates the number and amount of overpayments owed to child support payers will decrease because there will be fewer cases in which child care support is paid when not owed.

Unnecessary court intervention. This proposal is anticipated to reduce the number of cases brought to court to modify child care support.

The option to suspend collection of child care support is not available to parents who do not utilize county child support services. In those cases, parents have two options:

- Submit an agreement to the court modifying child care support
- Bring a motion to modify child support.

Some parents, particularly high conflict parents, will not be able to reach an agreement to modify child care support. Going to court is an expensive and time consuming process that can increase parental conflict that is harmful to children. It also unnecessarily adds work to an already overburdened court system. For some child care support payers, that financial cost and risk of conflict that comes with litigation are too high to seek court assistance in terminating a child care support obligation when appropriate. Instead, those parents continue to pay child care support they do not owe, creating overpayments as they do. Unfortunately, there is no data counting the number of cases brought to court to modify child care support.

Streamlined child care support collection. Automatic termination of child care support will eliminate the need for the child care support payer to make a request. It will also eliminate the need for the county child support office to contact the parent receiving support and to manually suspend the child care support obligation.

Suspension of a child care support obligation is a complex, labor intensive process for county child support offices. To suspend child care support collection administratively, one of the parents will contact the county child support office. Child support office staff then contacts the child support recipient to ask if child care expenses are still being paid. If the recipient informs the county child support office that child care support should not be suspended, verbally or in writing, the county will continue to collect child care support. If parents disagree about whether such expenses exist they can resolve their dispute in court. This proposal will not eliminate the ability of parents to use the suspension process for children under age 13.

Proposal:

Effective July 1, 2018, this proposal would result in the automatic termination of child care support obligations when the parties' youngest child turns 13, unless a different age or triggering event is stated in a court order or the family continues to receive child care assistance for the 13-year-old child. If an order calculates child care support on a per-child basis, each child's child care support obligation would end when that child turns 13.

This proposal is intended to:

- Reduce the number of child support payers who pay child care support unnecessarily
- Support the Department's goal of seeking "right-sized" child support orders
- Decrease debts owed by child support recipients to child support payers (overpayments)
- Lessen reliance on the court system to terminate child care support
- Simplify the process of terminating child care support obligations for parents, counties and courts.

Department staff will need to update policy and training documents, any informational/educational materials available to parents, and work with MN.IT staff to plan for changes to PRISM, Minnesota's automated child support system.

This proposal requires a one-time investment of $154,366 (state share of $55,000) for programming changes to PRISM, the state child support computer system, necessary for implementation and a one-time cost for the postage required to provide notice of the change in the law to all current child care support recipients and payers with child support orders enforced by county child support offices.

IT Related Proposals:

This proposal will require changes to PRISM.

Results:

This proposal should make child care support payers, child care recipients and their children better off because:

- Right-sized child support obligations are more likely to be paid in full
- Right-sized child support obligations will better ensure children have adequate support in both parental homes
- Fewer overpayments will result in fewer child support recipients receiving reduced monthly child support
- Less litigation will be required to terminate child care support when a child no longer receives care.

Success will be measured by:

- A significant reduction in cases when child care support is collected when the youngest child is age 13 or over
- A reduction in the number of cases and balance of overpayment debt owed to child support payers.

It is anticipated that the reduction of cases when child care support is collected for children age 13 or over will begin to occur almost immediately after implementation. The reduction in number and amount of overpayments will take more time to see in department data.

Statutory Change(s):

The results of this proposal are not able to be achieved through an administrative process. Amendments to Minn. Stat. §§ 518.68 and 518A.40 are required.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			55	0	55	0	0	0
HCAF								
Federal TANF								
Other Fund								
Total All Funds			55	0	55	0	0	0
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	11	Operations (PRISM)	55	0	55	0	0	0
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**

Change Item Title: American Indian Child Welfare Expansion (CF41)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	866	0	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	866	0	0	0
FTEs	**1**	**0**	**0**	**0**

Recommendation:

Effective July 1, 2017, the Governor recommends investing $866,000 in fiscal year 2018 for an additional year of planning for expansion of the American Indian Child Welfare Initiative to the Mille Lacs Band of Ojibwe and the Red Lake Nation to support tribal delivery of child welfare services to American Indian children and families.

Rationale/Background:

The American Indian Child Welfare Initiative is a collaboration among tribal, county and state governments with the shared goal of improving child welfare outcomes for American Indian children, and reducing the disproportionate number of American Indian children in the state's child welfare system. Expanding the initiative supports tribal sovereignty by building tribal capacity to serve their families in a way that is culturally relevant.

When compared to white children, American Indian children experience a higher rate of involvement in the child welfare system. Despite efforts to reduce disparities, the problem continues. According to 2014 child welfare data, American Indian children:

- Have the highest rates of contact with Minnesota's child protection system
- Are 5.5 times more likely to be reported as abused or neglected than white children
- Are 17.5 times more likely to be placed in foster care than white children. The number has been increasing each year.

Recent data from Minnesota health care programs show American Indian infants and women are being impacted at alarming rates for neonatal exposure and dependency on opiates.

- American Indian infants are 7.4 times more likely than non-Hispanic white children to be born with Neonatal Abstinence Syndrome, as a result of exposure to addictive illegal or prescription drugs during pregnancy.
- American Indian women are 8.7 times more likely to be diagnosed with maternal opiate dependency or abuse during pregnancy than non-Hispanic white women.
- 80 percent of opiate-affected children born in Minnesota are Medicaid recipients.

Proposal:

This proposal provides funding for an additional year of planning for the Mille Lacs Band of Ojibwe and the Red Lake Nation to prepare for participation in the American Indian Child Welfare Initiative. The tribes will work closely with the Minnesota Department of Human Services to define the scope of the program, conduct analysis of complex legal, program and financial issues, find mutually agreed upon solutions, and assess and identify areas for capacity building. Planning will include the development of a legislative proposal to fund the transfer of child welfare responsibilities from counties to tribes.

Partners include the Mille Lacs Band of Ojibwe and the Red Lake Nation, as well as Aitkin, Beltrami, Clearwater, Crow Wing, Kanabec, Mille Lacs, Morrison and Pine counties. This transition will improve child safety, permanency and well-being outcomes

for American Indian children through a tribal child welfare delivery system. The proposed funding is to prepare for the transfer of child welfare cases for American Indian children who are eligible from Aitkin, Crow Wing, Kanabec, Mille Lacs, Morrison and Pine counties to the Mille Lacs Band of Ojibwe and the transfer of child welfare cases for American Indian children, who are eligible, from Beltrami and Clearwater counties to the Red Lake Nation.

This funding will ensure continuity of staffing from the planning phase to the implementation phase for the tribes and the department.

The process will be in two phases: planning and implementation. This proposal focuses on the planning phase. The estimated time frame to complete is 24 months.

The proposal allocates new state general funds to the tribes:

- Mille Lacs Band of Ojibwe - $400,000
- Red Lake Nation - $400,000

This will be a continuation of state funding for the Mille Lacs Band of Ojibwe and the Red Lake Nation, and funding for one full-time department position. This department position is needed to assist throughout the planning phase for the initiative. This will involve coordinating work across programs and information systems within the department and with MN.IT @ DHS, as well as coordinating work with the two tribes. Department staff will have a lead role in facilitating the coordination and collaboration among the tribes and counties. This staff position will work with tribal programs to identify areas for capacity building, along with working to resolve and gain mutual understanding of the complex legal, program and financial issues involved in the transfer of child welfare cases from counties to tribes.

Other department staff will support the transition with expertise in planning, such as Title IV-E, foster care, adoption, Northstar Care for Children, child welfare training, federal relations, health care, child support and contracts.

Additional conversation is needed with the Mille Lacs Band of Ojibwe and the Red Lake Nation staff to determine the costs to implement the program. Federal reimbursements are anticipated to offset out-of-home placement and staffing costs for approximately two years after implementation.

Equity and Inclusion:

Expansion of the initiative will improve equity and reduce disparate outcomes within programs. The proposal supports the department's Framework for the Future by:

- Building new working partnerships and governance arrangements with counties and tribes to improve client services
- Lowering the disproportionate number of American Indian children in out-of-home placement.

Information Technology-related Proposals:

One-time funding for MN.IT @ DHS staff time to conduct analysis of the impact of this request on the Social Service Information System (SSIS) was appropriated in the 2016 legislative session. Costs were estimated at $100,000, of which the state share is $59,000.

Results:

Continued Expansion of the American Indian Child Welfare Initiative Anticipated Results

- Continue to use federal and state child welfare performance measures. Tribes participate in Minnesota Children and Family Services Reviews, federal Title IV-E audits and department on-site monitoring and fiscal audits.
- Data reveals promising results. The number of American Indian children needing out-of-home placement has declined by 23.5 percent. Tribal programs participating in the American Indian Child Welfare Initiative exceed statewide performance on state and federal child welfare outcome measures in the areas such as relative care, placement stability and foster care re-entry.

Foster care data

White Earth Band of Ojibwe and Leech Lake Band of Ojibwe
CY2013 – placed 221 children
CY2015 – placed 169 children
Reduction of 52 children
The combined foster care placements have been reduced by 23.5 percent from CY2013 to CY2015.

Rate of relative care – percentage of children who are in relative foster family homes or pre-adoptive homes compared to children in all family foster care or pre-adoptive homes. (Calendar Year 2015)

State standard	45% (meet or exceed the standard)
Statewide	46.8%
White Earth and Leech Lake	46.9% (comparable to statewide performance and exceed state standard)

Foster care re-entry – percentage of children who leave foster care and re-enter within 12 months. (Calendar Year 2015)

Federal standard	8.3% (meet or is below the standard)
Statewide	18.8%
White Earth and Leech Lake	2.9% (exceeds statewide performance and federal standard)

Placement stability – the rate is the number of placement moves children in out-of-home care experience per 1,000 days that children are in care. (Calendar Year 2015)

Federal standard	4.12 moves/per 1,000 days in care (meet or exceed the standard)
Statewide	4.15 moves/1,000 days in care
White Earth and Leech Lake	2 moves/1,000 days in care % (exceeds statewide performance and federal standard)

Statutory Change(s):

No statutory changes required as the commissioner has authority to enter into agreements with tribal governments. Minn. Stat. 256.01, subd, 2 (7).

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			866	0	866	0	0	0
HCAF								
Federal TANF								
Other Fund								
Total All Funds			866	0	866	0	0	0
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	12	CFS Admin (FTE 1,0,0,0)	102	0	102	0	0	0
GF	REV1	FFP@35%	(36)	0	(36)	0	0	0
GF	45	Children's Services Grants (Planning Grants)	800	0	800	0	0	0
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	12	CFS Admin	1	0	1	0	0	0

Change Item Title: White Earth Nation Child Welfare Initiative

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2020
General Fund				
Expenditures	$500	$500	$500	$500
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	$500	$500	$500	$500

Recommendation:

Effective July 1, 2017, the Governor recommends investing an additional $500,000 per year to increase funding that will assist in covering operating costs for White Earth Nation to participate in the American Indian Child Welfare Initiative (Initiative).

Rationale/Background:

Legislation in 2005 created the Initiative with the authority to transfer child protection responsibilities from Becker, Clearwater and Mahnomen counties to the White Earth Nation (Minn. Stat. 256.01, subdivision 14b). Legal and financial responsibilities were transferred from the counties to the tribe. The Initiative program serves White Earth children and families who live on the White Earth Reservation.

This proposal will provide the White Earth Nation additional state funding to help cover more of the costs of out-of-home placement for Initiative eligible children. The level of funding has not changed since 2005 and is not sufficient to cover these costs. The state appropriation has not kept up with the need.

American Indian children have the highest rates of contact with Minnesota's child protection system. They are 5.5 times more likely to be reported as abused or neglected and 16.9 times more likely to experience foster care than white children. Once in the child protection system, American Indian children are less likely to be reunified with their legal caregiver. American Indian children also experience longer stays in foster care than white children.

The American Indian Child Welfare Initiative has been successful in improving child welfare outcomes for American Indian children. From 2013 to 2015, the number of children entering foster care decreased by 23.9 percent for the White Earth Nation while statewide the number of children entering foster care increased by 13.3 percent. White Earth Nation has also exceeded statewide performance on some federal and state child welfare performance measures.

Investments made in support of a tribal child welfare delivery system mean that when American Indian children need to enter foster care, they are placed with people they know and trust. Their families receive culturally specific services, which are shown to produce improved outcomes. Tribes have expanded their child foster care licensing programs so many of their children are placed with relatives.

Proposal:

This proposal provides additional funding to the White Earth Nation to cover more of the actual costs the tribe is incurring for the provision of child protective services to Initiative eligible children living on the White Earth Reservation. The intended results of this proposal are to:

- Support tribes in providing child welfare services they know to be culturally meaningful and effective with their children and families
- Improve child safety, permanency and well-being outcomes for American Indian children served by these programs.

The current annual Initiative allocation is $2.375 million for White Earth Nation. This allocation was based on data from 2003 which no longer accurately reflects the costs to operate the Initiative.

Partners for this proposal include White Earth Nation and the department.

Equity and Inclusion:

There are significant disparities between American Indian and white children in the Minnesota child protection system. The American Indian Child Welfare Initiative has been successful in improving child welfare outcomes for American Indian children. From 2013 to 2015, the White Earth Nation program reduced the number of children placed in foster care by 23.9 percent while statewide the number of children entering foster care increased by 13.3 percent.

IT Related Proposals:

This proposal does not have IT implications.

Results:

- Continue to use federal and state child welfare performance measures. These include measures for child protection (e.g., timeliness to initial contact, absence of repeat maltreatment), out-out-home placements (e.g., rate of entry into foster care, relative care, placement stability), and adoption (e.g., timeliness to adoption). Tribes participate in Minnesota Children and Family Services Reviews, Title IV-E audits and on-site monitoring and fiscal audits conducted by the department's Internal Audits Division.
- Data reveals promising results. The number of American Indian children needing out-of-home placement has declined by 23.9 percent. Tribal programs participating in the American Indian Child Welfare Initiative exceed statewide performance on state and federal child welfare outcome measures in the areas such as relative care, placement stability and foster care re-entry.

Foster care data

White Earth Band of Ojibwe
CY2013 – placed 138 children
CY2015 – placed 105 children
Reduction of 33 children
The combined foster care placements have been reduced by 23.9 percent from CY2013 to CY2015.

Rate of relative care – percentage of children who are in relative foster family homes or pre-adoptive homes compared to children in all family foster care or pre-adoptive homes. (Calendar Year 2015)

Federal standard	45 percent (meet or exceed the standard)
Statewide	50.6 percent
White Earth Nation	59.2 percent (exceeds statewide and state standard)

Foster care re-entry – percentage of children who leave foster care and re-enter within 12 months. (Calendar Year 2015)

Federal standard	8.3 percent (meet or is below the standard)
Statewide	18.8 percent
White Earth Nation	3.2 percent (exceeds statewide performance and federal standard)

Placement stability – the rate is the number of placement moves children in out-of-home care experience per 1,000 days that children are in care. (Calendar Year 2015)

Federal Standard	4.12 moves/per 1,000 days in care (meet or exceed the standard)
Statewide	4.15 moves/1,000 days in care
White Earth Nation	2.5 moves/1,000 days in care percent (exceeds statewide performance and federal standard)

Statutory Change(s):

None

DHS Fiscal Detail for Budget Tracking

Net Impact by Fund (dollars in thousands)			FY 18	FY19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			$500	$500	$1,000	$500	$500	$1,000
HCAF								
Federal TANF								
Other Fund								
Total All Funds			$500	$500	$1,000	$500	$500	$1,000
Fund	**BACT#**	**Description**	**FY 18**	**FY19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
100	45	Children's Services Grants	$500	$500	$1,000	$500	$500	$1,000

Change Item Title: Help Me Grow

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	0	0	0
Total FTEs	**0**	**0**	**0**	**0**

*** DHS receives an annual transfer of $64,000 to support .75 FTE under this recommendation. This change item narrative is for information only.**

Recommendation:

The Governor recommends building upon the current Help Me Grow system to develop a comprehensive, statewide, coordinated system of early identification, referral and follow-up for young children and their families from birth to grade three who could benefit from the components of Help Me Grow. Expanding the current Help Me Grow system is a cross-agency effort, which includes: the Minnesota Department of Education; The Minnesota Department of Health; and the Minnesota Department of Human Services.

Children with "high needs" includes children who are:

- In poverty, highly mobile or experiencing homelessness.
- English learners.
- Demonstrating developmental delays or disabilities.
- From families experiencing mental health concerns.

Help Me Grow will work to connect children with high needs, and their families, to existing services within Minnesota's strong system of early learning and development programs. The system, built upon a model developed by the University of Connecticut Children's Hospital, includes four essential components.

1. A centralized telephone/web based access point.
2. Community outreach.
3. Health care provider outreach.
4. Data collection.

The Governor is requesting a total of $6 million from the general fund for FY 2018, FY 2019, FY 2020, and FY 2021. This funding supports maintaining and expanding the number of state staff who are focused on Help Me Grow. These maintained and new staff are housed at the Department of Education, the Department of Health, and the Department of Human Services. Funding staff at the three agencies allows a comprehensive approach to planning, entering into, and scaling to full implementation, a contract with a qualified vendor to implement this initiative to state specifications.

Rationale/Background:

Many early care and education programs exist to promote kindergarten readiness and academic success during the early elementary years. Because these programs are offered by a multitude of agencies funded by many sources it is often challenging for families to find and pay for needed services. Help Me Grow will enhance efforts to reduce or prevent the achievement gap between children with high needs and their peers by creating a navigation tool to connect children, especially those with high needs, to early intervention services.

Identifying and linking at-risk children to community-based supports as early as possible is essential to optimal child development. Families, child health providers, and other professionals often have difficulty recognizing when children show early signs of developmental delays or behavioral health issues. The Help Me Grow initiative will help to prevent the educational gaps between children with high needs and their peers by effectively connecting children most in need to existing intervention services within Minnesota's strong system of early learning and development programs.

Proposal:

This proposal, built upon meaningful collaboration across state agencies and public sectors, will expand Minnesota's existing Help Me Grow initiative to establish a more comprehensive system. When fully implemented and operational in 2018, more than 630,000 young children and their families from birth to grade three could benefit from the components of Help Me Grow which will include:

- A centralized access point (telephone, web-based, etc.) to services, staffed by highly trained early childhood specialists, who connect families to needed services and provide essential follow-up support. Computer hardware and software, used by call center personnel, will manage information on comprehensive early childhood services and supports available across Minnesota, and make and monitor referrals.
- Child health care provider outreach and education to promote the importance of periodic developmental and social emotional screening.
- A cost-effective mechanism to identify young children at risk for developmental and behavioral problems, and their linkage to community based services.
- Public awareness and outreach to providers and consumers of essential services.
- Efficient strategies for families to enroll in comprehensive services.
- An information infrastructure necessary to monitor the effectiveness and continuously improve the Help Me Grow system, including identification of gaps, barriers and lack of resources.
- The system will be implemented by non-profit entity, selected through a competitive process. 1.75 FTE will be maintained from the state's workforce to manage all aspects of the comprehensive system.

Equity and Inclusion:

The Minnesota Departments of Health, Human Services and Education hosted a Help Me Grow summit in December 2013 to obtain community feedback on whether to expand to a more comprehensive Help Me Grow model. Over 100 community stakeholders from health, human services, education, and parents participated. Through a follow-up survey, 98 percent of respondents agreed that Minnesota should pursue expanding to a more comprehensive Help Me Grow system. Since the summit a cross-agency planning team has received input from over 400 community stakeholders on how to best implement a more comprehensive system. These community stakeholders represented culturally and linguistically diverse populations, tribal nations, health care providers, education providers, human service and mental health providers, and families. Stakeholders also represented both greater Minnesota and Metro regions of the state.

Through this process recommendations have been made to ensure that Help Me Grow will be available to all Minnesota families with young children prenatal through age 8, regardless of income. Help Me Grow staff will provide targeted outreach to Minnesota's vulnerable populations to ensure timely connection and follow-up is made to community-based services. As a result, identifying and linking children to community-based supports as early as possible will support optimal child development thus resulting in children who enter school ready to learn.

IT Related Proposals:

None

Results:

Help Me Grow data collection and analysis procedures will require the centralized access entity to report on a set of key indicators that begins with a participant's initial inquiry to Help Me Grow and concludes with follow-up on service linkage referrals. Data will then be analyzed to identify gaps, barriers and lack of resources to inform a statewide continuous quality improvement process.

Help Me Grow will utilize the Results-Based Accountability framework using these three performance measures:

- How much is Help Me Grow doing?
- How well is Help Me Grow doing?
- Is anyone better off as a result of utilizing Help Me Grow?

Help Me Grow Key Indicators:

1. Help Me Grow Demographics

a) Total number of children entered into client tracking system (unduplicated count per calendar year).
b) Total number of entries from 1a. in which caregiver agreed to Care Coordination.
c) Who initially contacted *Help Me Grow* on behalf of the child?
d) Age of child at time of initial entry (Includes prenatal as an age)?
e) Race/Ethnicity of the child?
f) How did the initial caller/entry learn about *Help Me Grow*?
g) What state does the child live in?

2. Nature of Issues

a) Number by type of issues/concerns.

3. Developmental Screening

a) Total number of children who received screening using an evidence based tool through *Help. Me Grow** (unduplicated count of each child regardless of number of screenings and screening tools).

4. Referrals by Help Me Grow to Services/Programs (provide ranking and total number of entries for each)

a) Top five types of services/programs to which referrals were made.
b) Top five service/program gaps (service/program gap means a service/program does not exist to address the need).
c) Top five barriers that keep children from receiving a service/program that does exist.

5. Help Me Grow Outcomes

a) Total number of children successfully connected to at least one service.
b) Total number of children referred for services and are pending the start date.

Change Item Title: Reinvesting County Share in Community Mental Health Infrastructure (CS-93)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	3,000	2,981	2,981	2,981
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	3,000	2,981	2,981	2,981
FTEs	**2.0**	**2.0**	**2.0**	**2.0**

Recommendation:

Effective July 1, 2017, the Governor recommends providing grant funding to counties to build and expand community-based mental health infrastructure to support people with serious mental illnesses to live in the community and to avoid unnecessary placement in state-operated facilities.

Background/Rationale

When an individual is receiving care at Anoka Metro Regional Treatment Center (AMRTC), a Community-Behavioral Health Hospital (CBHH), or the residential competency restoration program (CRP) and no longer requires the level of care these programs provide, counties are responsible for 100 percent of the cost.

While the recent increases in county shares have facilitated more proactive discharge planning on the part of counties, they have also created significant financial pressure on county budgets and highlighted barriers related to finding community placements for people once they no longer need care at a state-operated facility. Currently, all of the revenue collected from counties for cost-of-care goes back into the state's General Fund, where it supports the entire range of state-funded priorities rather than specifically helping to address the underlying issues leading people to stay in state operated facilities when they don't need that level of care.

Last year, the Governor created a "Task Force on Mental Health" to develop comprehensive recommendations for improving Minnesota's mental health system. The task force included representatives of individuals and families with lived experience of mental illness, mental health advocates, mental health service providers, counties, courts, law enforcement, corrections, public health, human services, education, housing, and legislators. They met seven times between July and November 2016 and formed teams of subject matter experts to craft their recommendations.

The task force developed nine overarching recommendations, including that the state "implement short-term improvements to acute care capacity and level-of-care transitions" and that DHS collaborate with stakeholders and partners to assess the impact of recent increases in county shares and consider investing in community services in order to strengthen the community-based mental health system.

Proposal:

This proposal would provide an appropriation to be used for grants to counties to invest in their local mental health infrastructure. Grant funding could be used for the following purposes:

- Building local discharge planning capacity (hiring staff, contracting with local community mental health agencies, etc.)
- Developing new intensive mental health services – Intensive Residential Treatment Services (IRTS), Residential Crisis Services (RCS), and Assertive Community Treatment (ACT) teams – to prevent people from needing care at state operated facilities and/or to facilitate timely and successful discharge from state-operated facilities.
- Developing supportive housing options for people with serious mental illnesses.

- Developing local competency restoration programming to support people involved with the criminal justice system who need mental health services but not necessarily the level of care provided in state operated facilities.

Beginning January 1, 2018 and annually thereafter, the Mental Health Division of DHS will issue an RFP open to any county or regional partnerships for one time investments to develop necessary infrastructure.

The funds will be granted based on proposals and needs. The overarching goal is to develop the community capacity statewide so people can transition through various levels of service with having minimal do not meet criteria days. $2.8 million per year will be available for these grants. This represents approximately 20% of the funding generated by charging counties 100% of the cost of care for people who do no need care a state operated facilities. As the infrastructure develops across the state the amount of county share paid should decrease which will result in fewer grans but also fewer needs.

In addition to the grants, 2 FTE will be needed to coordinate this program. The staff will facilitate collaboration with internal stakeholders such as the different teams within the Mental Health Division, Direct Care and Treatment as well as other Divisions and Administrations within DHS, and with other state agencies as needed as well as external partners and stakeholders including counties, providers, individuals served and their support systems.

Staff will work with stakeholders to further define the parameters of the project, including eligibility to receive the funds, allowable uses of the grant dollars, the grant award process, grant monitoring and evaluation of project outcomes. The project will engage in continuous improvement planning in order to be able to improve and expand the project.

The functions of the 2 FTE are as follows:

1 –Coordinator: This position will act as lead for the project, primarily responsible for stakeholder engagement and the overall design of the program. The individual will work with DHS resources to create a continuous improvement process timeline, and as recommendations are given over time, the lead will be responsible for reengaging stakeholders and changing work plans as needed.

1 – Data and contract management: This position will complete the contracts, perform contract management and data collection, and be a part of the ongoing continuous improvement team.

Results:

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	# of do not meet criteria bed days			

Statutory Change(s):

245.4661

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			3,000	2,981	5,982	2,981	2,981	5,863
HCAF								
Federal TANF								
Other Fund								
Total All Funds								
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	15	Mental Health Admin (FTEs 2, 2, 2, 2)	277	248	525	248	248	496
GF	FFP	Federal Financial Participation	(97)	(87)	(184)	(87)	(87)	(174)
GF	57	Adult MH Grants	2,820	2,820	5,640	2,820	2,820	5,640
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	15	Community Supports	2	2		2	2	

Change Item Title: Substance Use Disorder Continuum of Care Redesign (CS-78)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	150	(1,209)	(804)	7,986
Revenues	0	0	0	0
Other Funds				
Expenditures	276	377	362	362
Revenues	0	164	339	1,267
Net Fiscal Impact = (Expenditures – Revenues)	426	(995)	(781)	7,081
FTEs	**2**	**3**	**3**	**3**

Recommendation:

The Governor recommends transforming Minnesota's substance use disorder (SUD) treatment system from an acute, episodic-based system to a modern, client-centered, and equitable model of care with an emphasis on longitudinal care for a chronic disease. This proposal enables the state to more effectively respond to current substance abuse trends, such as the opioid epidemic. The proposal establishes a streamlined, client-centered process for accessing SUD services; adds new services to the state's continuum of care, and lays the foundation for further reform in the future. This proposal also reduces the general fund cost for the Consolidated Chemical Dependency Treatment Fund by $1.2 million in the FY 18-19 biennium. It increases general fund spending by $7.2 million in the FY 20-21 biennium.

Rationale/Background:

Approximately one in ten Minnesotans meet the criteria for substance use disorders, but only about 10% of those who need treatment receive it in each given year. Data from Minnesota show that most of those who enter treatment complete it and show considerable improvement in outcomes related to housing, employment, use of substances, criminal behavior, and participation in self-help groups. Studies in Minnesota that follow people after treatment show that abstinence and other benefits tend to persist and that most people remain out of treatment in the year following discharge.

Publically funded SUD services in Minnesota are financed through the Consolidated Chemical Dependency Treatment Fund (CCDTF). The CCDTF combines several funding sources – Medical Assistance (MA), state appropriations, county funds and Federal Substance Abuse Block grant funding - into a single fund with a common set of eligibility criteria. The CCDTF pays for treatment services for people on fee-for-service MA and people who do not have insurance coverage but who meet the income guidelines for MA. Services for people on an MA managed care plan or MinnesotaCare, are not paid for through the CCDTF. The CCDTF also pays the room and board costs for residential treatment, including for individuals on an MA managed care plan or MinnesotaCare. Since 1988, counties have had a financial share of the treatment paid for through Minnesota's Consolidated Chemical Dependency Treatment Fund (CCDTF).

The current process to accessing SUD treatment requires a person to get a "Rule 25" assessment from a placing authority who is responsible for assessing eligible for services and the appropriate level of care. Counties and tribes serve as placing authorities for people on fee-for-service Medical Assistance (MA) or who lack insurance coverage and managed care organizations serve as the placing authority for people enrolled in an MA managed care plan. After a request for assessment is made, the placing authority has up to 30 days to complete the assessment and authorize services. Once approved, an individual may have additional wait time depending on availability in a treatment program. The current process results in unnecessary delays and invites other barriers to access.

In 2012, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) completed a review of Minnesota's continuum of care for individuals with substance use disorders. The review determined Minnesota's current process for accessing SUD treatment creates a "bottleneck" that limits timely access to services and noted that long wait times for an assessment and authorization of services are significant deterrents to individuals seeking help.

The current process also fails to be client-centered. Following the Rule 25 assessment process, the placing authority selects the specific treatment program that a client will receive services from. This process has required a waiver from the Centers for Medicaid and Medicare Services (CMS) that must be reviewed on an on-going based. CMS recently expressed concern about renewing the state's waiver of client choice and cited many of the same concerns noted by SAMHSA in 2013. CMS's most recent approval of the state's client choice waiver was approved following the state's assurances that the barriers and delays to client access in the current process would be addressed.

Minnesota also has a pressing need to build a continuum of detoxification services for people experiencing acute intoxication or withdrawal from drugs and alcohol. Detoxification in facilities other than hospitals is not a Medical Assistance benefit. Services provided in detoxification centers are mostly funded by counties, which are statutorily mandated to pay for services but receive no state or federal funding to cover those costs. Some counties struggle to pay for detox services. Facilities are closing, creating huge service gaps across the state. Since 2012, the number of detoxification programs in the state has decreased from 24 to 19, and currently only 16 of these programs serve publically-funded clients. Decreased capacity has affected access and delays to needed services, increased emergency department admissions, and transportation costs. In 2007 there were 31,710 statewide detox admissions. Despite increased population and subsequent increases in demand, there were fewer statewide detox admissions in 2015 (27,999).

In response to these and other systemic barriers, the 2012 legislature directed the Department of Human Services to collaborate with counties, tribes, and other stakeholders to "develop a model of care to improve the effectiveness and efficiency of Minnesota's current service continuum for chemically dependent individuals". The resulting legislative report, Minnesota's *Model of Care for Substance Use Disorder,* recommended a transformation of our state's SUD treatment system from an acute, episodic model of treatment to a longitudinal model of care for a chronic disease.

The report recommendations included replacing the current "placing authority" process with a streamlined process that would allow direct access to substance use disorder services through a comprehensive assessment completed by a substance use disorder provider, who would make a clinical placement and approval of treatment services based on the comprehensive assessment. The report also recommended adding a more comprehensive set of SUD services to the state's Medical Assistance benefit set as well as permitting direct reimbursement for appropriately credentialed and enrolled treatment professionals (currently only programs are eligible vendors). Finally, the report recommended reimbursement of telehealth SUD services, when appropriate. A pilot project testing this model has been operating in Red Lake Nation and White Earth Nation since late 2014, and pilot participants are experiencing decreased wait times for accessing treatment

In 2015, the legislature approved a Governor's initiative to allow SUD services by telemedicine as well as licensing standards for two new levels of detoxification services, known as withdrawal management. Enactment of these new standards laid the foundation for implementation of enhanced detoxification services designed to respond to higher acuity needs than are addressed in the current detox model. The language directed the DHS to develop a funding methodology for implementing the new withdrawal management services and seek legislative approval of the methodology prior to implementation.

In 2016, the legislature and Governor reiterated support and expectation for reform of the state's SUD continuum of care by enacting legislation directing DHS to design a SUD treatment system reform package that includes a direct access process, direct reimbursement, the addition of new services such as care coordination and peer support services, and implementation of withdrawal management.

The legislation also directed DHS to look at options for mitigating the impact of the Federal "institution for mental disease" rule. CMS is requiring Minnesota to designate certain residential SUD treatment programs as institutions for mental disease (IMDs). Programs that are determined to be IMDs will no longer be able to receive federal Medicaid funding. DHS determined more than 30 facilities as IMDs in December 2015 because they were standalone residential treatment facilities with more than 16 beds. DHS is awaiting final approval from CMS on a methodology to assess additional programs that may also be IMDs. While this loss of federal funding does not impact payment to providers, it has and will continue to result in substantial cost increases for the state as well as counties who bear a larger share of the cost when federal funding is not available.

In response to this, DHS will be applying for a federal 1115 innovation waiver that would request federal financial participation for short term stays (30 days or less) in residential treatment programs that are considered IMDs and which provide services in accordance with American Society of Addiction Medicine (ASAM) standards. CMS has indicated that such a waiver could only

be granted in the context of broader transformation of the state's SUD treatment continuum. This proposal lays the foundation for that transformation. However, any waiver would be at the discretion of CMS and would not fully address the fiscal impact of the IMD rule. Additionally, the waiver must be budget neutral to the federal government. As such, additional work is needed to develop models of residential substance use disorder treatment that will not be IMDs and which will also be financially sustainable for providers and to support programs to transition in order to mitigate the long term impact of the IMD rule on state and county budgets.

Proposal:

This proposal reforms and transforms Minnesota's SUD care system and access process. The reform will redesign and modernize the state's SUD treatment system by making the following changes:

Direct Access

The current process for publically-funded individuals to access treatment requires a Rule 25 assessment from a placing authority, i.e. county, tribe or MCO. Once a request for assessment is made, the placing authority has up to 30 days to complete the assessment and authorize services. Once approved, an individual may have additional wait time depending on bed availability and program space. The current process allows unnecessary delays and invites other barriers to access, and is not client-centered because it is the placing authority that chooses the provider, not the client. In addition, counties pay a financial share of the treatment provided.

This proposal would streamline the process for accessing SUD treatment by permitting an individual to go directly to a service provider to receive an assessment for SUD treatment services. The assessor will still determine the need, intensity and duration of services, but the choice of provider will be with the client. Placements will be subject to utilization review to measure for appropriateness of level and duration of care recommended. The comprehensive assessment would serve the dual purpose of determining a person's needed level of care and informing the development of a treatment plan, which under the current system is accomplished with two separate assessments, one by the placing authority for placement, and then another assessment for treatment planning purposes completed by the provider upon starting treatment.

The proposed process is currently being tested at two pilot sites and is demonstrating reduced wait times, improved efficiency and increased client choice. The current "placing authority" process is permitted only under federal waiver authority from CMS. The Department has been in ongoing conversations with CMS concerning the deficiencies in the current process and the need to align with CMS expectations for client access to Medicaid services. The most recent approval of the state's waiver relied on the state's assurances that the barriers and delays to client access in the current process would be addressed. The reformed access process is responsive to the concerns expressed by CMS. DHS will work with CMS to ensure a smooth transition from the current to the proposed process so as not to disrupt access to care.

This proposal will allow clients to access services without county or tribal Rule 25 assessment or placement referral, which results in a significant shift in process for state residents. In the absence of the current Rule 25 process county social service agencies, tribes, courts, county probation and correction offices will need to prepare to assist clients in finding a treatment provider to do the clinical assessment and determination of treatment need. Treatment service providers will need to assess and adapt to the market changes likely to result when county and tribal agencies no longer directing client placements.

Enhancing Detoxification/Withdrawal Management Services

Currently, Minnesota relies on a non-medical/social service model that is not eligible for federal Medicaid reimbursement. This proposal would add two new levels of detoxification/withdrawal management services, "clinically managed" and "medically monitored", to Minnesota's SUD benefit set, including under Medical Assistance and MinnesotaCare.

Clinically Managed withdrawal management services include an initial health assessment and 24 hour medical evaluation and consultation with a licensed practical nurse, and availability to access 24 hour emergency consult with a medical director or delegated licensed practitioner.

Medically Monitored withdrawal management services include an initial health assessment and 24 hour medical evaluation and consultation with a registered nurse, and meeting with a medical director or delegated licensed practitioner within 24 hours of admission – or sooner if medically necessary, and availability of the medical director or delegated licensed practitioner to provide on-site monitoring seven days a week.

During the 2015 session, licensing standards for these two new levels withdrawal management services were enacted. This proposal would establish a rate methodology and provide the state funding necessary to implement these new services as Medical Assistance benefits. These enhanced detoxification services are intended to be an improvement over the current model of detoxification services in Minnesota by addressing clinical issues, more proactively engaging clients, and supporting transition to other needed services.

Peer Recovery Support Services

Peer recovery support services are provided by an individual in long-term recovery who has been trained to help support a person with substance use disorder. Currently in Minnesota peer support services for SUD are grant funded when provided. This proposal would add these services to Minnesota's SUD benefit set, including under Medical Assistance. Licensed SUD treatment programs, withdrawal management programs, and recovery community organizations (who currently provide grant funded peer services), would all be eligible providers.

Peer support services are client-centered and include the following elements: mentoring, education, advocacy and recovery support services provided to a client in the interim following an assessment but before admission to treatment, during treatment and following discharge from a treatment program. Peer support services assist the client and help them navigate and connect to the resources that will support their recovery. The service is provided by a person who has received peer support training and is supervised by a SUD professional who understands the scope of practice of a peer specialist.

Care Coordination

Care coordination is a service intended to support a person in accessing the clinical services needed to ensure the redevelopment and restoration of the basic living skills and social skills necessary to independently function in the community. This proposal would add Care Coordination to Minnesota's SUD benefit set, including under Medical Assistance. Care coordination would be billable in 15-minute increments. Eligible vendors would include licensed SUD treatment programs, counties, and enrolled licensed individuals who are credentialed to provide SUD treatment services. It is anticipated that care coordination in the early stages of substance use disorder would decrease the number of subsequent individual treatment sessions required, and prevent symptoms from worsening.

Direct Reimbursement

Currently, publically-funded SUD treatment services can only be billed when provided within a licensed treatment center and the treatment center must be the billing provider. Individual licensed providers cannot be directly reimbursed for services. This proposal will allow appropriately-credentialed individual clinicians to bill directly for SUD treatment services. Allowing direct reimbursement will allow treatment services to be provided in primary care settings, schools, jails, etc. and will not only support more convenient access, but as well will promote the integration of SUD services with mental and physical health care systems.

IMDs, Residential Treatment and Payment Rate Reform

DHS will contract with an outside expert to create recommendations for developing treatment models and a payment structure for residential SUD treatment that will not be subject to the IMD exclusion and that will be financially sustainable for providers, while also incentivizing best practices and improved treatment outcomes. This analysis will also include recommendations and a timeline for supporting providers to transition to these new models of care delivery. A report with recommendations will be delivered to the legislature by December 15, 2018.

Beginning January 1, 2018 new or expanding SUD treatment programs that would be considered IMDs will be required to demonstrate the need for the proposed bed capacity that would make the program an IMD and that the program would be more cost-effective for the state than a non-IMD model.

Implementation Timeline

Spring/Summer 2017

- DHS submits application to CMS for 1115 demonstration waiver.

September 2017

- DHS submit proposed SPA to CMS to include comprehensive assessment, peer recovery support, and care coordination in the state's Medicaid benefit set.
- DHS issues request for proposals (RFP) for a contracted vendor to conduct the analysis on residential treatment and payment rate reform.

September 2017 – July 2018

- Provide technical assistance to programs across the state on the direct access process, comprehensive assessments, peer support services and care coordination.
- Provide trainings across the state to support and technical assistance to placing authorities, individual professionals and programs on the use of comprehensive assessments to accomplish the combined functions of service authorization and case plan development. Work with counties, health licensing boards, providers, and educational programs to support and encourage increased capacity across the state, including through the use of increased utilization of telehealth opportunities.
- Begin to provide education, technical assistance and other support to providers interested in transitioning current Rule 32/detoxification programs to the Withdrawal Management level of care.

January 1, 2018

- New and expanding programs that would be considered IMDs subject to heightened scrutiny.

July 1, 2018

- Upon approval of the SPA, begin reimbursement of comprehensive assessment, care coordination and peer support services. Continue technical assistance and begin monitoring for compliance and quality assurance.
- Begin new access process and continue technical assistance to providers while continuing to allow Rule 25 assessments to accomplish service authorizations for two years.

September 2018 – July 2019

- DHS submit proposed SPA to CMS to include withdrawal management services in the state's Medicaid benefit set.
- Continue technical assistance to programs across the state as needed on the direct access process, comprehensive assessments, peer support services and care coordination.
- Provide technical assistance to transitioning or new programs that will provide withdrawal management level of services upon CMS approval.

December 15, 2018

- DHS issues report to legislature with finding and recommendations from contracted vendor on residential treatment models and payment rate reform.

July 1, 2019

- Full implementation of direct access process completed and phase-out of the placing authority/Rule 25 access process completed.
- Withdrawal management services operational in the state and eligible for Medicaid reimbursement.

Additional Services

The state share of the costs for the new services proposed through the Substance Use Disorder reform (comprehensive assessments, care coordination, peer recovery services and withdrawal management services) will produce general fund savings of $1,440,000 in FY19, savings of $820,000 in FY20, and a cost of $7,970,000 in FY21. The investment of lower cost

upstream interventions, as compared to downstream intensive and costly interventions, will produce cost savings in the fund in the FY18-19 biennium that will help to offset the costs of the new services in the FY 20-21 biennium.

Direct access is anticipated to result in shorter wait time for treatment, which will result in not only individuals having a choice of provider location, but also the ability to choose a lower level of care than the clinical assessment indicates. Historic placement and payment trends indicate that 10,851 of placements will likely result in an assessed level of residential care. Additionally, non-residential providers outnumber residential providers across the state at a 2:1 ratio. Based on input from stakeholders that a percentage of clients will choose non-residential placement over the assessed residential service, ADAD is predicting that almost 25 percent of the 10,851 will choose non-residential (outpatient). This will result in a significant downward cost of placement that is likely to continue.

Withdrawal Management changes are expected to result in a decrease in detox re-admissions rates, decreases in clients detoxifying in jails and presenting in emergency rooms for detoxification. Care Coordination & Peer Recovery support is expected to increase workforce capacity by increasing the number of Recovery Coaches in substance use disorder and increase linkages to follow-up services which all result in a cost saving offsets. Care coordination and peer support utilization prior to, during and following treatment episodes is expected to result in decreased avoidable treatment readmissions and decreased intensity levels of many readmissions. Care Coordination and Peer Support will facilitate linkages for individuals to treatment services, where in the past, long wait times and lack of care coordination resulted in the person not following through to treatment after the initial Rule 25 assessment.

Fiscal Summary		**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**
A. Comprehensive Assessments					
Net CD Fund Cost	BACT 35		$(2,097,576)	$(2,586,316)	$(2,638,910)
MA federal share to admin. revenue	DED REV		$(86,863)	$(145,505)	$(153,598)
B. Care Coordination & Peer Recovery Support for Treatment Population					
Net CD Fund Cost	BACT 35		$657,433	$236,461	$(1,126,310)
MA federal share admin. revenue	DED REV		$(75,921)	$(33,801)	$113,973
C. Clinically Managed Withdrawal Management (Level 3.7)*					
Net CD Fund Cost	BACT 35		$ -	$ -	$4,622,454
MA federal share to admin. revenue	DED REV		$ -	$ -	$(494,309)
D. Medically Monitored Withdrawal Management (Level 3.2)*					
Net CD Fund Cost	BACT 35		$ -	$1,530,335	$7,112,571
MA federal share to admin. revenue	DED REV		$ -	$ (159,229)	$(733,041)
		FY 2018	**FY 2019**	**FY 2020**	**FY 2021**
Grand Total					
Net CD Fund Cost	BACT 35		$(1,440,143)	$(819,520)	$7,969,805
MA federal share to admin. revenue	DED REV		($162,784)	($338,535)	($1,266,975)

*the costs of Care Coordination and Peer Recovery Support for these populations are contained within these costs.

Professional Contract for Residential Treatment and Payment Rate Analysis

This proposal includes $150,000 in FY 2018 and $150,000 in FY 2019 is for a professional contract with a vendor to provide recommendations on residential treatment models and payment rate reform.

DHS Staff

This proposal will require the addition of 3 FTEs:

- One FTE for Licensing division. The addition of Withdrawal Management services will entail additional programs and compliance monitoring, which will require an additional one FTE once these services are added to the State Plan Amendment.
- One FTE in Alcohol and Drug Abuse Division for support to data collection operations and training and technical support to providers doing data entry in the state's data collection systems.
- One FTE for Alcohol and Drug Abuse Division for evaluation work.

These additional staff will be funded by the CCDTF Administrative Fund, consequently there is no additional cost to the general fund.

Systems Changes

Systems costs are included for project management, MMIS procedure and claims code changes, testing, and forms. The cost also includes a business analyst to complete the requirements and documentation. Implementation costs of $81,000 will occur in SFY 2019, with on-going annual maintenance costs of $16,000 beginning in SFY 2020.

	Hours	Total Cost	State Share @29%
Project Management/Analysis	1,716	$105,390	
Mainframe Development	500	$41,875	
CHATS/Danes	500	$41,875	
Forms changes	120	$10,050	
QA Testing	1,190	$78,707	
Total Implementation Costs– FY2019	**4,026**	**$277,897**	**$80,590**
Annual ongoing maintenance costs (FY2020 and FY2021)		**$55,579**	**$16,118**

IT Related Proposals:

MMIS work will be necessary to facilitate the direct access process for treatment service authorizations and to process claims for comprehensive assessment, care coordination and peer support services. Much of the systems work is already in development to support the ongoing work of the Model of Care pilots. However, there will be additional systems work required prior to statewide implementation and for the addition of the billing codes for withdrawal management services. Generous timelines are projected for implementation to reflect timeline uncertainties due to the unknown nature and quantity of IT projects that may exist following 2017 session and recognizing timelines will depend where the work fits overall within DHS priorities of IT projects.

Results:

Transforming our state's SUD treatment system from an acute, episodic model of treatment to a chronic disease, longitudinal model of care will lead to better outcomes. The integration and coordination of SUD services with the rest of health care will normalize the treatment of addictions to that of other chronic illnesses such as heart disease or diabetes. A person-centered, recovery-oriented system of care will identify and support the needs of each individual. Timely access and linking the service intensity to the identified need and effective duration will prevent progression of the addiction. Addressing addictions early requires less intensive and expensive services and leads to better outcomes.

This will result in more Minnesotans maintaining a higher quality of life. Most Minnesotans who enter treatment complete it and show considerable improvement in substance use, employment, housing, criminal behavior and participation in recovery support groups. Studies that follow Minnesotans after treatment show that abstinence from substance use and other benefits tend to persist, especially when clients receive additional care coordination and peer support.

The proposal, when implemented, will contribute to "turning the curve" by firstly, permitting more immediate access to services for those who request them and providing a more effective link between withdrawal management services and treatment, secondly, by supporting and nurturing those in early recovery through care coordination and peer support services for those in both "traditional" treatment programs and those receiving Medication Assisted treatment from an opioid treatment program, and thus avoiding or reducing the need for readmission to more intensive costly levels of care. This will then permit those funds to be used to support these new services.

Direct Access

- Decreased wait time from assessment to treatment

Care Coordination/Peer Recovery

- Decrease acute care readmissions
- Decrease in treatment costs
- Increase number of Certified Recovery Peer Specialists in the workforce
- Increased client satisfaction in services provided

Direct Reimbursement

- Shorter wait times for treatment.

Withdrawal Management

- Decrease in clients receiving detoxification in jails
- Decrease in clients presenting in emergency rooms for detoxification

As part of this proposal, counties, tribes, and all recognized service providers will enter detail into a newly developed system, Chemical Health Access to Treatment System (CHATS). CHATS was initially developed to monitor existing Rule 25 timelines, and has been enhanced to act as service authorization, data collection and reporting portal for the proposed service continuum. The system has been in use since March of 2015 and has been updated and refined further over the past two years. CHATS is a web-based application that requires staff training of the providers using it, but no additional costs for the providers.

The current MMIS authorization and payment system does not collect sufficient detail to clearly identify access issues, CHATs will address this gap by measuring the reasons for delay in the admission. This would include reasons such as client choice to delay start of treatment services, or lack of treatment availability (e.g. beds availability or open places in an outpatient group setting).

The proposal also includes collection of client satisfaction surveys based on the current Pilot Outcome Monitoring System (POMS) being tested in the Continuum of Care Pilots.

Statutory Change(s):

The proposal creates a new Chapter to codify and modify the existing licensing standards for programs providing Substance Use Disorder services, which are presently found in Minnesota Rules. In addition, the proposal requires changes to Chapters 254A and 254B.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			150	(1,209)	(1,059)	(804)	7,986	7,182
HCAF								
Federal TANF								
Other Fund			276	214	490	23	(905)	(882)
Total All Funds			426	(995)	(569)	(781)	7,081	6,300
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	35	Consolidated CD Treatment Fund (CCDTF)	0	(1,440)	(1,440)	(820)	7,970	7,150
DED	REV	Revenue to CCDTF Admin Acct	0	(163)	(163)	(339)	(1,267)	(1,606)
DED	15	ADAD Admin	276	377	653	362	362	725
GF	11	System changes- MMIS state share	0	81	81	16	16	32
GF	15	ADAD – Professional/Technical Contract	150	150	300	0	0	0
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
DED	15	CCDTF Admin	2	3		3	3	

Change Item Title: Redesigning Intensive Mental Health Services for Children (CS 94)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	2,694	4,051	4,078	700
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	2,694	4,051	4,078	700
FTEs	**0**	**0**	**0**	**0**

Recommendation:

Effective July 1, 2017, the Governor recommends time-limited state funding to ensure continued access to children's residential mental health treatment programs that are expected to become ineligible for federal funding due to their designation as Institutions of Mental Disease (IMD). The Governor also recommends an in-depth analysis and recommendations for how to redesign Minnesota's continuum of intensive mental health services for children and adolescents in order to ensure the well-being of children with significant mental health issues and maximize federal participation.

Rationale/Background:

This proposal is driven by both an urgent crisis and by long-term strategic planning around the continuum of intensive services for children with the serious mental health issues.

Since 2001, the Centers for Medicare and Medicaid Services (CMS) has allowed Minnesota to receive federal Medicaid matching funds on residential mental health treatment for children on Medical Assistance (MA). CMS is now requiring Minnesota to designate children's residential mental health treatment programs with over 16 beds as IMDs. Programs that are determined to be IMDs will no longer be able to receive federal Medicaid funding. CMS has given the Department of Human Services (DHS) until January 2018 to complete its review of all children's residential mental health treatment programs in the state and there are about 700 children's residential treatment beds that are in jeopardy of losing federal funding as a result of this change.

While the impending loss of federal funding has created a short-term crisis, it also presents an opportunity to reevaluate Minnesota's approach to serving children with serious mental health needs. To date, Minnesota has focused on options to continue federal participation in the current residential treatment programs. Unfortunately, those efforts have been exhausted, and at this point, the message Minnesota has been given from CMS is clear that we must change our system of care.

Minnesota has a program in place that pays for MA covered services for individuals when they are in an IMD using state-only funds". However, children's residential treatment services are not eligible to utilize this funding stream under current state law. Without a change to allow Medical Assistance to make up for the loss of federal funding for residential mental health treatment, counties would bear 100 percent of the cost for children on fee-for-service MA and there would be no mechanism to pay for services for children who receive MA through managed care.

Minnesota's current model of residential mental health treatment for children with severe emotional disturbance has limitations. Accessing residential treatment requires an out-of-home placement, either voluntary or involuntary. Children and youth may not be accepted for treatment, or may be discharged when their extreme behaviors and mental health needs exceed a facility's available staffing, resources, competencies and training, or present safety concerns for other children and staff and liability issues.

In 2015, the legislature approved children's Psychiatric Residential Treatment Facility (PRTF) services as a new MA benefit to be fully implemented by July 1, 2018. PRTFs are intended to serve children who require a more intensive level of care due to serious and complex mental health needs and other conditions. These needs and conditions include highly aggressive or self-harming behaviors, mental health diagnoses, neurodevelopmental disorders, psychosis and/or other health conditions. The first PRTF beds are expected to be available in July 2017, and will enroll providers to create capacity for 150 beds state-wide at up to six sites. These beds are intended to fill a gap in Minnesota's continuum of care by providing a psychiatric residential level of care not currently available. Although PRTFs may also be considered IMDs, PRTFs are exempt from the IMD exclusion for reimbursement using Federal Medicaid funds. Admission to a PRTF for treatment is determined based on medical necessity, and does not require children to go through an out-of-home placement process. Treatment is intended to achieve discharge at the earliest possible time in order to ensure reintegration into home, school, and community.

Many states have developed community-based alternatives to serve children and adolescent who would otherwise be served in residential treatment and/or PRTFs. Nine states participated in a 5-year demonstration program that provided home and community-based services to children as alternatives to PRTF's. These alternatives served children youth and families by offering intensive community-based care to individuals with high levels of need, who may be eligible for or at risk for requiring residential treatment. Such services may include wraparound, comprehensive service coordination or care management, respite care, clinical and therapeutic consultation, training and support for caregivers, family and youth peer support services, transition services, flex funds, and transportation.

The demonstration ended in 2012 and the final report identified the following major findings: (1) Children and youth generally maintained or improved their functioning when receiving services in the community and (2) the alternative community-based services cost about a third (32 percent) of comparable services provided in PRTFs. Several states that participated in the demonstration have continued to provide these community-based alternatives. These could be models that Minnesota could look to replicate and other states have sought federal waivers to support similar reform efforts.

Minnesota has created other new services in an effort to address the need for more intensive mental health services. An "intensive treatment services in foster care" benefit under MA intended to support children with serious mental health issues in the foster care system is currently in the beginning phase of implementation. This model could potentially be expanded to serve children with intensive needs beyond the foster care system. Further analysis is needed to explore the feasibility of this change and additional state funding and federal approval would be required. The legislature also funded a study to look at options for creating short-term residential crisis services for children that would not require an out-of-home placement for children. DHS has contracted with outside experts to conduct this analysis, which is just getting underway. Recommendations are due to DHS by June, 30 2017.

All of these efforts and initiatives lay a foundation and provide a roadmap for Minnesota to continue working towards a sustainable continuum of intensive services for children. In the short term however, Minnesota faces a serious gap in services if action is not taken to address the loss of federal funding for Minnesota's current residential treatment system while the state continues to design and implement reforms.

Proposal:

This proposal seeks to ensure children with serious mental health issues do not have their care disrupted because of the loss of federal matching funds for residential treatment while also incentivizing and providing resources to develop reforms to the state's continuum of intensive mental health services for children that will be sustainable and improve outcomes.

The proposal would modify state law to allow for state-only funded MA to replace lost federal revenue for children's residential mental health treatment in facilities that are determined to be IMDs on a time-limited basis. This provision would sunset on July 1, 2020 (State Fiscal Year 2021) and no new children's residential treatment programs with more than 16 beds will be eligible to enroll in MA during this period. This bridge funding allows the state time to thoughtfully examine how to effectively build a continuum of care that will be sustainable in the long-term.

The proposal would also provide one-time funding for a contracted vendor to support DHS in developing recommendations for creating a more sustainable and community-driven continuum of care for children with serious mental health needs, including those currently being served in residential treatment. The analysis would consist of a thorough examination of Minnesota's

current continuum, treatment models, existing data from state and national studies, as well as models from other states in order to develop recommendations for the State.

Areas of analysis would include, but not be limited to:

- Current Residential Mental Health Treatment for Children with Severe Emotional Disturbance and data related to access, utilization, efficacy and outcomes.
- Potential expansion of the state's PRTF capacity and further development of this model for treatment. This may include increasing the number of PRTF beds in Minnesota, as well as conversion of existing children mental health residential treatment programs into PRTFs.
- Analysis of the needed capacity for PRTF and other group settings within the state should adequate community-based alternatives be accessible, equitable, and effective statewide.
- Recommendations for further developing alternative community-based service models to meet the needs of children with serious mental health issues who would otherwise require residential treatment and potential service models that could be utilized, including data related to access, utilization, efficacy and outcomes.

This analysis would also be supported and informed by extensive stakeholder engagement with consumers, family members, providers, counties, health plans, advocates and others. High quality processes to take on other complex issues in this area have included interviews with key stakeholders, intentional outreach to parents and individuals, and regional listening sessions. DHS will contract with a vendor to design and facilitate a robust stakeholder engagement process and provide analysis and specific recommendations for the design and implementation of new service models, including actuarial analysis to inform rate setting as necessary

A report with specific recommendations and timelines for implementation will be delivered to the legislature by November 2018.

For children in fee-for-service MA at the time they are placed in a Rule 5 that is determined to be an IMD, the following conditions will apply:

- The child will stay in FFS
- All claims for that child will be state funded until the child is discharged from that facility
- Counties will be billed for their share of the Rule 5 treatment costs by the state
- Counties continue to pay for room and board

For children in managed care at the time they are placed in a Rule 5 that is determined to be an IMD, the following conditions will apply:

- The child will stay in managed care (unless other circumstances require them to be disenrolled)
- Capitation payments to MCOs will be paid with all state funds for any month that the child was in an IMD for more than 15 days
- Counties continue to pay for room and board

This proposal includes $125,000 in FY 2018 and $125,000 in FY 2019 for a professional contract with a vendor to develop the analysis and recommendations described above.

Results:

This proposal will ensure continued access to over 700 children's residential treatment beds. The proposal will also facilitate strategic planning to support the design and implementation of a comprehensive and sustainable continuum of intensive services for children with serious mental health issues.

Statutory Change(s):

256B.055, subd. 13

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			2,694	4,051	6,746	4,078	700	4,778
HCAF								
Federal TANF								
Other Fund								
Total All Funds								
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	33	Medical Assistance – Children & Families	2,613	3,970	6,583	4,078	700	4,778
GF	15	Mental Health Division Vendor Contact	125	125	250			
GF	REV1	FFP @ 35%	(44)	(44)	(88)			
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**

Change Item Title: Department of Human Services Operating Adjustment (15-OP40)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	16,963	30,204	30,204	30,204
Revenues	1,159	2,370	2,370	2,370
Other Funds				
Expenditures	493	950	950	950
Revenues				
Net Fiscal Impact = (Expenditures – Revenues)	16,297	28,784	28,784	28,784
FTEs	**174.82**	**306.83**	**306.83**	**306.83**

Recommendation:

Effective July 1, 2017, the Governor recommends appropriating $45.081 million in FY 2018-19 to provide an operating increase for the Department of Human Services (DHS) Central Office Operations and Direct Care and Treatment services, eliminate a structural operating shortfall in the Deaf and Hard-of-Hearing Services Division, and cover the cost of Attorney General's Office services. This increase will provide the resources DHS needs to meet anticipated compensation increases as well as other operational costs without a reduction in staffing levels.

Central Office

Rationale/Background:

Over the last ten years, the Department of Human Services has managed through periodic reductions in our administrative funding, and has absorbed administrative inflationary pressures within a set administrative funding base. An exception was in the 2015 session when agencies received an annual increase of 1.8% in FY 2016 and FY 2017 to partially offset increases for wage and benefit costs. DHS has managed these budgetary pressures through attrition and leaving positions unfilled, and by controlling other operating expenses where possible.

In the past few years our agency has also taken on significant amounts of new and complex work. This includes compliance with the Jensen settlement, nursing facility payment reform, behavioral health homes and child protection oversight. To accomplish the new work the agency needed, asked for, and received funding for new staff for the FY2016-17 biennium. We have managed the salary cost increases by delaying hiring when there is a vacancy, reducing services where possible, reducing some professional/technical contracts and by making additional reductions to non-salary administrative purchases.

The strategy of delaying hiring and reducing other spending only works in the short term. After many years of using those strategies, we no longer have excess staff capacity in our Central Office Operations. We cannot continue to absorb cost increases without negative consequences for the vulnerable Minnesotans we serve.

Central office staff carry out critical functions that are compromised by lack of adequate staffing. For example, loss of staff in the Office of the Inspector General may limit our capacity to investigate fraud and pursue overpayments from health care providers. Inadequate staffing in health care might lead to backlogs in MinnesotaCare applications, or limit our ability pursue third party payments on health care claims. In Children and Family Services, staff provide training and technical assistance to county child protection workers, critical work that is already understaffed. For an agency that serves over a million Minnesotans, many of them children and vulnerable adults, proper oversight of our programs and services is dependent on adequate staffing. Likewise, as an agency that spent over $16 billion in FY2016, oversight of funding is dependent on our staff and systems.

Proposal:

Based on SEMA4 projections, relative to FY 2017, the Department has estimated that overall compensation costs will increase by 1.76 percent in FY 2018 and 3.79 percent in FY 2019. Absent an operating adjustment, the Department would need to reduce central office FTEs by 93.84 positions in FY 2019 in order to remain within its budget.

To relieve some of the pressure on the agency's budget, this recommendation increases DHS central office administrative budget for the General Fund and Health Care Access Fund by 1.76 percent in FY 2018 and 3.79 percent in FY 2019. The Department further requests an additional 1% for future cost of living adjustments and an additional amount for pension costs. This allows DHS to cover current projected compensation costs in in the FY2018-19 biennium without reducing staffing levels.

Funding this recommendation will ensure that DHS has the resources needed to accomplish our work. It will also allow the agency to maintain the current level of commitment to our mission -- working with many partners to help people meet their basic needs so they can live in dignity and achieve their highest potential.

Central Office Operating Budget Chart (includes net fiscal impact of proposal FY 2016 to FY 2019)

DHS Central Office ($ in 000's)	FY 2017 Budget	FY 2018 Request	FY 2019 Request	FY 2020 Planning Estimate	FY 2021 Planning Estimate
Base Compensation Budget[1]	$137,219	$134,433	$134,468	$134,468	$134,468
Average Cost Per FTE[2,3]	$90,188	$91,662	$93,371	$93,371	$93,371
Average Annual Cost Increase		1.76%	3.79%	3.79%	3.79%
Operating Increase		$4,422	$8,762	$8,762	$8,762
Federal Financial Part. @35%		($1,472)	($2,906)	($2,906)	($2,906)
Net Expenditure		$2,950	$5,856	$5,856	$5,856
Number of FTEs Maintained		48.24	93.84	93.84	93.84

[1] Totals are for GF and HCAF
[2] FTEs are GF + HCAF
[3] Average cost per FTE calculated by dividing total Program 10 compensation costs by the number of FTEs.

Direct Care and Treatment

Rationale/Background:

Each year, the cost of doing business rises—employer-paid health care contributions, pension contributions, FICA and Medicare, along with other salary and compensation-related costs increase. Other operating costs, like rent and lease, fuel and utilities, and IT and legal services also grow. This cost growth puts pressure on agency operating budgets that remain flat from year to year. While DCT's appropriated programs (Mental Health Services, Forensic Services and the Minnesota Sex Offender Program) received funding for the FY2015 & FY2016 labor contract settlements, it did not receive sufficient funding for the growing insurance costs or non-discretionary step increases. In addition, DCT did not receive increased funding to cover compensation growth for the FY2018-19 biennium for the new staff funded by the 2016 Legislature.

In addition to the appropriated programs, DCT operates the Minnesota State Operated Community Services (MSOCS) and the Chemical Addition Recovery Enterprise (C.A.R.E.) programs. These programs operate within an Enterprise Fund. Enterprise services are to operate within the revenues received. Over the past 3-5 years, these programs have struggled with rates not being sufficient to cover increasing compensation costs resulting in significant operating losses. However, these programs are limited in their ability to reduce staff due to a need to maintain sufficient staffing for patient care.

Recently, DCT has seen a significant increase in the number of aggressive patient/clients admitted to our programs. This has resulted in an increased number of workplace injuries. As the State is a self-insured entity, workers compensation cost have increased with no increases in funding. Maintaining optimal staffing levels will reduce injuries to direct care staff.

Six out of every ten computers in Direct Care and Treatment (DCT) are beyond the MN.IT life expectancy. As of September 2016, nearly 60% of DCT's 2,000 laptop computers are beyond MNIT's life expectancy (older than 3 years), as well as nearly 70% of the DCT 2,000 desktop computers are beyond 4 years old. This causes significant issues with speed, capability, and maintenance of these devices, ultimately impacting on staff's ability to efficiently and effectively do their job.

As a direct care service provider personnel costs comprise over 80% of the total operating costs for DCT programs and services. When faced with costs outside its control as identified above, the only recourse DCT has is to hold positions open which in turn reduces a program's ability to serve patients and clients and maintain the safety of employees. Adequate staffing is a prerequisite of operating 24 hour health care facilities that care for vulnerable people. Understaffing in DCT means making choices between reducing the number of people we serve, providing inadequate care and/or subjecting our patients and staff to unsafe treatment environments. Reducing the number of people we serve can lead to people with critical mental health needs becoming backed up in community hospitals or jails, as well as subjecting DHS to legal challenges if we cannot provide care to people who are civilly committed to DHS. Providing inadequate or subjecting our staff or patients to unsafe environments is not an option.

Proposal:

Based on SEMA4 projections, relative to FY 2017, the Department has estimated that overall compensation costs will increase by 1.76 percent in FY 2018 and 3.79 percent in FY 2019. Absent an operating adjustment, the Department would need to reduce DCT FTEs by 243.62 in FY 2019 in order to remain within budget.

To relieve some of the pressure on the DCT budget, this recommendation increases DCT base funding for Appropriated and Enterprise services by 1.76 percent in FY 2018 and 3.79 percent in FY 2019. The Department further requests an additional 1% for future cost of living adjustments and an additional amount for pension costs. This allows DCT to cover current projected compensation costs in the FY2018-19 biennium without significantly reducing staffing levels.

This proposal also requests increased funding for workers compensation expense as well as on-going funding to replace computers on a rotating basis to align with MN.IT's desktop and laptop computer life expectancy standards.

DCT Operating Budget Chart (includes Net fiscal impact of proposal FY 2018 to FY 2021)

Direct Care and Treatment ($ in 000's)	FY 2017 Budget	FY 2018 Request	FY 2019 Request	FY 2020 Planning Estimate	FY 2021 Planning Estimate
Base Compensation Budget[1]	$375,755	$365,850	$365,850	$365,850	$365,850
Average Cost Per FTE[2,3]	$81,000	$82,361	$85,482	$85,482	$85,482
Average Annual Compensation Cost Increase		1.76%	3.79%	3.79%	3.79%
Compensation Increase		$10,178	$20,825	$20,825	$20,825
Workers Compensation Increases		$3,165	$3,165	$3,165	$3,165
Computer Replacement		$600	$600	$600	$600
Cost of Care Recoveries		($1,159)	($2,370)	($2,370)	($2,370)
Net Expenditure		$12,784	$22,237	$22,237	$22,237
Number of FTEs Maintained		123.58	243.62	243.62	243.62

[1] Totals are for GF and Enterprise Fund
[2] FTEs are GF + Enterprise Fund
[3] Average cost per FTE calculated by dividing total compensation costs by the number of FTEs

Deaf and Hard of Hearing Division

The Deaf and Hard of Hearing Division (DHHSD) is facing more than a $400,000 annual budget deficit beginning in state fiscal year 2018. This is due to a combination of budget reductions during the state's economic challenges and rising salary and operational costs. Due to lack of funding, DHHSD is unable to fill three vacant positions. This proposal will allow DHHSD to fill the direct service specialist/manager position for the central region that includes 22 counties from the eastern border of the state

to the western border. It also includes an assistant director position that oversees the five DHHSD regional offices and a part-time administrative assistant in the Metro regional office. The funding will also enable the division to lift restrictions on administrative spending that includes regional office operating costs, travel for staff visits with clients and team meetings and professional development opportunities for staff. The increase in FY 2018 is $404,000, and the net expenditure increase after factoring in federal FFP is $263,000. The increase in FY 2019 and each year thereafter is $450,000, and the net expenditure increase after factoring in federal FFP is $293,000.

Attorney General Costs

The cost of services provided by the Attorney General to the department have been increasing over time and payments from the department have not kept up. Nor has there been sufficient funding to the department to cover those costs. This proposal provides additional funding to DHS payments for increased costs of AGO services. The increase in FY 2018-19 is $1.102 million, and the net expenditure increase after factoring in federal FFP is $716,000.

Results:

This proposal is intended to allow the Department to continue to provide current levels of service and information to the public.

Statutory Change(s):

None.

Fiscal:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			15,804	27,834	43,638	27,834	27,834	55,668
HCAF			493	950	1,443	950	950	1,901
Federal TANF								
Other Fund								
Total All Funds			16,297	28,784	45,081	28,784	28,784	57,569
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	11	Ops-Admin	3,450	6,839	10,289	6,839	6,839	13,678
GF	REV1	FFP@35%	(1,511)	(2,775)	(4,286)	(2,775)	(2,775)	(5,550)
HCAF	11	Ops-Admin	758	1,462	2,220	1,462	1,462	2,924
HCAF	REV1	FFP@35%	(265)	(512)	(777)	(512)	(512)	(1,023)
GF	11	Systems	214	461	675	461	461	922
GF	11	AGO Costs	463	639	1,102	639	639	1,278
GF	15	DHHS	404	450	854	450	450	900
GF	61	MHSATS	3,792	6,597	10,389	6,597	6,597	13,194
GF	61	CARE--4101	395	797	1,192	797	797	1,594
GF	62	CBS	198	433	631	433	433	866
GF	62	MSOCS--4350	2,082	4,231	6,313	4,231	4,231	8,462
GF	63	Forensics	2,782	5,111	7,893	5,111	5,111	10,222
GF	64	MSOP	1,800	3,633	5,433	3,633	3,633	7,266
GF	65	DCT Operations	2,894	3,788	6,682	3,788	3,788	7,576
GF	REV2	Recoveries	(1,159)	(2,370)	(3,529)	(2,370)	(2,370)	(4,740)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	11	Ops-Admin	37.64	73.25	110.88	73.25	73.25	146.49
HCAF	11	Ops-Admin	8.27	15.66	23.93	15.66	15.66	31.32
GF	11	Systems	2.34	4.94	7.27	4.94	4.94	9.87
GF	15	DHHS	3.00	3.00	6.00	3.00	3.00	6.00
GF	61	MHSATS	33.61	56.34	89.95	56.34	56.34	112.67
GF	61	CARE--4101	3.50	6.81	10.31	6.81	6.81	13.61
GF	62	CBS	1.75	3.70	5.45	3.70	3.70	7.40
GF	62	MSOCS--4350	18.45	36.13	54.59	36.13	36.13	72.26
GF	63	Forensics	24.66	43.65	68.30	43.65	43.65	87.29
GF	64	MSOP	15.95	31.03	46.98	31.03	31.03	62.05
GF	65	DCT Operations	25.65	32.35	58.00	32.35	32.35	64.70
Total			174.82	306.83	481.66	306.83	306.83	613.67

Change Item Title: Systems Modernization

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	4,500	4,500	10,000	10,000
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	4,500	4,500	10,000	10,000
FTEs				

Recommendation:

The Governor recommends $4.5 million per year in fiscal years 2018-19 and $10 million beginning in fiscal year 2020 and beyond to continue efforts currently underway to modernize several major DHS technology systems. Funds will be used to support the development of an Integrated Service Delivery System (ISDS) and modernization efforts for the Medicaid Management Information System (MMIS).

Due to the size and complexity of these modernization efforts, they are anticipated to take several years to complete.

The federal Department of Health and Human Services (DHHS), Center for Medicare and Medicaid Services (CMS), currently provides up to 90 percent enhanced federal funding to support the modernization of these major systems. Once cost allocation methods are applied, the rate of federal funding received is approximately 84 percent. This investment of state resources is anticipated to leverage up to $50 million in federal funds in FY 2018-19 and $110 million in FY 2020-21.

Rationale/Background:

The majority of human services are state supervised and county (or tribal) administered. Many of the IT systems used to support the administration and delivery of critical human services programs and process health care claims are on technology that is antiquated, having been built over 20 years ago. These systems were developed over time to serve separate and specific program purposes. They are complex and maintaining them as (legal or other) program requirements change requires a significant investment in resources. Technical expertise is extremely limited, costly and difficult to find and sustain, which results in the inability to maintain the technology in the future, requiring the state to modernize the technologies whether or not federal funding is available.

Counties, tribes, providers and DHS staff struggle with the use of these antiquated technology systems resulting in significant time dedicated to working with the technology and limited time addressing the needs of the clients being served.

Integrated Service Delivery System

DHS, working in partnership with counties, has developed a vision to move to an integrated, person-centered delivery of human services. This integrated system will allow for a more holistic assessment of client needs. The current technology supporting the programs is fragmented and unable to communicate critical information between systems. In many cases, individuals have to provide the same information multiple times to different county workers in order to access programs and determine eligibility. The development of ISDS will provide an opportunity for a single entry portal and allow individuals to access services through modernized means, rather than having to go into their county offices. This capability will streamline and inform case management, while tracking individual progress toward self-sufficiency goals.

Medicaid Management Information System (MMIS)

MMIS is used to process claims and payments to providers and managed care organizations that serve well over one million of Minnesota citizens receiving health care and long-term services and supports. Each year MMIS processes over 100 million transactions, distributes close to $12 billion in payments to more than 60,000 providers, counties, tribes and managed care organizations. Due to the size and complexity of the MMIS system, these efforts to improve the experience for all Minnesota citizens who rely on a functional and efficient MMIS will take several years to implement.

The mainframe portion of the MMIS is more than 20 years old and the technology is not positioned well to meet heavy business and legislative need for change in a timely manner. It also cannot meet the requirements necessary to achieve the integrated human services delivery model and the majority of the staff that support it will retire within 5-10 years. DHS must modify the underlying technology of MMIS to meet business demand, e.g. have the ability to more quickly allow for changes to citizen services passed by the legislature.

In addition, the federal government has established an initiative called the Medicaid Information Technology Architecture (MITA). MITA's mission is to establish a national framework of technologies and processes that support improved Medicaid program administration and improve healthcare outcomes and administrative procedures for Medicaid beneficiaries. MITA benefits for the public include greater beneficiary access to quality care, greater choice and independence for beneficiaries and improved public health program integrity outcomes. All states are required to complete a MITA State Self-Assessment to show improvement and progress over time in meeting the federal requirements through modernization. If progress is not achieved, Minnesota is in jeopardy of losing federal funding on development and operational costs.

Guidance from the federal government requires states to begin modernizing and integrating human services systems. States are working to create a newer system that will allow integration across states and eventually nationally and a new MMIS Certification process (which Minnesota's current system does not meet) has been released. To comply with federal requirements such as MITA and MMIS Certification, Minnesota must work to modernize MMIS.

It's a critical time to continue the development of ISDS and pursue modernization of MMIS. Both the opportunity to leverage enhanced federal dollars (up to 90% for development work) to support these efforts and the reality that key business and technical staff will be retiring in the coming years, make it necessary that these efforts are not delayed. Over 50% of the current technical staff working on MMIS are eligible for retirement and this will grow to 90% in the next five years. DHS and MN.IT Services have already lost key technical and business knowledge and although they have been successful in replacing some of the staff, the learning curve is very high and the pool of qualified COBOL developers is expected to shrink over time. Few schools continue to teach COBOL and fewer students want to learn an outdated language.

Without system modernization the state is at risk of being unable to meet federal compliance requirements and unable to maintain the current systems due to lack of staff resources and knowledge.

Proposal:

DHS is currently working to modernize the major information technology (IT) systems that support the administration and delivery of DHS services. These statewide systems are critical to DHS, counties, tribes and other service providers in the administration of human service programs. During the planning phases for overall systems modernization, DHS and MN.IT@DHS, contracted with vendors to assist in setting a course to implement an integrated, person-centered human services system that works better for the Minnesota citizens who use it and the workers who administer it. This funding will support efforts to continue the development of ISDS and modernize MMIS.

Working in partnership with counties and other stakeholders, DHS has developed a model and vision for delivering integrated, person-centered human services. This proposal builds upon work already underway to modernize many of the major information technology systems that support the administration and delivery of DHS services. These systems are critical to DHS, counties, tribes and providers in the delivery of human service programs. DHS is working in partnership with counties, MN.IT and other stakeholders to development the new ISDS and MMIS.

ISDS will modernize, integrate and support the delivery of person-centered human services by transforming major human services legacy systems including SSIS, MAXIS, PRISM and MEC2. It will include the capacity for individuals to access and

DHS, counties, and tribes to administer programs, support document management, forms/data collection and reporting. This includes a multitude of programs including licensing, child and adult incidence reporting, child support, child and adult protection, cash assistance, supplemental nutrition assistance, child care assistance and non-modified adjusted gross income (MAGI) health care.

MN.IT@DHS will lead the development of ISDS based on the business needs identified by DHS, counties and tribes to transform the delivery of services to an integrated, person-centered approach. The funding requested will be specifically used to support the state share necessary to leverage enhanced federal funding. The system is currently anticipated to be developed over the course of the next several years with a phased approach that transitions the administration of programs from their legacy systems to the new ISDS. As programs begin to be administered through the new ISDS, the programs will be certified operational by DHHS and other federal funding agencies. The costs of ongoing system operations are not funded under the "enhanced federal funding" umbrella, but are still eligible for federal funding to support system and program operational and administrative costs.

MMIS modernization efforts have been in the planning phase for several years without the need for additional state funding. MMIS modernization received federal funding in January 2016, which allowed DHS and MN.IT@DHS to conduct more in depth planning and analysis. This included conducting an assessment of the state's alignment with MITA goals, defining the scope and phasing of the modernization work, staffing the projects for the first phase of modernization, defining the architectural foundation for the modernization; exploring software to assist in the 'decoding' of 28+ million lines of code; and examining other states' solution for parts of MMIS modernization.

The partnership between DHS, MN.IT@DHS, counties, tribes, managed care organizations and providers requires all parties to be involved in all aspects of the development of ISDS and MMIS. This includes planning, technical design and architecture, business process redesign, testing, training and communication efforts. This work will be accomplished both with existing resources (to ensure the appropriate level of subject matter expertise), with new and additional state staff and through contracted services. The results of this initiative will be not only updated and modernized technical systems for use by the counties, tribes, providers and DHS, but also a transformation of the delivery of human services to a person-centered approach in order to improve outcomes for the citizens of Minnesota

DHS received state funding in 2013 to begin development efforts for ISDS. $15.5 million of that appropriation remains available and will be used to support the state share of activities that will occur in FY 2018. In addition, DHS has absorbed the costs necessary to support the state share of $7.2 million for the planning efforts of MMIS modernization within the DHS systems account; however, as the implementation of this modernization effort moves forward the required state share is significant and DHS does not have the capacity to support it without additional state resources.

IT Related Proposals:

Due to the number of major systems that will be replaced and the business process transformation that will occur, funding will be necessary beyond FY 2021 to support both the complete development of ISDS and MMIS modernization efforts as well as ongoing operations for the systems. DHS is requesting that these funds be added to the base to cover staffing, hardware replacement, licensing and support costs as well as contractor services. Funding received through this proposal will be used to support the development of ISDS and modernize MMIS and includes DHS and MN.IT@DHS staff, contractors, county/tribal involvement, hardware, software licensing/support, travel and training costs.

Results:

The development of ISDS and modernization of MMIS will result in:

- more integrated service delivering to DHS clients resulting in a more holistic view of all services provided
- increases in DHS, county, tribal and provider efficiencies when using the systems
- streamlined on-line access to services and information
- automation of many processes that are currently manual (report generation, notifications, workflow, etc.)
- integrated technology
- comprehensive data sharing and alignment
- increases in the timeliness of service delivery

- modernized and supported technology
- decreases in county and tribal worker time utilizing outdated technology resulting in increased time for service delivery to clients
- enhance program integrity
- $12 billion in annual payments to providers, counties, tribes, and managed care organizations will be supported through modern and stable technology
- providers will be able to more easily navigate the enrollment and payment process, resulting in increased services to individuals
- data management is more robust allowing for more ability to detect/prevent fraud & prevent overpayments, and accommodate new program rules and share data amongst DHS programs
- ability to reuse technology efforts within MN and with other states
- easier access to hire qualified staff

DHS must report progress on the development of ISDS and MMIS modernization on a monthly basis to CMS. Measurements of success will include implementation of new technical systems, project completion within budget, ability to comprehensively report on client outcomes, user satisfaction and level of effort to support and maintain the new technology.

Statutory Change(s):

Currently there are no specific statutory changes necessary; however, as the work of DHS and counties moves forward there may be changes proposed that will simplify the administration of programs and reduce the complexity and cost of developing ISDS.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			4,500	4,500	9,000	10,000	10,000	20,000
HCAF								
Federal TANF								
Other Fund								
Total All Funds			4,500	4,5000	9,000	10,000	10,000	20,000
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	11	State share of systems cost (	4,500	4,500	9,000	10,000	10,000	20,000
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**

Change Item Title: Fines for Maltreatment in DHS-Licensed Facilities (OP77)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	0	0	0	0
Revenues	(45)	(45)	(45)	(45)
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	(45)	(45)	(45)	(45)
FTEs	**0**	**0**	**0**	**0**

Recommendation:

Starting July 1, 2017, the Governor recommends modifying the fines issued to license holders following determinations of maltreatment for services and programs licensed by the Department of Human Services.

Rationale/Background:

DHS completes maltreatment investigations as they relate to 9,009 licensed settings, which includes both DHS directly-licensed and monitored programs (approximately 7,875 licensed programs) and adult foster care homes (approximately 1,134 licensed programs). The Maltreatment of Minors Act (MOMA), enacted in 1975, and the Vulnerable Adults Act (VAA), enacted in 1980, are state laws meant to protect adults and children particularly vulnerable to maltreatment. Maltreatment, as described in the VAA, is abuse, neglect and/or the financial exploitation of a vulnerable adult. The MOMA characterizes maltreatment as any of the following: physical abuse, neglect, sexual abuse, or mental injury of a child. Both individuals and license holders can be found responsible for maltreatment.

An individual found responsible for serious or recurring maltreatment is disqualified for seven years under Minnesota Statutes, chapter 245C, the Human Services Background Study Act. If the individual is also a license holder, the disqualification results in revocation of the license under Minnesota Statutes, section 245A.07, subdivision 3, unless the disqualification is set aside or a variance is granted. A license holder found responsible for maltreatment is subject to appropriate licensing sanction under Minnesota Statutes, chapter 245A, the Human Services Licensing Act. Minnesota Statutes 245A.07, subdivision 3(c)(4) requires that a license holder be assessed a $1,000 fine after a determination of maltreatment of a child, as defined by MOMA, or maltreatment of a vulnerable adult, as defined by the VAA.

	FY14	FY15	FY16	FY17 (anticipated)
Maltreatment Fines Issued by DHS	86	80	51	60

Proposal:

This proposal will modify the fines for maltreatment to require a license holder to forfeit $5,000 when the commissioner determines that a determination of maltreatment meets the definition of “serious maltreatment” under Minnesota Statutes, section 245C.02, subdivision 18. Currently, the license holder must forfeit $1,000 for each determination of maltreatment. Under this proposal, a license responsible for “serious maltreatment” would be required to forfeit $5,000. Family child care programs and programs that operate out of the home of a license holder would not be subject to this requirement and fines would not exceed $1,000 per determination of maltreatment for these license holders, in recognition that fines higher than $1,000 per determination of maltreatment may be excessive for license holders with smaller operations with limited revenue. In FY16, 9 of the 51 maltreatment fines issued would have resulted in a $5,000 fine had this proposal been in place.

Fiscal Impact:

Based on FY16 data, the Department anticipates that approximately 9 maltreatment determinations per fiscal year would meet the definition of "serious maltreatment" under Minnesota Statutes 245C.02 subdivision 18 and result in a $5,000 fine. Given that fine revenues are deposited in the General Fund and assuming 9 maltreatment determinations per fiscal year would meet the statutory requirements for a $5,000 fine, this proposal would result in revenue of approximately $45,000 per fiscal year to the General Fund.

IT Related Proposals:

N/A

Results:

The proposal will result in increased fines to certain license holders that are determined responsible for maltreatment that meets the definition of "serious maltreatment." This new structure for fines may deter maltreatment in the future by imposing higher penalties on maltreatment that meets the statutory definition of "serious maltreatment."

Statutory Change(s):

Minn. Stat. 245A.07, subd. 3.

DHS/GO Specific Considerations:

Fiscal Detail

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund – Additional revenue from fines			(45)	(45)	(90)	(45)	(45)	(90)
HCAF								
Federal TANF								
Total All Funds			(45)	(45)	(90)	(45)	(45)	(90)
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
1000		Revenue from increased fines	(45)	(45)	(90)	(45)	(45)	(90)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
			0	0	0	0	0	0

Change Item Title: Maltreatment Investigations in Department of Corrections Children's Residential Facilities (OP78)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	79	68	68	68
Revenues				
Other Funds				
Expenditures				
Revenues				
Net Fiscal Impact = (Expenditures – Revenues)	79	68	68	68
FTEs	1.0	1.0	1.0	1.0

Recommendation:

Beginning July 1, 2017, the Governor Recommends investigations of maltreatment occurring in children's residential facilities licensed by the Department of Corrections be conducted by the Department of Human Services Licensing Division.

Rationale/Background:

Children's residential facilities (CRFs) are licensed providers that may operate residential care, treatment, and detention programs for children. CRFs may also hold one or more program certifications based on the services they provide. CRFs are governed by Minnesota Rules Chapter 2960. Based on an interagency agreement, CRFs may be licensed by both the Department of Human Services and the Department of Corrections, as you can see in Table 1. There are a limited number of CRFs that are jointly licensed by both departments through an interagency agreement due to a desire to provide various levels of service within one facility.

Table 1 – Active Licenses for Children's Residential Facilities

Children's Residential Facilities		
Active CRF Licenses	**Facility Type**	**114**
Dept. of Human Services	• Shelters • Transitional programs • Group Residential Facilities providing Mental Health • Chemical Dependency Treatment programs	70
Dept. of Corrections	• Detention facilities • Group residential facilities that are correctional or secure	41
Joint DHS/DOC		3
Source: LIS, number of licenses as of 9/12/16		

Under current law, counties are responsible for child maltreatment investigations in DOC-licensed programs. DHS completes maltreatment investigations as they relate to the approximately 7,875 DHS directly-licensed programs (including the 70 DHS licensed CRFs). As a result, DHS performs comparatively more maltreatment investigations in facilities than any individual county and, therefore, has comparative experience and expertise in both assessing and investigating child maltreatment in licensed facilities. In addition, DHS has experience enforcing the standards that apply to programs for children in Minnesota Rule 2960, which will allow for more consistent application of the rule and investigation of maltreatment occurring in DOC-

licensed CRFs. This proposal would utilize this experience and expertise to ensure that maltreatment alleged to have occurred in CRFs licensed by the Department of Corrections is consistently assessed and investigated.

Proposal:

Under this proposal, the Department of Human Services would assume the assessment and investigations of allegations of child maltreatment occurring in CRFs licensed by the Department of Corrections. The proposal would not modify the common entry point for maltreatment reporting; rather, the Department of Human Services would collaborate with counties to ensure that all allegations of maltreatment are provided to the Department for assessment and, if appropriate, investigation.

DHS anticipates receiving approximately 74 additional maltreatment reports (= 1.8 reports x 41 DOC-licensed CRFs) under this proposal, resulting in approximately 38 additional assigned maltreatment investigations.1 DHS based this estimate on the maltreatment investigation data that it has from the CRFs it licenses with mental health and chemical dependency (MH/CD) certifications, because the DOC-licensed CRFs serve a similar child population and there is limited data on the maltreatment investigations in those facilities. On average, DHS receives approximately 1.8 reports of maltreatment per licensed CRF with a MH/CD certification, see table 2 below – more than twice the rate of maltreatment reports in CRFs generally.

Table 2. Maltreatment Reports in Children's Residential Facilities in Calendar Year 2015

Maltreatment Reports in CRFs in CY2015			
	All DHS-Licensed CRFs (73)	**All CRFs with MH/CD Certifications (34)**	**All DOC-Licensed CRFs* (41)**
Received	89	60	-**
Assigned	38	30	12
Completed	42	34	-**
Substantiated	15	13	1
Report ratio	1.2	1.8	-

*SSIS Data. This data is not collected separately by DOC and the SSIS data available may underestimate the occurrence of maltreatment incidents and reports in DOC-licensed CRFs.
**This data is not captured in SSIS.

Data on maltreatment reports occurring in DOC-licensed CRFs is maintained in SSIS by the counties investigating the maltreatment allegations. Due to variability in how counties utilize SSIS and intake and assign maltreatment reports for investigation, DHS estimates that existing data in SSIS on maltreatment does not fully capture the number of maltreatment reports that would be assessed for investigation and assigned for investigation under this proposal.

One FTE investigator would be required to perform the investigations resulting from this proposal. Additional costs related to intake and assessment of reports of maltreatment in DOC-licensed CRFs would be absorbed by the Department of Human Services.

Results:

Measure	Value	Anticipated Results	Impact
Maltreatment reports from DHS-licensed CRFs received and assessed by DHS	89 (CY15)	163, due to inclusion of maltreatment reports in DOC-licensed CRFs	83% increase in maltreatment reports assessed from CRFs

[1] Calculated based on data demonstrating that 50% of maltreatment reports in CRFs with a mental health or chemical dependency certification were assigned for investigation in CY2015 .

Maltreatment reports in CRFs assigned for investigation	38 (CY15)	76, estimated based on the rate of maltreatment reports assigned for investigation in CRFs with MH/CD certifications	100% increase in maltreatment investigations in CRFs
Licensed capacity for children in CRFs with DHS-maltreatment investigation authority	1,556 (9/30/16)	2,976	91% increase capacity for children in CRFs with DHS maltreatment investigation authority

Statutory Change(s):
Minn. Stat. 626.556 to grant maltreatment investigation authority to the Department of Human services for CRFs licensed by the Department of Corrections.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			79	68	147	68	68	136
Other Fund, SGSR								
Other Fund, SR								
Total All Funds			79	68	147	68	68	136
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	11	DOC licensed CRF - maltreatment investigator	121	105	226	105	105	210
GF	REV1	GF admin FFP 35%	(42)	(37)	(79)	(37)	(37)	(74)
		Requested FTE's						
Fund	**BACT#**	**Description**						
GF	11	DOC licensed CRF - maltreatment investigator	1.0	1.0	1.0	1.0	1.0	1.0

Change Item Title: Ensuring Greater Integrity in Data Practices

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	228	209	399	380
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	228	209	399	380
FTEs	2	2	4	4

Recommendation:

The Governor recommends investment to strengthen DHS data practices efforts and begin to address the rapid growth in data privacy obligations, regulations, and expectations that DHS faces and will continue to face into the future.

Rationale/Background:

DHS resources have not kept pace with the rapid pace by which privacy laws and regulation has changed or the focus on compliance oversite, which have increased legal and audit risk for DHS. As a result, DHS is not meeting its data privacy compliance goals and obligations. The DHS Privacy Office staff (4 FTEs) is challenged in its ability to plan for and respond to the many data practices needs of the agency, including but not limited to:

- Providing training to agency staff on privacy policy,
- Policy review, update, and development,
- Preparation for audits, and
- Providing legal counsel to business units.

Although DHS has made improvements to reach its privacy compliance goals and obligations, the privacy risks are simply growing more quickly than DHS can address with current resources. This inability to meet privacy goals and obligations matters at a time when federal auditors routinely impose millions of dollars in civil money penalties against entities like DHS for not complying with regulations. It also matters because the people who DHS serves deserve to have their sensitive private data properly handled.

Proposal:

The investment sought in this proposal furthers DHS' realignment of its data practices efforts using the principles of Privacy by Design to move from a reactive privacy culture to a proactive one that is focused on meeting increasing federal privacy regulations, while protecting the highly sensitive personal data of the people who DHS serves. Implementation of this proposal would call for the addition of 4 FTE over the FY2018-19 and FY2020-21 Biennium's with 2 FTE in FY2018-19, and 2 additional FTEs in FY2020-21.

Adding staff resources to the DHS Privacy Office will enable a faster realignment of DHS' privacy culture that will:

- Proactively address privacy-related weakness across DHS.
- Encourage tailored training of employees based on their roles and tasks.
- Meet the growing needs of DHS business areas for legal advice, as they craft business solutions to protect data.
- Create a strong, consistent privacy strategy to seek efficiencies and plan for future privacy risks and obligations.

At the same time, this proposal improves efficiency and safeguards for critical legal functions, such as litigation holds, and reduces the potential for errors by seeking an investment in a litigation hold software solution.

With an enhanced focus on safeguarding sensitive private data, the risk of improper use or disclosure will decrease. This will allow the people who DHS serves to feel more confident in how their data is handled by DHS.

IT Related Proposals:

This proposal includes a $120 thousand investment in FY2018-19 for a litigation hold software solution to ensure that data related to litigation is handled more efficiently and with enhanced safeguards.

Results:

The shift is intended to get these results:

- Improve HIPAA compliance by DHS business areas, reducing the risk of substantial federal penalties.
- Provide greater forward-thinking help and guidance to business areas on how to maintain privacy standards.
- Revise privacy incident response procedures to seamlessly coordinate with MN.IT and other key partners.

Statutory Change(s):

No statutory change required.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			228	209	437	399	380	779
HCAF								
Federal TANF								
Other Fund								
Total All Funds			228	209	437	399	380	779
Fund	BACT#	Description	FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
GF	11	Salaries & overhead for Data Privacy Office	291	262	553	554	525	1,079
GF	11	Supplies (Software)	60	60	120	60	60	120
GF	REV1	Admin FFP @ 35%	(123)	(113)	(236)	(215)	(205)	(420)
		Requested FTE's						
Fund	BACT#	Description	FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
GF	11	Privacy Staff	2	2	2	4	4	4

Change Item Title: Increased Digital Evidence Investigation Capacity

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	85	75	75	75
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	85	75	75	75
FTEs	**1**	**1**	**1**	**1**

Recommendation:

The Governor recommends an investment in program integrity by ensuring DHS continues to be able to keep up with its digital evidence investigation case load.

Rationale/Background:

The Digital Evidence Lab handles technological device location, recovery, and analysis resulting from MA and CCAP fraud investigations as well as personnel investigations and e-discovery projects for the department. Over the past few years, there has been an increase in cases being investigated by the Office of the Inspector General (OIG) and referred to the Attorney General's Office, resulting in more search warrants being issued and devices being seized. This emphasis and increased efforts to combat MA and child care fraud has resulted in an increased case load for the Digital Evidence Lab. The table below shows how the participation in search warrants and number of devices processed has trended up since CY 2013.

Year	Search Warrants	Devices
2013	6	41
2014	7	45
2015	18	117
2016*	21	216

* As of October 21, 2016

Additionally, there has been an increase in the sophistication of both the skill and technology utilized by providers committing MA and child care fraud and abuse. This is because these providers have access to significant resources many billing millions of dollars to MA or child care. These resources give them access to the newest devices and latest technologies to store and secure their data. To locate, recover and analyze this data often requires the latest or newest forensic hardware and software.

For example, on a recent search warrant a hidden external drive was recovered. This drive was formatted and protected in a manner that made the data extremely difficult to access. Thanks to recent training and tools the specialized formatting of the device was detected allowing critical information to be shared with investigators.

In another example, on a recent search warrant we identified online or cloud services being used to store relevant data. By acting quickly, we were able to serve a preservation letter to the service and acquire the data once a search warrant was issued. The preservation letter being issued before the vendor had the chance to delete this information was key to obtaining the files. Without the skills and efforts of our lab, this critical data would have been missed.

Our work doing personnel investigations and e-discovery projects has been delayed or put on hold to help accommodate the increased criminal investigation workload. We have no other options available to reassign or reorganize the workflow.

Proposal:

This proposal requests the addition of 1 FTE in the Digital Evidence Lab to handle the increased volume of technological device location, recovery, and analysis resulting from MA and CCAP fraud investigations. It also includes an investment to purchase new software and equipment to ensure the Digital Evidence Lab is able to keep up with changing technologies used by providers attempting to commit financial fraud and abuse. This proposal increases program integrity by ensuring DHS has the evidence necessary to hold MA and CCAP providers who commit financial fraud and abuse accountable by bring them into compliance or as appropriate, have their participation as a provider ended. This ensures more public recipients will receive the service quality they deserve from legitimate providers.

The Digital Evidence lab currently is funded through the Internal Audits Division. This proposal increases FTEs in the Digital Evidence Lab from 2 to 3.

IT Related Proposals:

This proposal does not have an IT impact.

Results:

This proposal will results in more cases being completed, faster and more accurately.

Type of Measure	Name of Measure	2013	2014	2015	2016*	2017
Quantity	Number of Search Warrants successfully handles	6	7	18	21	
	Number of devices correctly handled.	41	45	117	216	
Quality	Number Cases charged (new)					
Results	Number of Convictions (new)					

* As of October 21, 2016

This data gathered from DHS Financial Fraud and Abuse Division and the Attorney General's Office.

Statutory Change(s):

This proposal does not require a statutory changes.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			85	75	160	75	75	150
HCAF								
Federal TANF								
Other Fund								
Total All Funds			**85**	**75**	**160**	**75**	**75**	**150**
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	11	Salary and overhead	101	86	187	86	86	172
GF	11	Equipment (software)	30	30	60	30	30	60
GF	REV1	FFP at 35%	(46)	(41)	(87)	(41)	(41)	(82)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	11	Management Analyst 2	1	1	1	1	1	1

Change Item Title: SIRS and Child Care Financial Fraud and Abuse Investigations Expansion (OP63)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	1,588	1,448	1,477	1,509
Revenues	1,750	1,750	1,750	1,750
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	(162)	(302)	(273)	(241)
FTEs	**18**	**18**	**18**	**18**

Recommendation:

The Governor recommends expanding the two investigative sections of the Office of the Inspector General (OIG) that investigate 1) Medical Assistance (MA) providers and 2) Child Care providers to prevent and intervene in fraud and abuse.

Rationale/Background:

1) MA Provider Fraud Investigations. Currently, there are 14 Surveillance and Integrity Review Section (SIRS) MA provider investigators for over 175,000 enrolled MA providers, being paid over $10 billion per year. The investigators are severely limited in their ability to review the complexity of provider claims, investigate cases, and proactively prevent fraud in all MA provider types. The MA Provider unit currently investigates about 17 of the more than 100 MA provider types at various levels. The OIG's current lack of investigative and analytic resources is the major obstacle to increasing the number and scope of successful investigations and favorable prosecutions.

2) Child Care Provider Fraud Investigations. The first cases brought to the OIG when this unit was started in 2014 were very complex criminal cases. The OIG is investigating under the lead of the BCA on these cases, but with such an initially small unit (four investigators), there is a backlog of 40 child care centers referred to OIG by counties, law enforcement, and community members that reportedly involve large amounts of program funding and may merit a criminal level investigation.

   In conducting administrative investigations, a review of provider attendance records is conducted to check for compliance with MS 119B.125 Subd. 6. The child care centers whose attendance are reviewed include centers being reviewed by DHS Licensing at the end of the provider's first year of operation, as well as centers OIG believes to be at high risk of non- compliance, including those centers that DHS has received information on regarding possible illegal activity. After approximately one year of reviews, OIG has seen a failure rate of approximately 40% of these centers. Of this group, the failure rate is significantly higher for the centers considered high risk, compared with the overall group of providers completing their first year of operation.

Proposal:

1) The proposal adds ten FTE for MA provider fraud investigations: seven investigators, a data analyst, an attorney, and a supervisor. Each additional SIRS MA provider fraud investigator is expected to yield $250,000/year in recoveries. The proposal provides federal and state recoveries estimated at $1.7 million per year. The additional staff will investigate providers who have demonstrated significant noncompliance with requirements, or who have been identified as having fraud risk indicators. This will allow the OIG to substantially cover more provider types, warranting surveillance, investigation and intervention.

2) This proposal also adds eight FTE for Child Care Provider fraud investigations: six child care provider investigators and two investigative assistants. The additional staff will be conducting administrative investigations which can be

completed much more quickly than the criminal investigations, allowing for earlier interventions involving more fraudulently run child care providers. We will also expand the number of criminal investigations we participate in with Law Enforcement agencies. This will result in bringing more providers into compliance, disqualifying or convicting fraudulent providers from the program, and stopping the funding to those providers.

IT Related Proposals:

This proposal does not have IT impacts.

Results:

The OIG SIRS and Child Care Investigations components of this proposal will allow:

- DHS to expand investigations to more MA provider types and bring more providers into compliance.
- DHS to recover an estimated $3.5 million MA dollars per biennium.
- DHS to address the backlog of child care centers referred for investigation and restore more Child Care Assistance Program (CCAP) funding and stop fraudulent providers' exploitation of children and parents.

DHS OIG will continue to measure:

- Number and types of completed investigations,
- Numbers of fraudulent providers terminated,
- Numbers of providers whose payment are withheld,
- Recoveries depending on the investigations.

Statutory Change

There are no statutory changes related to this proposal.

Fiscal Details

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			(162)	(302)	(464)	(273)	(241)	(514)
HCAF								
Federal TANF								
Other Fund								
Total All Funds			(162)	(302)	(464)	(273)	(241)	(514)
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	11	18 FTEs, Fringe Benefits and Overhead	2,443	2,227	4,670	2,273	2,321	4,594
GF	REV1	Admin FFP @ 35%	(855)	(779)	(1,634)	(796)	(812)	(1,608)
GF	REV2	MA Recoveries	(1,750)	(1,750)	(3,500)	(1,750)	(1,750)	(3,500)
Requested FTE's								
GF	11		18.0	18.0		18.0	18.0	

Change Item Title: 245D Licensing Fee Reform

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	(270)	(270)	(270)	(270)
Revenues				
Other Funds				
Expenditures	3,135	3,135	3,135	3,135
Revenues	(3,100)	(3,100)	(3,100)	(3,100)
Net Fiscal Impact = (Expenditures – Revenues)	(235)	(235)	(235)	(235)
FTEs	**14.0**	**14.0**	**14.0**	**14.0**

Recommendation:

Effective July 1, 2017, the Governor recommends the implementation of a new fee structure for the licensure of Home & Community-Based Services (HCBS) providers in order to adequately fund the state's cost of licensing and maltreatment-related activities. The fee program impacts providers licensed under Chapter 245A and providing services governed by standards under Chapter 245D. The recommendation also includes a change to better align DHS SGSR revenues and expenses. General Fund (GF) savings generated by this proposal will fund vulnerable adult work (e.g. maltreatment investigations & appeals) currently funded from the State Government Special Revenue (SGSR) fund. SGSR activities are typically fee driven. Given these activities generate no fees, they are more appropriately funded from the GF.

Rationale/Background:

In 2012 and 2013 the Legislature enacted new and comprehensive home and community-based services licensing standards that covered 19 services, many of which were previously unlicensed, under one statewide license in Chapter 245D, and shifted responsibility for certain licensing and maltreatment investigative functions from the counties to the State. Specifically, the Legislature recognized that because many waiver services were unlicensed, consumers did not have basic protections consistently applied or enforced, due to county variations in enforcement activities of these unlicensed services. Therefore, the Legislature required more than a dozen previously unlicensed services now be licensed and monitored for compliance by DHS. Also, alleged maltreatment in the previously unlicensed waiver services that had been previously investigated by the counties is now investigated by DHS. As a result, the number of providers increased from 650 to 1,250 when previously unlicensed services became licensed in 2013; the number of service recipients increased from 12,000 to 32,000. Currently there are more than 1,350 providers licensed to provide services governed by Chapter 245D, and more services are being developed, increasing the range and complexity of the regulatory scheme.

In 2013, the Legislature adopted a three-year interim license fee schedule for 245D providers. During the interim license fee schedule period, providers previously licensed under Minnesota Statutes, chapter 245B, paid an annual license fee for calendar years 2014, 2015, and 2016 equal to the license fees paid under chapter 245B. During this same period, previously unlicensed providers paid a license fee based upon the provider's revenue generated through the provision of services governed by chapter 245D. Beginning in calendar year 2017, all HCBS providers must pay a fee based on the provider's revenue generated through the provision of services governed by chapter 245D.

The interim fee schedule was also supplemented by a general fund appropriation. The general fund appropriation is necessary to ensure adequate staffing to assume maltreatment investigations that had previously been performed by the counties when the service recipient had been receiving unlicensed services. This appropriation continues even under the new revenue-based fee schedule.

The interim fee schedule lasted through calendar year 2016; beginning with calendar year 2017, all providers must pay a fee based upon a provider's revenue. However, it has been determined that the general fund appropriation and the revenue-based fee schedule will not adequately fund the DHS work related to HCBS licensing and maltreatment investigations under Chapter

245D. DHS recommends that providers have an on-site inspection at least every two years. Under our federally approved waiver plans, DHS is required to inspect providers at least every three years. If no changes are made, the current fee schedule provides resources sufficient for reviews of all providers only once every four or five years. In 2016, DHS proposed a new fee structure that would cover costs of biennial inspections, but it was not enacted.

The Department's Licensing Division largely operates on an enterprise business model, collecting fees adequate to fund its licensing and investigative work. Costs associated with licensing HCBS fall into the following categories: direct licensing review, complaint investigation and application assistance, intake and maltreatment costs, legal costs, administrative hearings, management and administrative support, and information technology (IT) costs. Under the proposal, it is estimated that if new staff are hired on July 1, 2017, the total HCBS-related costs would be $6.0 million the first year and $5.8 million the second year, and thereafter. However, due to anticipated delays in hiring new staff, the first year expenditures will likely be $5.8 million.

Currently, there are 14 FTEs in the Licensing Division whose duties are solely related to licensing and oversight of HCBS providers (11 FTE licensors, two unit supervisors and one unit manager). This proposal requests 14 additional staff to perform HCBS licensing activities. With the additional FTEs, the Division anticipates being able to meet a two-year review schedule that meets the assurances made in Minnesota's waiver plans and ensure that all programs are reviewed at a reasonable interval and that licensing violations reported to DHS can be promptly investigated and corrective action ordered if warranted. DHS needs Legislative approval in 2017 for the new fee structure so it can begin billing HCBS providers under the new fee schedule for the licenses issued in calendar year 2018.

HCBS providers licensed by DHS already pay a fee to fund, in part, licensing costs. The new fee schedule would allow the Department to fully recoup costs related to HCBS licensing and maltreatment investigations as detailed below:

Costs by category	First year	Second year
1. Direct HCBS licensing costs	$2,871,462	$2,664,958
2. Maltreatment	$1,741,050	$1,730,232
3. Intake	$518,563	$518,563
4. Legal / due process	$285,702	$285,702
5. Office of Administrative Hearings	$68,000	$68,000
6. Management & administrative support	$308,952	$308,952
7. IT costs	$200,000	$200,000
Total	$5,993,049	$5,776,407

Proposal:

A new fee schedule will be established for licensing, maltreatment investigation, and related activities for providers licensed under Minnesota Statutes, chapter 245A and who provide Home and Community-Based Services (HCBS) governed by chapter 245D. The new fee schedule is designed to keep fees reasonable for both small and large providers. The new schedule is based on an annual licensing fee of $350 or 0.325 of one percent of each provider's annual revenue generated from Medical Assistance reimbursement for Chapter 245D licensed services; whichever is higher. DHS licenses HCBS services and performs licensing reviews to ensure the safety and integrity of services and facilities licensed under 245D – ensuring adequate protection for vulnerable Minnesotans receiving these services. The new fee schedule ensures that the Licensing Division has the resources to perform biennial licensing visits – a schedule necessary to meet visitation schedules assured in Minnesota's waiver plans that have been approved by CMS and necessary to adequately monitor 245D activities.

This proposal will provide a stable source of funding that enables the Licensing Division to adequately staff its Home and Community-Based Services unit and respond in a timely manner to maltreatment complaints, licensing reviews, licensing violations and ongoing monitoring, appeals of licensing and maltreatment determinations, in addition to provider requests for technical assistance. Timely response to maltreatment complaints as required in section 626.557, subd. 9c(e), licensing violations, and performing ongoing monitoring on a two year schedule is key to ensuring the safety and integrity of HCBS provided to Minnesotans. In order to meet the increased need for licensing oversight of previously unlicensed services following the enactment of Chapter 245D standards in 2014, and also the 1-3 year licensing review schedule outlined in Minnesota's approved waiver plans, the new fee structure will allow DHS to hire an additional 14 full-time-equivalent staff (10 licensors, a unit supervisor, a licensing complaint triage assessor and a unit support position). The licensing staff will complete inspections

of license holders at least once every two years, and more often as needed in response to complaints of licensing violations, and monitor for compliance with Chapter 245D standards. Staff will also provide technical assistance to HCBS providers, develop and revise sample policies and procedures as needed to assist providers in adhering to Chapter 245D standards and reduce the potential for maltreatment by HCBS staff or providers.

The proposal would have fiscal impacts in two ways: increased total fee receipts from licensed HCBS providers, and it would end General Fund support for 245D maltreatment investigation activities. The anticipated annual costs of licensing and maltreatment investigative activities in HCBS programs is $6.0 million the first year if new staff are hired on July 1, 2017, and $5.8 million the second year and thereafter. However, due to anticipated delays in hiring all staff in early FY18, the first year costs will likely be $5.8 million.

In FY17, DHS has been appropriated $3.752 million from the SGSR account for licensing activities ($2.10 million related to HCBS and $1.65 million related to other DHS licensed programs). It is estimated that in FY17 DHS will receive $4.35 million in licensing fees from HCBS and other service classes. DHS also receives $1.4 million from the General Fund to cover the costs of HCBS maltreatment investigations. This proposal requests an additional appropriation of $3.7 million to replace the General Fund appropriation and to recover the increased costs of HCBS licensing activities and maltreatment investigations . Existing license fee revenues combined with the revenues under the new fee structure will fully fund the appropriation. With the increased funding, the Licensing Division will be able to complete biennial licensing reviews and other licensing and maltreatment investigation activities related to HCBS programs. Since 2011, funding for most of DHS' licensing's activities have shifted from the General Fund to license holders through license fees, which are deposited into the SGSR with a legislative appropriation from the SGSR to cover licensing activities. If the proposal is adopted, total funding from the State Government Special Revenue Fund for licensing activities would be $7.45 million in FY18 ($5.8 million for HCBS and $1.65 million for other service classes).

DHS has been appropriated $565,000 from the SGSR to fund maltreatment investigations and appeals related to maltreatment investigations. These activities do not generate fee revenue as is typical of most SGSR activities. This results in an imbalance in DHS SGSR revenue and appropriations. This proposal moves this activity funding to the GF. This shift is paid for through savings generated from this proposal's shift of 245D licensing from the GF to the SGSR. This refinancing will create structural balance for DHS' SGSR funding.

IT Related Proposals:

The proposal includes $200,000 annually to fund HCBS licensing related IT maintenance and improvements.

Results:

Name of Measure	*FY15*	*FY16*	*Anticipated Outcome of Proposal*
Licensed 245D providers	Program licenses: 1,277 Facility licenses: 3,956	Program licenses: 1,341 Facility licenses: 3,994	No effect due to the proposal, but the Licensing Division estimates an increase of 60 HCBS providers per year
Number of technical assistance or licensing review visits completed	320 visits, associated with 299 different licenses	992 visits, associated with 859 different licenses	More
Percentage of all licensed 245D providers reviewed or visited per year	Program licenses: 21% Community residential settings: 9% Day services facilities: 0% Residential services facilities: 0%	Program licenses: 33% Community residential settings: 11% Day services facilities: 18% Residential services facilities: 0%	Approximately 50% of all licensed programs; 100% every two years Approximately 12.5% of all community residential settings; 25% every two years. Approximately 50% of all day service facilities; 100% every two years

Statutory Change(s):

Minnesota Statutes, section 245A.10; 256B.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			(270)	(270)	(540)	(270)	(270)	(540)
SGSR Fund			35	35	70	35	35	70
Spec. Rev. Fund			0	0	0	0	0	0
Total All Funds			(235)	(235)	(470)	(235)	(235)	(470)
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	11	End GF support of 245D Licensing activities	(1,439)	(1,439)	(2,878)	(1,439)	(1,439)	(2,878)
GF	REV1	Loss of associated GF admin FFP	504	504	1,008	504	504	1,008
GF	11	Refinance Vulnerable Adults appropriation	565	565	1130	565	565	1130
GF	REV1	FFP on VAA appropriation	(198)	(198)	(396)	(198)	(198)	(396)
GF	62	MSOCS licensing fee	298	298	596	298	298	596
SGSR	REV2	Increased DHS Licensing Revenue - SGSR	(3,100)	(3,100)	(6,200)	(3,100)	(3,100)	(6,200)
SGSR	11	Refinance Vulnerable Adults appropriation	(565)	(565)	(1,130)	(565)	(565)	(1,130)
SGSR	11	Licensing Activities	3,700	3,700	7,400	3,700	3,700	7,400
Fund	**BACT#**	**FTEs**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	11	End GF support of 245D Licensing activities	(12)	(12)	(12)	(12)	(12)	(12)
SGSR	11	Refinance 245D Licensing activities from GF	12	12	12	12	12	12
SGSR	11	Additional staff for 245D Licensing activities	14	14	14	14	14	14
		Net FTE Impact	14	14	14	14	14	14

Current DHS base appropriation from SGSRF for licensing activities is $3.752 million. If the proposal is adopted, the total appropriation from the SGSRF would be $ $7.45 million which will match the license fees collected.

Change Item Title: Repeal Transfer of Funding for Managed Care Audits by the Office of Legislative Auditor

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	0	0	0	0
FTEs	**0**	**0**	**0**	**0**

Request:

Effective the day following final enactment, the Governor recommends eliminating a requirement that the Department of Human Services transfer $1.74 million to the Office of the Legislative Auditor (OLA) each biennium for the OLA's managed care audit activities. In 2015 the Legislature enacted a House proposal, "Repeal 2012 OLA Audit," that permanently reduced the Department's appropriation to fund the transfer. However, the 2015 Legislature left intact the requirement that DHS transfer $1.74 million to the OLA in each even-numbered fiscal year. This recommendation ends the requirement to transfer the funds consistent with the repeal of the appropriation.

Rationale/Background:

In response to concerns about spending by the managed care organizations that serve Minnesotans enrolled in the Medical Assistance and MinnesotaCare programs, the 2012 Legislature required the Office of the Legislative Auditor (OLA) to audit certain financial and other information submitted by managed care and county-based purchasing health plans to the Department of Human Services. Rather than appropriate funding for the new audit requirements directly to the OLA, the Legislature appropriated it to the Department, and required the Department to transfer the funding to the OLA.

In carrying out the new duties, the OLA found that the narrowly written statute left it unable to contract with a suitable independent third party audit firm to do the first of what was to be a regular cycle of auditing managed care plans and county-based purchasing plans. So the OLA conducted an audit using its own staff and resources, leaving much of the appropriation unspent. Although the Legislature cut the funding for those duties, rather than repealing the narrowly-written statute, in the 2015 Omnibus Health and Human Services bill (Laws 2015, chapter 71) the Legislature rewrote the audit mandate to make it workable for the OLA and placed it in a new subdivision of statute.

Proposal:

This proposal amends a 2012 state law to that requires the Department of Human Services to transfer $1.74 million to the Office of the Legislative Auditor (OLA) each biennium for the OLA's managed care audit activities.

In the 2015 legislative session, partly in response to a new OLA audit of Managed Care Organizations' administrative expenses, the Legislature enacted a governor's recommendation to provide new funding for the Department to conduct ad hoc audits of Managed Care Organizations. The Legislature also amended the OLA's existing duties around managed care audits to improve the OLA's ability to carry out those duties, and it enacted a legislative proposal, "Repeal 2012 OLA Audit," that removed $1.74 million from the Department's budget related to the OLA transfer.

Due to these 2015 session actions, the connection between the OLA's managed care audit duties and the requirement that DHS transfer funding to the OLA is less direct and is unclear. On the one hand, the amended statute no longer directly connects the OLA's audit duties to the Department's resources that were supposed to be used to pay for those duties. On the other hand, the Legislature stopped short of clearly ending the requirement that DHS transfer that funding to the OLA. This proposal

assumes that the legislature's intent is to audit managed care organizations that serve people in our publicly-funded health care programs at the level provided for under the 2015 legislation, making the transfer of funds to the OLA unnecessary.

This proposal is intended to allow the Department to maintain our current level of Central Office operations. Although this request is relatively small (0.5%) compared to the department's budget for Central Office administrative activities, that budget is already committed to administer and support the many important and complex programs that make up the state's human services system, and the over 1,800 staff who work in the DHS Central Office.

Results:

This proposal will help the Department to continue to provide current levels of service and information to the public.

Statutory Change(s):

Amendment to rider in Laws 2012, chapter 247, article 6, section 2, subdivision 2, paragraph (b).

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			0	0	0	0	0	0
HCAF								
Federal TANF								
Other Fund								
Total All Funds			0	0	0	0	0	0
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	13	FTEs	0	0	0	0	0	0

Change Item Title: Modernizing Pharmacy Reimbursement – Federal Compliance (HC-53)

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	3,875	3,702	3,924	4,253
Revenues				
Other Funds				
Expenditures				
Revenues				
Net Fiscal Impact = (Expenditures – Revenues)	3,875	3,702	3,924	4,253
FTEs	**1.5**	**1.5**	**1.5**	**1.5**

Recommendation:

Effective July 1, 2017, the Governor recommends modernizing fee-for-service (FFS) Medical Assistance (MA) reimbursement for outpatient prescription drugs to more accurately reflect the cost of prescription drug products and the cost of dispensing the prescriptions. These changes are required for federal compliance with the 2016 Covered Outpatient Drug final rule and has a net cost to the General Fund of $7.3 million in the FY2018-19 biennium and $3.9 million in the FY 2020-21 biennium.

Rationale/Background:

In March of 2016, the Centers for Medicare and Medicaid Services (CMS) released a new final rule on Covered Outpatient Drugs. There are two primary components of pharmacy reimbursement: drug acquisition cost and cost of dispensing. The new rule requires State Medicaid programs to base pharmacy reimbursement on the cost to pharmacies of acquiring the drug from the manufacturer and dispensing drugs to patients. Current pharmacy reimbursement is based on list prices established by the drug manufacturers and the dispensing fee in current statute. The intent is for reimbursement to more accurately reflect the acquisition cost of drug products and the pharmacy's cost of dispensing the prescriptions.

The new rule requires that reimbursement for prescription drugs cannot exceed the actual acquisition cost of the drug plus a professional dispensing fee. Actual acquisition cost is a measure of a pharmacy's actual cost to obtain a prescription drug product from a wholesaler or manufacturer. Both the acquisition cost and the dispensing fee must be based on a survey or other reliable supporting data.

The National Average Drug Acquisition Cost (NADAC) is a new drug pricing benchmark that was developed and published by CMS for the use of state Medicaid agencies and other payers. The data used to create it is based on actual pharmacy invoice prices and is collected in a voluntary national survey of retail community pharmacies. The benchmark is updated weekly and is available for the state to use in the MMIS claims system.

Some pharmacy providers have access to discounted drug pricing through the 340B program. The 340B program allows disproportionate share hospitals (DSH), critical access hospitals, family planning clinics, and federally qualified health centers (FQHCs) to purchase drugs at a significant discount. The Health Resources and Service Administration (HRSA) establishes a ceiling price which is the maximum price a manufacturer can charge for a medication sold to a 340B provider. Under the new CMS Covered Outpatient Drugs final rule, reimbursement cannot exceed the HRSA 340B ceiling price plus a professional dispensing fee for 340B procured medications. .

Proposal:

This proposal would make changes Minnesota's pharmacy reimbursement formula for outpatient prescription drugs purchased under fee-for-service MA to align with the new federal requirements. Total FFS reimbursement for pharmacy services was approximately $256 million in FY2016. The new reimbursement would be effective for claims with dates of service on or after April 1, 2017 to comply with the federal rule.

Drug Acquisition Cost: Minnesota currently estimates the acquisition cost of prescription drugs at Wholesale Acquisition Cost (WAC) plus 2% for branded products and uses a state-calculated State Maximum Allowable Cost (SMAC) for generic and specialty products. This proposal would use the National Average Drug Acquisition Cost (NADAC) to determine the acquisition cost for brand and generic prescriptions. Specialty products and generic products without a listed NADAC would continue to be priced based on SMAC. Drug products for which no NADAC cost data is available would be priced based on WAC minus 2%.

The drug acquisition cost for 340B medications is currently estimated at WAC minus 40%. This proposal would change the drug acquisition cost component to an aggregate approximation of the Health Resources and Services Administration (HRSA) 340B ceiling price. The 340B ceiling price is the maximum amount that a manufacturer can charge a 340B entity for a drug sold through the 340B program.

Professional Dispensing Fee: Minnesota's current dispensing fee is $3.65 per prescription for most prescriptions. Unit dose prescriptions for beneficiaries in long term care facilities receive an additional $0.30 per prescription. A dispensing fee of $8.00 per bag is paid for sterile compounded prescriptions and a fee of $14 per bag is paid for cancer chemotherapy prescriptions.

Under this proposal, the professional dispensing fee for a prescription is increased to $11.35 per prescription or per bag of sterile compounded solution. The $11.35 dispensing fee is based on the median cost to dispense a Medicaid prescription in Minnesota, per an independent analysis commissioned by the Coalition for Community Pharmacy Action in September of 2015.

The specifics of the new methodology were developed in consultation with pharmacy stakeholders via a formal request for information solicitation as well as a series of public meetings with multiple opportunities for comment. A report summarizing the meetings and the feedback received will be submitted to the legislature.

Based on modeling of claims data using the existing methodology compared to the new methodology, it is estimated that the new methodology for brands and generics will result in a 4.25% increase to overall fee-for-service pharmacy spending. The cost will be offset by a projected 1.68% reduction in pharmacy spending due to the savings associated with changing 340B reimbursement to the HRSA ceiling plus a professional dispensing fee. The result is a net increase of 2.57% for FFS pharmacy reimbursement.

This prospoal requires additional sfafff resources to record 340B pharmacy data and perform the new pricing calculations. The cost for this additional staff is included in this proposal.

Equity and Inclusion:

Minnesota is among the healthiest states in the nation and enjoys relatively high rates of health insurance coverage. However, when compared with white people in Minnesota, people of color and American Indians residing in the state experience significant disparities in health status and in rates of health insurance coverage. While the majority recipients enrolled in Medical Assistance and MinnesotaCare are white, people of color, especially African Americans and American Indians make up a disproportionate share of total program enrollment. In fact, over 60 percent of African Americans and American Indians residing in the state were enrolled in the programs in July 2014. In 2015, Minnesota boasted the fifth lowest rate of un-insurance in the country at 4.3 percent. However, the rates of un-insurance for African Americans and American Indians residing in the state was roughly double the statewide average, and the rate for Hispanics was about three times the state average. Minnesota's health care programs play a significant role in providing health care coverage to racial and ethnic minority populations in the state, and to the extent that these programs can affect the health status of recipients may also play a large role in reducing health disparities.

The new reimbursement methodology is more transparent than the previous methodology. Reimbursement values will be based on actual cost data on drug acquisition and cost of dispensing. The reimbursement methodology will apply equally to all pharmacy providers, including those providers serving diverse clientele.

IT Related Proposals:

System changes to the MMIS claims system will be needed to pay for prescriptions using the new pricing methodology.

Results:

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Results	Average cost per brand name prescription, 340B and non-340B	Not currently available		
Quantity	Average cost per generic prescription, 340B and non-34B	Not currently available		
Quantity	Generic utilization percentage	Not currently available		

Statutory Change(s):

Changes will be needed to MN Statue 256B.0625 Subd. 13e to reflect the new reimbursement methodology.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			3,875	3,702	7,578	3,924	4,253	8,177
HCAF								
Federal TANF								
Other Fund								
Total All Funds			3,875	3,702	7,578	3,924	4,253	8,177
Fund	**BACT#**	**Description**						
GF	33-ED	MA Grants	2,709	2,631	5340	2,744	2,966	5,710
GF	33-AD	MA Grants	73	75	148	107	135	242
GF	33-FC	MA Grants	955	876	1831	952	1,033	1,985
GF	11	Systems (MMIS)	37	7	43	12	12	24
GF	13	HCA Admin	156	174	330	167	165	332
GF	REV1	FFP @ .35	(55)	(61)	(116)	(58)	(58)	(116)
		Requested FTE's						
Fund	**BACT#**	**Description**						
GF	13	HCA Admin	1.5	1.5		1.5	1.5	

Change Item Title: Federal Compliance for Payments of Durable Medical Equipment

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	(1,104)	(3,556)	(561)	(625)
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	(1,104)	(3,556)	(561)	(625)
FTEs	**0**	**0**	**0**	**0**

Recommendation:

Effective January 1, 2018, the Governor recommends modifications to the payment methodology for durable medical equipment (DME) in Medical Assistance (MA). This change would comply with legislation passed at the federal level limiting the amount of federal match available for payments of certain durable medical equipment. This proposal has a net savings to the General Find of $4.6 million in the FY2018-19 biennium and $1.2 million in the FY2020-21 biennium.

Projected fee for service MA expenditures for DME are expected to reach nearly $187 million in FY20-21. This proposal is expected to reduce expenditures in the FY20-21 biennium by roughly $17.1 million or 9 percent.

Rationale/Background:

For several years, Medicare has competitively bid for durable medical equipment, prosthetics and orthotics (DMEPOS). In doing so, Medicare has recognized savings by lowering their rates to match the competitive bid rates. Due to these changes, legislation was passed directing the Centers for Medicare and Medicaid Services (CMS) to cap federal financial participation at the aggregate value that would have been paid for certain DMEPOS products had they been paid at the Medicare rate. The 21st Century Cures Act passed in December of 2016 moved the effective date for this provision to January 1, 2018.

If payments are made for DMEPOS above the Medicare rate, Minnesota would need to provide an analysis on the selected DMEPOS products to assure CMS that the aggregate cap of federal financial participation was not surpassed. This analysis would need to occur annually and due to the timing of claim payments, could be performed up to 18 months after a claim was paid. In the event the payments do surpass the cap, the Department would need to recover the overpayments made to providers in order to reimburse CMS. The current methodology paid for DMEPOS is higher than the Medicare rate for the vast majority of DMEPOS services and would result in overpayments if a change is not made.

Proposal:

This proposal would modify the payment methodology used for some durable medical equipment, orthotics and supplies (DMEPOS). In order to ensure compliance with the aggregate cap for DMEPOS, this proposal would update the payment methodology to pay equivalent to the Medicare rate. By aligning the Medicaid rate with the Medicare rate, it eliminates the risk that providers may experience take backs due to payments that exceed the federal upper payment limit, and ensures the state is collecting federal match only on the payments for which it is allowed.

Fiscal Impact:

The 21st Century Cures Act caps federal Medicaid funding for DME at the Medicare rate starting in 2018, and the current rate specified in state law exceeds these limits. The February 2017 MA forecast assumed that payments in excess of the Medicare limits would result in DHS reprocessing DME claims to recover payments above the Medicare limit starting in 2019. This proposal updates the payment methodology for DME to the Medicare payment rate starting January 1, 2018. The fiscal effect of this proposal is the difference between the savings realized by the lower payment rate for DME and the reductions recognized in the forecast from reprocessing overpayments which are assumed approximately 18 months following payment.

Equity and Inclusion:

Minnesota is among the healthiest states in the nation and enjoys high rates of health insurance coverage. However, when compared with white people in Minnesota, people of color and American Indians experience significant disparities in health status and in rates of health insurance coverage. While the majority of recipients enrolled in Medical Assistance and MinnesotaCare are white, people of color, especially African Americans and American Indians make up a disproportionate share of total program enrollment. In fact, over 60 percent of African Americans and American Indians residing in the state were enrolled in the programs in July 2014. In 2015, Minnesota boasted the fifth lowest rate of un-insurance in the country at 4.3 percent. However, the rates of un-insurance for African Americans and American Indians residing in the state was roughly double this statewide average, and the rate for Hispanics was about three times the state average. Minnesota's health care programs play a significant role in providing health care coverage to racial and ethnic minority populations in the state, and to the extent that these programs can affect the health status of recipients may also play a large role in reducing health disparities.

IT Related Proposals:

This proposal would require changes to the payment methodology in the MMIS system. The level of effort is minor and can be completed using existing resources.

Statutory Change(s):

256B.766

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			(1,103)	(3,556)	(4,659)	(561)	(625)	(1,186)
HCAF								
Federal TANF								
Other Fund								
Total All Funds			(1,103)	(3,556)	(4,659)	(561)	(625)	(1,186)
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	33 ED	MA Grants	(864)	(2,788)	(3,652)	(462)	(510)	(972)
GF	33 AD	MA Grants	(11)	(43)	(54)	(5)	(7)	(12)
GF	33 FC	MA Grants	(228)	(725)	(953)	(94)	(108)	(202)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**

Change Item Title: Exempt Supplemental Payments from MA Surcharge

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
General Fund				
Expenditures	0	0	0	0
Revenues	(627)	(1,254)	(1,254)	(1,254)
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	627	1,254	1,254	1,254
FTEs	**0**	**0**	**0**	**0**

Recommendation:

The Governor recommends exempting revenue from certain supplemental payments made under Medical Assistance (MA) from the 1.56 percent surcharge on net patient revenue.

Rationale/Background:

State law directs DHS to make supplemental MA payments to Regions Hospital and Hennepin County Medical Center for outpatient, hospital, physician and professional services, and ambulance services. Hennepin and Ramsey County provide the nonfederal share of these MA payments which are subject to federal limits. This proposal exempts revenue from these supplemental MA payments received on or after July 1, 2016 from the 1.56 percent surcharge on net patient revenue described in Minnesota Statutes 256.9657. DHS currently invoices hospitals for this surcharge using hospital revenue reported to the Minnesota Department of Health. Revenues collected from the surcharge are deposited in the state General Fund.

Hospital surcharge payments to DHS are made in nine monthly installments between October and June and are based on revenues from the previous calendar year. This proposal exempts revenue from supplemental payments for half of calendar year 2016 which would result in lower surcharge collections starting in FY2018. The estimate assumes a reduction in FY2018 revenue from exempting half of the supplemental payment revenue in 2016 and reductions in FY2019-21 from exempting the full value of supplemental payments The net result of the exemptions is a reduction in non-dedicated revenue to the general fund.

Proposal:

This proposal would exempt revenue from certain supplemental payments made under Medical Assistance (MA) from the 1.56 percent surcharge on net patient revenue.

IT Related Proposals:

This proposal does not require changes to state IT systems.

Statutory Change(s):

256B.9657

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund			627	1,254	1,881	1,254	1,254	2,508
Total All Funds			627	1,254	1,881	1,254	1,254	2,508
Fund	**BACT#**	**Description**	**FY 18**	**FY 19**	**FY 18-19**	**FY 20**	**FY 21**	**FY 20-21**
GF	NDR	MA Surcharge	627	1,254	1,881	1,254	1,254	2,508

Change Item Title: Opiate Stewardship Program

Fiscal Impact ($000s)	FY 2018	FY 2019	FY 2020	FY 2021
Board of Pharmacy				
Special Revenue Fund				
Expenditures				
Revenues	21,000	21,000	21,000	21,000
Human Services				
Special Revenue Fund				
Expenditures	21,000	21,000	21,000	21,000
Revenues				
Net Fiscal Impact = (Expenditures – Revenues)	0	0	0	0
FTEs	2	2	2	2

Recommendation:

Effective July 1, 2017, the Governor recommends the creation of an opiate stewardship program, which will assess an annual fee on opiate manufacturers, and utilize the revenue generated to fund efforts to prevent, treat, and mitigate the impact of opioid abuse across Minnesota.

Rationale/Background:

Minnesota is facing an opioid abuse crisis. Drug overdose deaths in Minnesota have increased by 400 percent since the year 2000, and by 11 percent from 2014 to 2015. Preliminary data collected from Minnesota death certificates show 572 people in 2015 died from a drug overdose as compared to 516 in 2014. The leading drug categories associated with deaths are opioid pain relievers (216) and heroin (114).

The Governor and legislature have taken steps to address the issue. Key initiatives include, the Minnesota State Substance Abuse Strategy, the Opioid Prescribing Improvement and Monitoring Work Group, the Integrated Care for High Risk Pregnant Women Initiative grant funds to expand care for pregnant women and substance exposed infants, funding to increase access to naloxone, and efforts to make disposing unused prescription opioids easier. The federal government has also recognized the impact the opioid crisis is having throughout the country and Minnesota is taking full advantage of funding available through the Substance Abuse and Mental Health Services Administration (SAMHSA). While these efforts are an important start, the scope and impact of this crisis requires even more robust, urgent, and sustained action.

This proposal seeks to build upon and expand these existing efforts and ensure there are on-going and sustainable resources available to address opioid abuse.

Proposal:

This proposal seeks to address Minnesota's opioid epidemic by establishing an s opiate stewardship program in order to provide a robust and sustainable resource to fund targeted efforts to prevent, treat, and mitigate the impact of opioid abuse.

The program will be funded through a stewardship fee on manufacturers of one cent per morphine milligram equivalent of opiates produced. Opiate manufacturers will be required to pay the stewardship fee in order to renew a manufacturer license in the state of Minnesota with the Board of Pharmacy. Fees collected by the Board of Pharmacy will be deposited in a special revenue fund specifically designated for the opiate stewardship program. This fee is anticipated to generate $21 million annually.

Revenue generated by the stewardship fee will be utilized by the Department of Human Services, the Department of Health, and the Board of Pharmacy to fund efforts to address opiate abuse. Fee revenue is expected to be collected between March

and June of a given fiscal year at which point it will be available for use by the specified agencies. An advisory council will be established to make recommendations on the criteria and procedures for allocating available funds from the opiate stewardship account. The council will review local, state and federal initiatives and activities related to education, prevention, treatment, and services for individuals and families experiencing and affected by opioid abuse, establish priorities and actions to address the state's opioid epidemic for the purpose of allocating funds, ensure a coordinated state effort, and develop measurable outcomes.

At least 50% of the funds will be made available for expanding prescriber education, public awareness and prevention programming, and the Department of Human Services may use up to 5 percent of the money appropriated for administration. In FY 2018, $2.5 million shall be transferred to the Department of Health to establish up to 12 opioid use prevention pilot projects to model alternative methods of prevention, treatment and education around opioid abuse. $50,000 in 2018 is designated for the Board of Pharmacy for system updates necessary to collect the new fee.

DHS administrative activities will include support for the Opioid Product Stewardship Advisory Council, grant administration and other activities determined to be necessary by the Advisory Council and Commissioner. 2 FTE are assumed sufficient at this time, but may be adjusted based on the number of grants administered or scope of activities necessary to support the Advisory Council. Funds not needed for administrative activities will be available for grants.

Use of Funds	Amount
DHS Administration (max)	$21,000,000 x 5% = $1,050,000
Competitive Grants for education, awareness, prevention	$21,000,000 x 50% = $10,500,000
Other Opioid grants/transfers (est.)	$21,000,000 - $10,500,000 - $1,050,000 = $9,450,000

IT Related Proposals:
N/A

Equity and Inclusion:
We anticipate that the strategies proposed will begin to reduce the disparate impact that opioids have had on American Indian and African American Minnesotans by providing a full continuum of services to opioid dependent individuals.

Results:
It is anticipated that the changes proposed in this proposal will have the following impact on opioid use in Minnesota with the following measureable indicators:

- Reduce opioid overdose related deaths;
- Increase the number of people who receive opioid use disorder treatment and recovery services
- Reduce percentage of people reporting past 12-month pain reliever misuse
- Increased the number of buprenorphine waivered physicians
- Increased number of naloxone kits distributed for use

Statutory Change(s):
151.065; 151.252; and 151.255 (New Section)

Net Impact by Fund (dollars in thousands)			FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
General Fund								
HCAF								
Federal TANF								
Other Fund			0	0	0	0	0	0
Total All Funds								
Fund	BACT#	Description	FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
OTH	15	ADAD Administration	1,050	1,050	2,100	1,050	1,050	2,100
OTH	15	Transfer out to BOP	50	0	50	0	0	0
OTH	59	ADAD Grants	17,400	19,950	37,350	19,950	19,950	39,900
OTH	59	Transfer out to MDH	2,500	0	2,500	0	0	0
		Requested FTE's						
Fund	BACT#	Description	FY 18	FY 19	FY 18-19	FY 20	FY 21	FY 20-21
			2	2		2	2	

AT A GLANCE

- Conducts more than 14,000 administrative fair hearings per year (CY 2015)
- Reviews and approves more than 2,100 contracts per year
- Provides human resource management for about 6,400 state staff and about 3,900 county staff
- Resolves more than 100 requests for disability accommodations, investigates over 50 employment discrimination complaints, and resolves over 300 complaints relating to service delivery per year
- Sponsors development, accreditation, and engagement opportunities for all 6,400 DHS employees
- Promotes continuous improvement and measures delivery of 11 essential human services in all 87 counties.
- Licenses 21,930 service providers
- Conducts more than 7,000 recipient and 700 provider fraud investigations resulting in over $5.4 million and $6 million in identified overpayments (FY2015) respectively. To the extent we can realize recoveries, they are returned to county state and federal funding sources.
- Annually investigates 1,719 maltreatment allegations
- All funds spending for non-IT Operations activity for FY 2015 was $77.5 million. This represents 0.5% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

The Operations area within the Department of Human Services (DHS) serves external customers, internal staff, and ensures integrity in spending of public resources. To external customers, we license service providers and conduct background studies – key activities that keep Minnesotans safe and protect our most vulnerable citizens. We also provide appeals processes, tribal, county, and community relations, and communication resources.

To internal staff, we provide human resources services, financial management, legal services, and facilities management.

Finally, we work to ensure the prudent use of public dollars by investigating, preventing, and stopping fraudulent uses of state and federal money.

SERVICES PROVIDED

Our **Compliance Office** is responsible for legal and compliance activities throughout the agency:

- The *Appeals Division* conducts applicant or recipient appeal hearings on challenges economic assistance or social services denials, reductions, suspensions, terminations or delays. Our staff handle long-term care provider appeals over rate determinations and resolve disputes between counties over financial responsibility for providing services.
- The *Contracts, Purchasing and Legal Compliance Division* is the agency wide facilitator of DHS goods and services acquisitions including services delivered directly to program clients through grant contracts. The Division provides legal analysis and advice regarding contract development and vendor and grantee management.
- The *Internal Audits Office* tests, analyzes, evaluates and maintains the overall internal control environment at DHS. The Office has of three primary functions: Internal Audits, Program Compliance and Audits, and the Digital Forensics Lab. Our staff conducts audits of DHS grantees, contractors, vendors, and counties.
- The *General Counsel's Office* provides legal advice, counsel, and direction for all of DHS' legal activities.
- The *Management and Policy Division* oversees prevention, providing counsel on ethics, risk management, business continuity, records management, agency internal administrative policies, Commissioner Delegations of Authority, and policy bulletins.

Our **External Relations Office** oversee and provides direction to communications and key stakeholder relation efforts across the agency.

- Our *Office of Indian Policy* helps implement and coordinate programs with Tribes and provides ongoing consultation for program development for the delivery of services to American Indians living both on and off reservations. This office promotes government-to-government relations, and works to enhance tribal infrastructure, reduce disparities, and design effective programs.
- Our *Communications Office* leads agency communications efforts. We respond to inquiries from the news media and prepare information that helps the general public understand the agency's services and human services policies.
- Our *Legislative Relations* area participates in all aspects of legislative session planning and activities. We serve as a resource to managers and staff regarding the legislative process, prepare information for lawmakers, budget recommendations and position statements, as well as monitoring, tracking and analyzing legislative bills.
- Our *Community Relations* area supports, develops, and facilitates relationships between DHS and the community.
- Our *County Relations* area takes a lead role in the agency's relationships with Minnesota's 87 counties. These counties administer most of the human services system that the agency oversees.

Our **Human Resources Division** provides human resources management services for 6,400 staff at the agency and for approximately 3,900 county human services employees. This division provides staffing, health, safety, compensation, job classification, labor relations, management consulting, benefits administration, workers compensation and employee assistance services to managers and employees. The division is also responsible for the agency's continuous improvements training and initiatives, and for recycling, facilities management, mail processing, security, information desk services, and vehicle management.

Our **Office for Equity, Performance, and Development** helps DHS to maintain and cultivate a diverse and inclusive workforce, ensures that DHS uses equitable practices in employment and service delivery, provides consultation on performance measurement and continuous improvement, data analytics, survey development, and strategic planning, and promotes employee development, learning, and engagement.

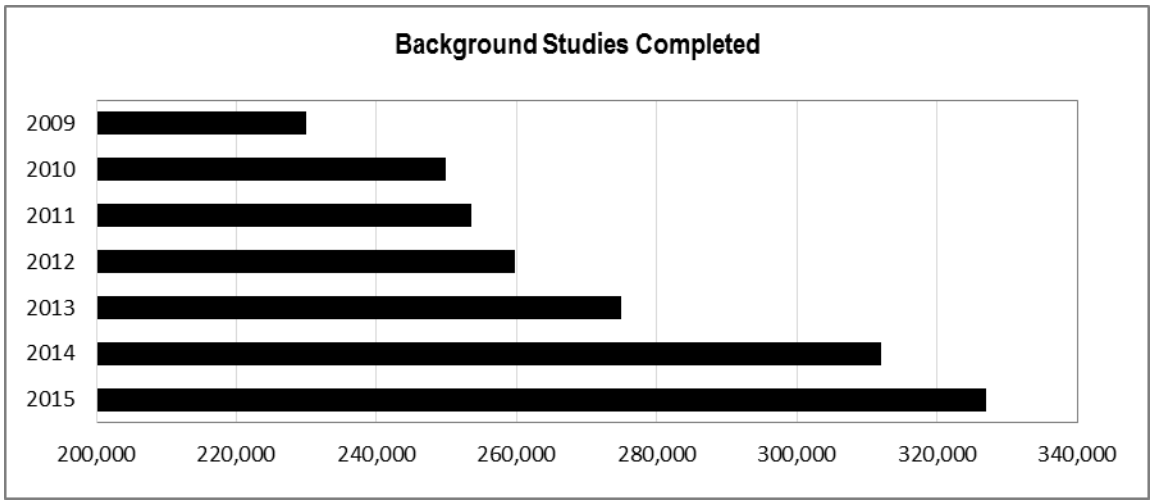
The **DHS Office of Inspector General** (http://mn.gov/dhs/general-public/office-of-inspector-general/) manages financial fraud and abuse investigations; licenses programs such as family child care, adult foster care, and mental health centers; and conducts background studies on people who apply to work in these settings:

- Our Licensing Division (http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_057547) licenses residential and nonresidential programs for children and vulnerable adults to ensure that the programs meet the requirements and the law. These programs include child care centers, family child care (via counties), foster care, adoption agencies, and services for people with developmental disabilities, chemical dependency, and mental illness. Our staff also completes investigations of maltreatment of vulnerable adults and children receiving services licensed by DHS.
- Our Background Studies Division (http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION &RevisionSelectionMethod=LatestReleased&dDocName=id_054413) annually conducts over 327,000 background studies on people working with children or vulnerable adults.
- Our Fraud Investigations Division (http://mn.gov/dhs/general-public/office-of-inspector-general/fraud-investigations/index.jsp) oversees fraud prevention and financial recovery efforts in health care, economic assistance, child care assistance, and food support programs.

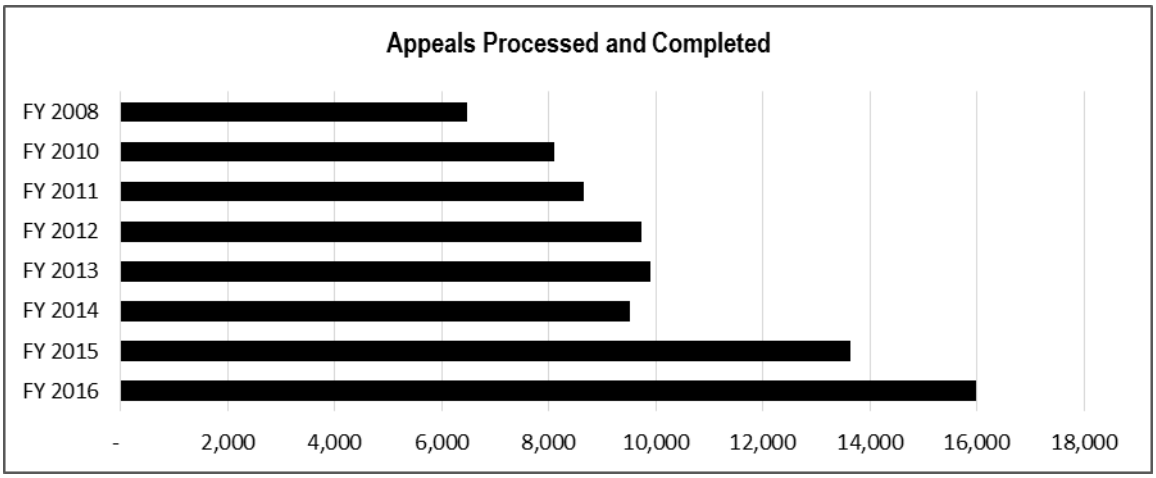
Our **Office of the Chief Financial Officer** provides fiscal services and controls the financial transactions of the agency, including the Central Office and Direct Care and Treatment. Core functions include preparing budget information, paying agency obligations, providing federal fiscal reporting, conducting patient revenue generation and collections, administering the Parental Fee program, processing agency receipts and preparing employees' payroll. The Reports and Forecasts Division (http://mn.gov/dhs/general-public/publications-forms-resources/reports/financial-reports-and-forecasts.jsp) is responsible for meeting federal reporting requirements for economic assistance programs, Minnesota Health Care Programs, and the Supplemental Nutrition Assistance Program. Our staff provides forecasts of program caseloads and expenditures, provides fiscal analyses of proposed legislation affecting these programs, and responds to requests for statistical information on the programs.

RESULTS

Number of background studies completed annually: Individuals who provide direct contact services to clients



Number of Appeals processed and completed by fiscal year



Operations' legal authority is in several places in state law: M.S. chapter 245A (Human Services Licensing); chapter 245C (Human Services Background Studies) and sections 144.057, 144A.476, and 524.5-118; and chapter 245D (Home and Community-Based Services Standards), M.S. Chapter 43A, sections 43A.19, 43A.191 (Affirmative Action), M.S. Chapter 363A (Human Rights), M.S. Chapter 402A (Human Services Performance Management).

Additional statutes give the agency authority to investigate fraud: M.S. sections 119B.125, 152.126, 256.987, 256D.024, 256J.26, 256J.38, 609.821, 626.5533, and chapter 245E (Child Care Assistance Program Fraud Investigations).

M.S. sections 626.556 and 626.557 authorize the agency's work conducting background studies and investigating reports related to maltreatment of minors and of vulnerable adults.

M.S. chapter 256 (Human Services) provides authority for many of the agency's general administrative activities. M.S. sections 256.045 to 256.046 give authority for the agency's appeals activities.

NOTE: MN.IT spending, which previously was reported under Operations, is now reflected on its own budget activity page.

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
1000 - General	46,341	47,284	49,912	50,343	52,241	53,543	64,075	67,713
1200 - State Government Special Rev	3,872	4,444	4,346	4,192	4,149	4,149	7,284	7,284
2000 - Restrict Misc Special Revenue	4,722	5,899	7,743	9,016	5,998	5,998	8,365	8,021
2001 - Other Misc Special Revenue	14,237	13,153	15,957	27,216	28,437	27,439	28,437	27,439
2360 - Health Care Access	4,247	4,304	4,262	6,710	7,058	6,555	7,816	8,017
3000 - Federal	1,294	1,826	2,580	2,441	2,475	2,475	2,475	2,475
3001 - Federal TANF	102	98	104	100	100	100	100	100
Total	**74,815**	**77,008**	**84,904**	**100,018**	**100,459**	**100,260**	**118,553**	**121,050**
Biennial Change				33,099		15,797		54,681
Biennial % Change				22		9		30
Governor's Change from Base								38,884
Governor's % Change from Base								19

Expenditures by Category

Compensation	42,725	48,723	51,611	54,869	51,342	51,342	66,465	69,329
Operating Expenses	30,809	27,625	31,312	44,900	48,420	48,221	51,391	51,024
Other Financial Transactions	745	151	556	248	248	248	248	248
Grants, Aids and Subsidies	534	497	57	0	448	448	448	448
Capital Outlay-Real Property	1	11	1,367	0	0	0	0	0
Total	**74,815**	**77,008**	**84,904**	**100,018**	**100,459**	**100,260**	**118,553**	**121,050**
Full-Time Equivalents	**484.9**	**539.4**	**553.2**	**682.8**	**662.2**	**639.4**	**807.0**	**831.2**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	2,899	0	454	0	0	0	0
Direct Appropriation	105,615	97,054	115,577	114,291	114,652	114,687	134,149	134,843
Net Transfers	(56,757)	(52,169)	(65,211)	(64,402)	(62,411)	(61,144)	(70,074)	(67,130)
Cancellations	0	501	0	0	0	0	0	0
Expenditures	**46,341**	**47,284**	**49,912**	**50,343**	**52,241**	**53,543**	**64,075**	**67,713**
Balance Forward Out	2,516	0	454	0	0	0	0	0
Biennial Change in Expenditures				6,630		5,530		31,534
Biennial % Change in Expenditures				7		6		31
Gov's Exp Change from Base								26,004
Gov's Exp % Change from Base								25
Full-Time Equivalents	314.9	346.7	353.4	440.6	424.9	407.5	547.4	569.7

1200 - State Government Special Rev

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	108	0	43	0	0	0	0
Direct Appropriation	3,974	4,385	4,389	4,149	4,149	4,149	7,284	7,284
Net Transfers	(13)							
Cancellations	0	49	0	0	0	0	0	0
Expenditures	**3,872**	**4,444**	**4,346**	**4,192**	**4,149**	**4,149**	**7,284**	**7,284**
Balance Forward Out	88	0	43	0	0	0	0	0
Biennial Change in Expenditures				222		(240)		6,030
Biennial % Change in Expenditures				3		(3)		71
Gov's Exp Change from Base								6,270
Gov's Exp % Change from Base								76
Full-Time Equivalents	40.3	36.1	35.7	42.5	42.5	42.5	42.5	42.5

2000 - Restrict Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	2,523	3,432	4,394	4,525	2,883	4,105	2,883	4,105
Receipts	5,721	6,642	7,833	8,055	8,054	8,054	10,421	10,077
Net Transfers	(102)	177	41	(681)	(834)	(871)	(834)	(871)
Expenditures	**4,722**	**5,899**	**7,743**	**9,016**	**5,998**	**5,998**	**8,365**	**8,021**

(Dollars in Thousands)

2000 - Restrict Misc Special Revenue

Balance Forward Out	3,420	4,352	4,525	2,883	4,105	5,290	4,105	5,290
Biennial Change in Expenditures				6,138		(4,762)		(372)
Biennial % Change in Expenditures				58		(28)		(2)
Gov's Exp Change from Base								4,390
Gov's Exp % Change from Base								37
Full-Time Equivalents	46.0	65.1	71.8	88.4	88.4	88.4	102.4	102.4

2001 - Other Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	1,399	1,769	2,395	2,272	8,059	13,391	8,059	13,391
Receipts	15,777	16,015	18,197	23,944	24,758	24,608	24,758	24,608
Net Transfers	(1,088)	(2,887)	(2,363)	9,060	9,012	8,164	9,012	8,164
Expenditures	**14,237**	**13,153**	**15,957**	**27,216**	**28,437**	**27,439**	**28,437**	**27,439**
Balance Forward Out	1,852	1,743	2,272	8,059	13,391	18,723	13,391	18,723
Biennial Change in Expenditures				15,783		12,704		12,704
Biennial % Change in Expenditures				58		29		29
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0
Full-Time Equivalents	33.6	35.2	36.6	43.8	43.8	43.8	43.8	43.8

2360 - Health Care Access

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	44	0	280	0	0	0	0
Direct Appropriation	13,177	13,004	9,793	10,503	20,025	20,025	23,618	21,516
Net Transfers	(8,896)	(8,168)	(5,251)	(4,073)	(12,967)	(13,470)	(15,802)	(13,499)
Cancellations	0	575	0	0	0	0	0	0
Expenditures	**4,247**	**4,304**	**4,262**	**6,710**	**7,058**	**6,555**	**7,816**	**8,017**
Balance Forward Out	34	0	280	0	0	0	0	0
Biennial Change in Expenditures				2,420		2,641		4,861
Biennial % Change in Expenditures				28		24		44
Gov's Exp Change from Base								2,220
Gov's Exp % Change from Base								16
Full-Time Equivalents	34.3	36.2	34.2	37.0	32.2	26.7	40.4	42.4

(Dollars in Thousands)

3000 - Federal

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	7	5	41	6	0	0	0	0
Receipts	1,292	1,825	2,545	2,435	2,475	2,475	2,475	2,475
Expenditures	**1,294**	**1,826**	**2,580**	**2,441**	**2,475**	**2,475**	**2,475**	**2,475**
Balance Forward Out	5	5	6	0	0	0	0	0
Biennial Change in Expenditures				1,901		(71)		(71)
Biennial % Change in Expenditures				61		(1)		(1)
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0
Full-Time Equivalents	14.8	19.2	20.5	29.3	29.3	29.3	29.3	29.3

3001 - Federal TANF

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	0	0	0	0	0	0	0
Receipts	102	98	104	100	100	100	100	100
Expenditures	**102**	**98**	**104**	**100**	**100**	**100**	**100**	**100**
Balance Forward Out	0	0	0	0	0	0	0	0
Biennial Change in Expenditures				4		(4)		(4)
Biennial % Change in Expenditures				2		(2)		(2)
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0
Full-Time Equivalents	1.0	0.9	0.9	1.3	1.3	1.3	1.3	1.3

Program: Central Office Operations
Activity: Children & Families

mn.gov/dhs/people-we-serve/children-and-families/

AT A GLANCE

- Provides child support services to more than 360,000 custodial and non-custodial parents annually and 250,000 children
- Provides child care assistance to more than 30,000 children in an average month
- 988 children were either adopted or had a permanent transfer of legal custody to a relative in 2015
- Facilitates Supplemental Nutrition Assistance Program (SNAP) payments to more than 466,000 Minnesotans every month
- All funds administrative spending for the Children and Families activity for FY 2015 was $39.5 million. This represented 0.3% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

Children and Families administers, and provides administrative support to counties, tribes and social service agencies for programs that provide child safety and well-being services, and for economic assistance programs serving low-income families and children.

These services help ensure that low-income people receive the support they need to be safe and help build stable families and communities. Programs administered in this area seek to:

- Keep more people fed and healthy by increasing nutrition assistance participation;
- Keep more children out of foster care and safely with their families;
- Decrease the disproportionate number of children of color in out-of-home placements; and,
- Increase access to high quality child care.

Our statewide administration of these programs ensures that federal funds are used according to federal regulations, resources and services are distributed equitably across the state, and quality standards are maintained.

SERVICES PROVIDED

The Children and Family Services Administration is organized into five principal Divisions:

- Child Safety and Permanency,
- Child Support,
- Community Partnerships and Child Care Services,
- Economic Assistance and Employment Supports, and
- Management Operations

In the Children and Families Services Administration our staff provides administrative direction and supports to counties, tribes and community agencies. Our work includes:

- Researching, recommending and implementing statewide policy and programs
- Managing grants
- Training and giving technical assistance to counties, tribes and grantees
- Evaluating and auditing service delivery
- Conducting quality assurance reviews to make sure that effective services are delivered efficiently and consistently across the state

Our areas of responsibility include administering several forecasted programs: the Minnesota Family Investment Program (MFIP) and Diversionary Work Program, and MFIP Child Care Assistance. Our staff also supports grant programs that provide funding for housing, food and child welfare services. We also administer the federal Supplemental Nutrition Assistance Program (SNAP). We review approximately 2,600 SNAP cases annually to see if benefits and eligibility were determined correctly. In addition, we review overall county and tribal administration and management of SNAP in 30-35 agencies each year. We provide oversight of statewide child welfare services that focus on ensuring children's safety while supporting families. We ensure that core safety services focus on preventing or remedying neglect, and providing basic food, housing and other supports to the most at-risk adults and children. In 2015, we provided more than 950 classroom and over 3,800 on-line trainings for county staff on SNAP, family cash assistance and child care assistance.

Funding for our programs comes from a combination of state and federal dollars. Major federal block grants that support programs in our Administration include Temporary Assistance for Needy Families, the Child Care and Development Fund, the Social Services Block Grant and the Community Services Block Grant. Funding from these four federal sources totaled $382 million in federal fiscal year 2015.

RESULTS

We provide administrative support to a broad array of programs and services for low-income families and adults and children. We report some key measures related to child protection and to the SNAP program.

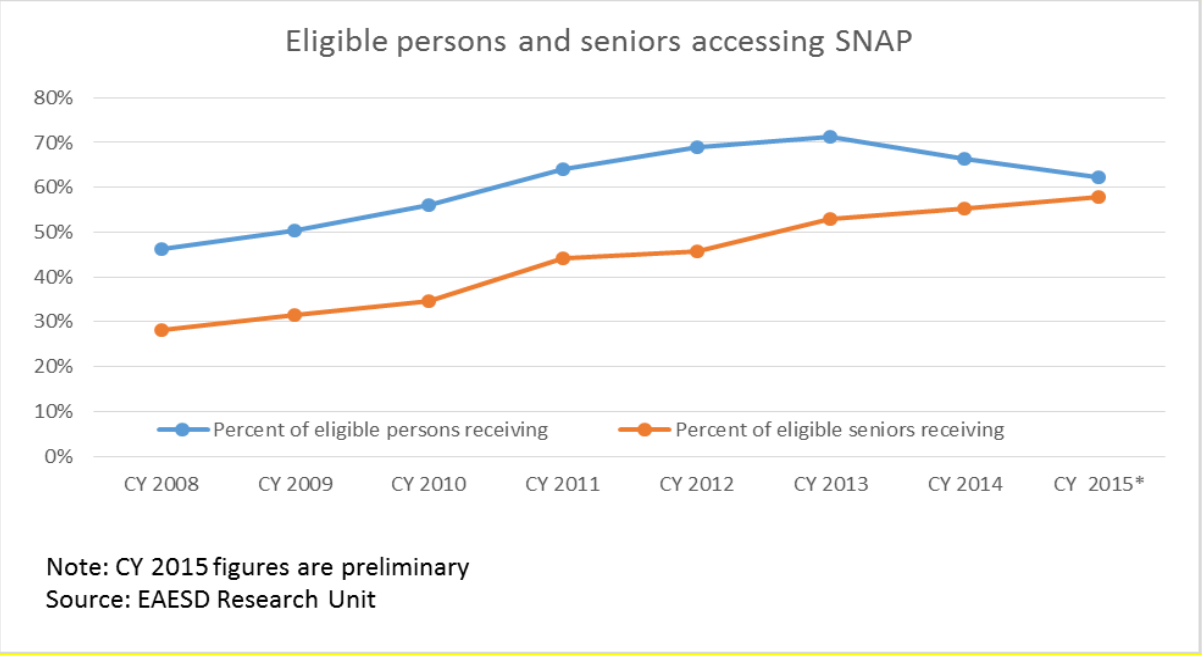
Type of Measure	***Description of Measure***	***2010***	***2011***	***2012***	***2013***	***2014***	***2015***
Quality	Percent of children not experiencing repeated abuse or neglect within 6 months of a prior report	95.1%	95.6%	97.5%	97.2%	96.7%	97.0%
Quality	Percent of children reunified with parents or living with relatives in fewer than 12 months from latest removal from home	84.5%	85.7%	85.9%	85.1%	86.2%	83.9%
Quality	Percent of children adopted in fewer than 24 months from latest removal from home	48.2%	48.1%	49.4%	54.7%	59.9%	54.2%

Performance Measures notes:

All measures in the above table are from Minnesota's Child Welfare Reports, 2010-2014. Child Protection statistical reports are posted on the DHS Child Protection Publications (http://www.dhs.state.mn.us/main/id_003712) page. The 2015 data come from the DHS Child Welfare Data Dashboard (http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_148137).

SNAP Participation Rate

The quality measure below shows increased participation in the SNAP program to help keep people fed and healthy.



Data for SNAP Participation Rate is from the Economic Assistance & Employment Supports Division Research Unit at the Department of Human Services, based on administrative data.

M.S. chapter 256 (Human Services) (https://www.revisor.mn.gov/statutes/?id=256) provides authority for many of the agency's general administrative activities. For specific programs administered under Children and Families, we list legal citations that apply to the program at the end of each budget narrative.

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
1000 - General	6,975	7,645	8,186	10,287	9,153	9,068	10,561	10,287
2000 - Restrict Misc Special Revenue	675	1,007	136	70	62	62	62	62
2001 - Other Misc Special Revenue	20,860	21,497	20,791	23,990	21,776	21,771	21,776	21,771
3000 - Federal	9,218	9,383	11,065	12,480	12,546	12,464	12,696	12,614
3001 - Federal TANF	2,252	2,060	2,037	2,583	2,583	2,583	2,583	2,583
Total	**39,980**	**41,591**	**42,215**	**49,410**	**46,119**	**45,948**	**47,677**	**47,317**
Biennial Change				10,053		443		3,370
Biennial % Change				12		0		4
Governor's Change from Base								2,927
Governor's % Change from Base								3

Expenditures by Category

Compensation	25,829	27,135	27,100	31,055	30,879	30,793	32,214	31,924
Operating Expenses	14,017	14,403	14,839	18,319	15,208	15,123	15,431	15,361
Other Financial Transactions	89	49	152	36	32	32	32	32
Grants, Aids and Subsidies	46	5	123	0	0	0	0	0
Total	**39,980**	**41,591**	**42,215**	**49,410**	**46,119**	**45,948**	**47,677**	**47,317**
Full-Time Equivalents	**286.9**	**295.0**	**286.0**	**333.6**	**333.6**	**333.6**	**343.3**	**342.3**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	548	0	830	0	0	0	0
Direct Appropriation	8,023	8,015	9,974	9,961	9,176	9,176	10,520	10,331
Net Transfers	(517)	(770)	(958)	(505)	(23)	(108)	41	(44)
Cancellations	0	148	0	0	0	0	0	0
Expenditures	**6,975**	**7,645**	**8,186**	**10,287**	**9,153**	**9,068**	**10,561**	**10,287**
Balance Forward Out	531	0	830	0	0	0	0	0
Biennial Change in Expenditures				3,852		(252)		2,375
Biennial % Change in Expenditures				26		(1)		13
Gov's Exp Change from Base								2,627
Gov's Exp % Change from Base								14
Full-Time Equivalents	64.2	65.6	61.6	76.8	76.8	76.8	86.6	85.6

2000 - Restrict Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	303	375	303	105	47	47	47	47
Receipts	194	176	243	0	0	0	0	0
Net Transfers	552	690	(305)	13	62	62	62	62
Expenditures	**675**	**1,007**	**136**	**70**	**62**	**62**	**62**	**62**
Balance Forward Out	375	234	105	47	47	47	47	47
Biennial Change in Expenditures				(1,476)		(82)		(82)
Biennial % Change in Expenditures				(88)		(40)		(40)
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0
Full-Time Equivalents	6.7	7.7	2.1	2.0	2.0	2.0	2.0	2.0

2001 - Other Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	2,817	2,029	2,548	1,155	898	981	898	981
Receipts	3,295	3,804	3,310	2,698	2,677	2,691	2,677	2,691
Net Transfers	16,551	16,755	16,087	21,034	19,181	19,176	19,181	19,176
Expenditures	**20,860**	**21,497**	**20,791**	**23,990**	**21,776**	**21,771**	**21,776**	**21,771**
Balance Forward Out	1,804	1,090	1,155	898	981	1,077	981	1,077

(Dollars in Thousands)

2001 - Other Misc Special Revenue

Biennial Change in Expenditures				2,423		(1,233)		(1,233)
Biennial % Change in Expenditures				6		(3)		(3)
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0
Full-Time Equivalents	120.8	128.0	126.1	142.2	142.2	142.2	142.2	142.2

3000 - Federal

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	942	107	132	92	0	0	0	0
Receipts	8,346	9,352	11,024	12,388	12,546	12,464	12,696	12,614
Net Transfers			0					
Expenditures	**9,218**	**9,383**	**11,065**	**12,480**	**12,546**	**12,464**	**12,696**	**12,614**
Balance Forward Out	70	77	92	0	0	0	0	0
Biennial Change in Expenditures				4,945		1,465		1,765
Biennial % Change in Expenditures				27		6		7
Gov's Exp Change from Base								300
Gov's Exp % Change from Base								1
Full-Time Equivalents	81.7	81.6	85.1	99.2	99.2	99.2	99.2	99.2

3001 - Federal TANF

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	0	0	0	0	0	0	0
Receipts	2,252	2,060	2,037	2,582	2,582	2,582	2,582	2,582
Expenditures	**2,252**	**2,060**	**2,037**	**2,583**	**2,583**	**2,583**	**2,583**	**2,583**
Biennial Change in Expenditures				308		545		545
Biennial % Change in Expenditures				7		12		12
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0
Full-Time Equivalents	13.7	12.1	11.1	13.4	13.4	13.4	13.4	13.4

Program: Central Office Operations
Activity: Health Care

AT A GLANCE

- **Medical Assistance** provided coverage for an average of 1,049,819 people each month during FY 2015.
- **MinnesotaCare** provided coverage for an average of 91,105 people each month during FY 2015.
- In FY2015 our member services call center fielded 387,200 telephone calls from recipients.
- In FY2015 our provider help desk answered 342,071 calls from providers.
- All funds administrative spending for the Health Care activity for FY 2015 was $76.3 million. This represents 0.5% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

The Minnesota Department of Human Services (DHS) Health Care Administration administers the Minnesota Health Care Programs (MHCP), including:

Medical Assistance (MA; Minnesota's Medicaid program) which provides health coverage for low-income people including children and families, people 65 or older, people who have disabilities and adults without children; and

MinnesotaCare which provides coverage for those who do not have access to affordable health care coverage but whose income is too high for Medical Assistance.

These programs provide a health care insurance safety net for low-income families, elderly, disabled and very low-income adults without children.

Our goals are to:

- Increase the number of insured Minnesotans by helping eligible people get MA or MinnesotaCare coverage
- Improve and streamline Medicaid processes through the way we administer and deliver programs
- Improve the health outcomes, beneficiary experience and value of care delivered through MHCP
- Reform payment and delivery models by designing rates and models to reward quality and emphasize transparency
- Use research, data and analysis to develop policy recommendations, support DHS health care programs and evaluate results
- Encourage stakeholder communication to support our clients, partners and programs

SERVICES PROVIDED

The Health Care Administration's (HCA) Divisions and operational units include the following:

Office of the Assistant Commissioner

This office performs central functions including:

- Managing the partnership between DHS and the federal Centers for Medicare and Medicaid Services for all Medicaid state plan and waiver services
- Conducting Care delivery and payment reform projects including the Integrated Health Partnerships and the CMS State Innovation Models
- Ensuring that benefit and payment policies are supported by best clinical practices through the Office of the Medical Director
- Coordinating the development of recommendations on health care policy and legislation

Health Care Eligibility Operations

- Processes applications and makes eligibility determinations for MinnesotaCare and the Minnesota Family Planning Program
- Conducts 10,000-12,000 disability determinations for the purposes of Medical Assistance eligibility
- Provides ongoing case maintenance and processes changes in enrollee circumstance that may influence eligibility

Health Care Eligibility and Access

- Administers all eligibility policy for the Medical Assistance and MinnesotaCare programs including long term care services.
- Provides training, education, and support for county social service agencies, tribal governments, and other entities processing applications for MHCP
- Develops business requirements for eligibility systems including MAXIS, MMIS, and MNsure (METS)

Purchasing and Service Delivery (PSD)

- Coordinates the purchasing and delivery of services in state health care programs and administers coverage and benefit policy
- Establishes payment policies and calculations for fee-for-service and managed care rates
- Negotiates and manages annual contracts between DHS and managed care organizations

Member and Provider Services (MPS)

- Supports MHCP members and providers, conducts benefits recovery and claims processing, runs the member and provider call centers, enrolls health care providers, and manages all provider training and communication regarding the health care programs
- Benefits Recovery Unit assures that Medical Assistance program remains the payer of last resort by billing any insurers or other parties with primary responsibility for paying medical claims
- Responds to enrollee phone calls regarding eligibility, covered services, and provider availability

Healthcare Research and Quality

- Conducts data analysis, research, and data reporting responsibilities for the MHCP and oversees quality assurance activities for the managed care organizations contracting with DHS
- Uses heath care claims data to inform policy and program development and monitors the quality of health care services purchased by DHS

Our staff shares some health care coverage policy and rates development functions with the Community Supports administration for the services under the purview of those other administrations.

Our work supports the following strategies:

- Improve access to affordable health care
- Integrate primary care, behavioral health and long-term care
- Maintain a workforce committed to fulfilling the agency mission
- Expand the number of providers and enrollees participating in Integrated Health Partnerships
- Modernize eligibility and enrollment systems
- Reduce disparities so that cultural and ethnic communities have the same access to outcomes for health care
- Hold managed care plans accountable for health equity outcomes related to depression, diabetes and well child visits

RESULTS

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. DHS contracts with managed care organizations to serve enrolles in Minnesota's public health care programs. In 2015 the Department of Human Services implemented statewide competitive bidding for 2016 managed care contracts serving roughly 800,000 people. The responses that DHS received resulted in lower than expected managed care rates which lead to a sizable reduction in forecast expenditures. DHS estimates that the value of the reduced payments relative to the February 2015 forecast will produce savings of over $600 million to the state and federal government in the FY16-17 biennium.

As part of Minnesota's commitment to deliver quality health care more efficiently, the agency began a new payment model in 2013 that prioritizes quality preventive care and rewards providers for reducing the cost of care for enrollees in MA and MinnesotaCare programs.

The Integrated Health Partnerships (IHP) initiative gives participating providers financial incentives to manage the total cost of care through better coordination of medical care and prioritizing quality care. This initiative has resulted in over $150 milllion in lower than expected health care expenditures over three years as providers across the state developed and implemented innovative approaches to improving health care for low income people. A portion of these savings accrue to the state budget. On quality, the results for the provider groups that joined IHP in the first year show that they either outperformed statewide averages for quality metrics such as depression remission and optimal diabetes care, or showed significant improvement.

The IHP project began in 2013 with 6 participating providers providing care to 100,000 people in publically funded health care programs. In just three years the project expanded to 19 providers and covers more than 350,000 people. This growth puts DHS on track to meet its goal of 500,000 participants in IHP or similar value-based reforms by the end of 2018.

Type of Measure	*Performance Measure*	*Previous*	*Current*	*Dates*
Quality	Percent of electronically submitted claims paid within two days[1]	98.27%	98.28%	FY2013 and FY2015
Quantity	Number of Providers Enrolled in an Integrated Health Partnership[2]	9	19	2014 and 2015
Quantity	Total MA Benefit Recoveries (excluding fraud and cost avoidance)[3]	$52.6 million	$46 million	FY2014 and FY2015

Performance Measure Notes:

1. Source: FY 2015 Member and Provider Services Operational Statistics. Compares Fiscal year 2013 (Previous) to Fiscal year 2015 (Current). Our goal is to pay 98 percent of electronically submitted claims within two days. The trend is stable.
2. Measure is the number of providers voluntarily contracting with DHS as an IHP to serve MA and MinnesotaCare recipients. Compares 2015 (Previous) to 2016 (Current)
3. Source: Member and Provider Services Operational Statistics. Measure is the total amount of recoveries conducted by the benefit recovery unit at DHS and contractors performing recovery activities on its behalf. Compares FY 2014 (Previous) and FY 2015 (Current).

M.S. chapter 256 (Human Services) provides authority for many of the agency's general administrative activities. Some of the authority to administer MA is also in that chapter. Additional legal authority to administer MA is in M.S. chapter 256B (Medical Assistance for Needy Persons). Our authority to administer MinnesotaCare is in M.S. chapter 256L.

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
1000 - General	12,390	11,894	15,344	15,948	14,637	14,553	20,760	23,846
2000 - Restrict Misc Special Revenue	423	691	1,352	2,438	2,567	2,604	2,567	2,604
2001 - Other Misc Special Revenue	23,638	33,063	41,153	47,124	43,831	43,681	43,831	43,681
2360 - Health Care Access	22,716	25,989	24,176	25,375	23,397	23,504	33,631	23,684
3000 - Federal	6,217	13,114	16,517	15,992	4,593	45	4,593	45
Total	**65,383**	**84,750**	**98,542**	**106,877**	**89,026**	**84,388**	**105,383**	**93,861**
Biennial Change				55,286		(32,005)		(6,175)
Biennial % Change				37		(16)		(3)
Governor's Change from Base								25,830
Governor's % Change from Base								15

Expenditures by Category

Compensation	45,329	48,418	53,150	57,203	54,501	52,093	65,198	55,316
Operating Expenses	19,563	35,612	42,585	49,517	34,369	32,139	40,029	38,389
Other Financial Transactions	361	122	359	156	156	156	156	156
Grants, Aids and Subsidies	130	598	2,421	0	0	0	0	0
Capital Outlay-Real Property	0	0	28	0	0	0	0	0
Total	**65,383**	**84,750**	**98,542**	**106,877**	**89,026**	**84,388**	**105,383**	**93,861**
Full-Time Equivalents	**611.5**	**630.5**	**645.6**	**762.5**	**757.2**	**743.3**	**868.7**	**770.3**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	1,267	0	1,131	0	0	0	0
Direct Appropriation	14,817	14,512	16,667	16,683	15,812	15,728	21,935	25,021
Net Transfers	(1,236)	(3,828)	(192)	(1,866)	(1,175)	(1,175)	(1,175)	(1,175)
Cancellations	0	58	0	0	0	0	0	0
Expenditures	**12,390**	**11,894**	**15,344**	**15,948**	**14,637**	**14,553**	**20,760**	**23,846**
Balance Forward Out	1,191	0	1,131	0	0	0	0	0
Biennial Change in Expenditures				7,009		(2,102)		13,314
Biennial % Change in Expenditures				29		(7)		43
Gov's Exp Change from Base								15,416
Gov's Exp % Change from Base								53
Full-Time Equivalents	106.6	92.6	101.5	117.8	117.8	117.8	137.3	142.8

2000 - Restrict Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	380	291	203	159	561	567	561	567
Receipts	292	559	1,187	2,740	2,259	2,259	2,259	2,259
Net Transfers	(25)		120	100	314	351	314	351
Expenditures	**423**	**691**	**1,352**	**2,438**	**2,567**	**2,604**	**2,567**	**2,604**
Balance Forward Out	224	158	159	561	567	573	567	573
Biennial Change in Expenditures				2,676		1,381		1,381
Biennial % Change in Expenditures				240		36		36
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0
Full-Time Equivalents	2.7	0.8	1.7	10.0	10.0	10.0	10.0	10.0

2001 - Other Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	5,457	4,021	2,766	3,671	4,780	6,090	4,780	6,090
Receipts	4,363	3,614	6,302	7,692	7,692	7,692	7,692	7,692
Net Transfers	17,359	27,560	35,756	40,542	37,450	37,300	37,450	37,300
Expenditures	**23,638**	**33,063**	**41,153**	**47,124**	**43,831**	**43,681**	**43,831**	**43,681**
Balance Forward Out	3,542	2,132	3,671	4,780	6,090	7,400	6,090	7,400

(Dollars in Thousands)

2001 - Other Misc Special Revenue

Biennial Change in Expenditures				31,576		(764)		(764)
Biennial % Change in Expenditures				56		(1)		(1)
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0
Full-Time Equivalents	187.7	205.2	231.4	261.7	256.4	250.5	256.4	250.5

2360 - Health Care Access

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	1,309	0	41	0	0	0	0
Direct Appropriation	28,442	31,137	33,185	34,007	23,697	23,804	33,931	23,984
Net Transfers	(4,869)	(6,114)	(8,968)	(8,672)	(300)	(300)	(300)	(300)
Cancellations	0	343	0	0	0	0	0	0
Expenditures	**22,716**	**25,989**	**24,176**	**25,375**	**23,397**	**23,504**	**33,631**	**23,684**
Balance Forward Out	858	0	41	0	0	0	0	0
Biennial Change in Expenditures				848		(2,650)		7,764
Biennial % Change in Expenditures				2		(5)		16
Gov's Exp Change from Base								10,414
Gov's Exp % Change from Base								22
Full-Time Equivalents	310.1	321.4	298.0	361.5	361.5	361.5	453.5	363.5

3000 - Federal

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	0	0	0	0	0	0	0
Receipts	6,218	13,113	16,516	15,992	4,593	45	4,593	45
Expenditures	**6,217**	**13,114**	**16,517**	**15,992**	**4,593**	**45**	**4,593**	**45**
Biennial Change in Expenditures				13,178		(27,871)		(27,871)
Biennial % Change in Expenditures				68		(86)		(86)
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0
Full-Time Equivalents	4.4	10.6	13.0	11.5	11.5	3.5	11.5	3.5

Program: Central Office Operations
Activity: Continuing Care For Older Adults

mn.gov/dhs/people-we-serve/seniors/

AT A GLANCE

- Oversees services to over 400,000 people each year with a value of more than $1.32 billion in state and federal funds
- Performs statewide human services planning and develops and implements policy
- Obtains, allocates, and manages resources, contracts, and grants
- Sets standards for, and evaluates, service development and delivery, and monitors compliance
- Provides technical assistance and training to county and tribal agencies and supports local innovation and quality improvement efforts
- All funds administrative spending for the Continuing Care Administration activity for FY 2015 was $29.5 million.1 This represented 0.19% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

The Continuing Care for Older Adults Administration administers Minnesota's publicly funded long-term care programs and services for older Minnesotans and their families. Our Administration's mission is to improve the dignity, health and independence of the people we serve.

We have four goals:

- Support and enhance the quality of life for older people and
- Manage an equitable and sustainable long-term care system that maximizes value
- Continuously improve how we administer services
- Promote professional excellence and engagement in our work

SERVICES PROVIDED

The Continuing Care for Older Adults Administration is composed of the following Divisions and units, each charged with particular areas of responsibility:

- Aging and Adult Services Division
- Planning and Aging 2030
- Nursing Facility Rates and Policy Division
- Fiscal Analysis and Performance Measurement
- Operations and Central Functions

Our work includes:

- Administering Medical Assistance long-term care waiver programs and state plan services. This includes developing, seeking authority for and implementing policies, projects, and research. We also oversee state and federal grants and contracts, including Senior Nutrition Grants and Moving Home Minnesota, a federal Money Follows the Person Rebalancing Demonstration Program. These programs serve both seniors and people with disabilities;
- Providing training, education, assistance, advocacy and direct services, including overseeing the state's adult protective services system;
- Monitoring service quality by doing evaluations and measuring results using county waiver reviews;
- Staffing of the Governor-appointed Minnesota Board on Aging (http://www.mnaging.org/), a state agency administratively placed within DHS with oversight of the Office of Ombudsman for Long-Term Care;
- Working to improve the quality of services and share best practices across providers;
- Providing administrative, financial, and operational management and support for both the Continuing Care for Older Adults Administration and the Community Supports Administration; and
- Providing outreach, staff support and technical assistance to stakeholders and stakeholder workgroups.

Direct services we provide include:

- Providing statewide referrals to services, care transitions support, health insurance and long-term benefits counseling through the Senior LinkAge Line® to older Minnesotans and their caregivers so that they can get answers about long-term care and how to pay for it, resolve issues with Medicare and prescription drugs, connect with volunteer opportunities, or find resources;
- Providing long-term care ombudsman services, which help people resolve complaints and keep their services; and
- Developing, maintaining, and publishing provider quality rankings for consumers using the nursing home and HCBS report cards.

RESULTS

We use several information sources and data to monitor and evaluate quality outcomes and provider performance. Much of the information we analyze is from the DHS Data Warehouse or from surveys of consumers, providers, and lead agencies. More explanation of these measures is in the performance notes below the table.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quality	1. Percent of waiver review follow-up cases corrected after issuance of corrective actions	93%	94%	2013 to 2015
Quality	2. Average statewide risk-adjusted nursing facility quality of care score out of a possible 100 points	65.2	69.2	Dec. 2012 to Mar. 2016
Result	3. Percent of seniors served by home and community-based services	68.4%	71.3%	2013 to 2015

More information is available on the DHS Dashboard (http://dashboard.dhs.state.mn.us/) and the Continuing Care Performance Report (http://www.dhs.state.mn.us/main/dhs16_166609).

Performance Notes:

1. Measure one compares 2013 data to 2015 data. Round II of Waiver Reviews was completed in FY15. Source: Waiver review database
2. Measure two compares December 2012 data to March 2016 data. Source: Minimum Data Set resident assessments.
3. Measure three compares FY2013 to FY2015. This measure shows the percentage of seniors receiving publicly-funded long-term care services who receive HCBS services through the Elderly Waiver, Alternative Care, or home care programs instead of nursing home services. Source: DHS Data Warehouse

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M.S. chapter 256 (Human Services) provides authority for many of the agency's general administrative activities. Some of the authority to administer MA is also in that chapter. Additional legal authority to administer MA is in M.S. chapter 256B (Medical Assistance for Needy Persons). For other activities administered under Continuing Care, we list legal citations that apply to the program at the end of each budget narrative.

[1] In FY16, the Continuing Care Administration and the Chemical and Mental Health Administrations were reorganized. The Disability Services Division and the Deaf Services Division were combined with chemical and mental health in the new Community Supports Administration and the Continuing Care Administration was renamed the Continuing Care for Older Adults Administration.

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
1000 - General	19,559	24,715	13,491	15,743	14,029	14,031	17,652	18,089
1200 - State Government Special Rev	138	113	103	147	125	125	125	125
2000 - Restrict Misc Special Revenue	0	0	49	2,020	1,710	1,502	1,710	1,502
2001 - Other Misc Special Revenue	336	868	244	316	168	168	168	168
2403 - Gift	0	0	0	30	15	15	15	15
3000 - Federal	4,073	4,060	3,668	4,350	3,878	3,634	3,878	3,634
Total	**24,106**	**29,755**	**17,556**	**22,606**	**19,925**	**19,475**	**23,548**	**23,533**
Biennial Change				(13,699)		(762)		6,919
Biennial % Change				(25)		(2)		17
Governor's Change from Base								7,681
Governor's % Change from Base								19

Expenditures by Category

Compensation	18,212	21,582	11,280	12,140	12,064	11,967	14,196	13,432
Operating Expenses	5,580	8,016	6,097	10,425	7,820	7,469	9,311	10,062
Other Financial Transactions	269	114	109	41	41	39	41	39
Grants, Aids and Subsidies	46	42	71	0	0	0	0	0
Capital Outlay-Real Property	0	0	0	0	0	0	0	0
Total	**24,106**	**29,755**	**17,556**	**22,606**	**19,925**	**19,475**	**23,548**	**23,533**
Full-Time Equivalents	**206.6**	**235.7**	**120.8**	**132.6**	**132.6**	**132.6**	**141.4**	**143.1**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	75	949	0	1,716	0	0	0	0
Direct Appropriation	23,296	28,132	32,950	29,925	14,029	14,031	17,652	18,089
Net Transfers	(2,934)	(4,353)	(17,743)	(15,898)	0	0	0	0
Cancellations	0	13	0	0	0	0	0	0
Expenditures	**19,559**	**24,715**	**13,491**	**15,743**	**14,029**	**14,031**	**17,652**	**18,089**
Balance Forward Out	878	0	1,716	0	0	0	0	0
Biennial Change in Expenditures				(15,039)		(1,174)		6,507
Biennial % Change in Expenditures				(34)		(4)		22
Gov's Exp Change from Base								7,681
Gov's Exp % Change from Base								27
Full-Time Equivalents	166.1	196.0	84.8	93.9	93.9	93.9	102.7	104.4

1200 - State Government Special Rev

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	0	0	22	0	0	0	0
Direct Appropriation	125	125	125	125	125	125	125	125
Net Transfers	13							
Cancellations	0	12	0	0	0	0	0	0
Expenditures	**138**	**113**	**103**	**147**	**125**	**125**	**125**	**125**
Balance Forward Out	0	0	22	0	0	0	0	0
Biennial Change in Expenditures				(1)		0		0
Biennial % Change in Expenditures				0		0		0
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0
Full-Time Equivalents	1.3	1.1	0.6	1.3	1.3	1.3	1.3	1.3

2000 - Restrict Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	121	121	121	986	259	259	259	259
Receipts	0	0	0	187	187	187	187	187
Net Transfers			914	1,106	1,523	1,315	1,523	1,315
Expenditures	0	0	**49**	**2,020**	**1,710**	**1,502**	**1,710**	**1,502**

(Dollars in Thousands)

2000 - Restrict Misc Special Revenue

Balance Forward Out	121	121	986	259	259	259	259	259
Biennial Change in Expenditures				2,069		1,143		1,143
Biennial % Change in Expenditures						55		55
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0
Full-Time Equivalents	0.0	0.0	0.2	0.8	0.8	0.8	0.8	0.8

2001 - Other Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	236	343	397	84	0	0	0	0
Receipts	11	105	111	168	168	168	168	168
Net Transfers	427	734	(179)	64	0	0	0	0
Expenditures	**336**	**868**	**244**	**316**	**168**	**168**	**168**	**168**
Balance Forward Out	338	314	84	0	0	0	0	0
Biennial Change in Expenditures				(644)		(225)		(225)
Biennial % Change in Expenditures				(53)		(40)		(40)
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0
Full-Time Equivalents	2.1	3.1	0.3	0.3	0.3	0.3	0.3	0.3

2403 - Gift

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	13	14	15	15	0	0	0	0
Receipts	1	0	0	15	15	15	15	15
Expenditures	0	**0**	0	**30**	**15**	**15**	**15**	**15**
Balance Forward Out	14	15	15	0	0	0	0	0
Biennial Change in Expenditures				30		0		0
Biennial % Change in Expenditures				6,269		0		0
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

3000 - Federal

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19

(Dollars in Thousands)

3000 - Federal

Balance Forward In	6	8	5	6	0	0	0	0
Receipts	4,068	4,051	3,669	4,345	3,878	3,634	3,878	3,634
Expenditures	**4,073**	**4,060**	**3,668**	**4,350**	**3,878**	**3,634**	**3,878**	**3,634**
Balance Forward Out	4	0	6	0	0	0	0	0
Biennial Change in Expenditures				(114)		(506)		(506)
Biennial % Change in Expenditures				(1)		(6)		(6)
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0
Full-Time Equivalents	37.0	35.5	34.9	36.3	36.3	36.3	36.3	36.3

Program: Central Office Operations
Activity: Community Supports

AT A GLANCE

- 93,445 people received substance abuse treatment services in CY2015
- Provided 40,132 people with disability home and community-based services waivers in FY2015.
- Provided 26,646 people with Personal Care Assistance (PCA) services in FY2015.
- 20,165 people received assistance from the Deaf and Hard of Hearing Services Division in FY2015
- 155,723 adults received mental health services through Minnesota Health Care Programs (MHCP) in CY 2015
- 67,000 children and youth receive publically funded mental health services each year
- More than 2,900 individuals in 1,300 households receive transitional housing services annually
- More than 2,699 individuals at risk of or experiencing long-term homelessness received supportive services in FY 2015
- All funds administrative spending for the Community Supports (formerly Chemical and Mental Health) Budget Activity for FY 2015 was $15.5 million[1]. This represented 0.1% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

The Community Supports Administration (CSA) within the Department of Human Services oversees service delivery systems for mental health, people with disabilities, alcohol and drug abuse, people who are deaf, deafblind and hard of hearing, and people needing housing supports. This includes prevention, treatment, long-term services and supports, home and community based services and grant programs.

CSA trains, develops capacity and provides guidance and oversight for community partners including tribes, health plans, counties and community-based providers. Our current work encourages and supports research-informed practices and expanded use of successful models.

CSA goals are to support people to achieve meaningful outcomes, improve our operational excellence, and to manage an equitable and sustainable service delivery system.

SERVICES PROVIDED

We have five divisions within the Community Supports Administration (CSA):

- Alcohol and Drug Abuse Division
- Disability Services Division
- Deaf and Hard of Hearing Services Division
- Housing Supports Division
- Mental Health Division

Collaborating both with partners within state agencies and in local communities, our administration shapes and implements public policy on mental health, chemical dependency treatment and prevention services, home and community based services, services for people who are deaf, deafblind and hard of hearing and housing supports.

[1] In FY16, the Continuing Care Administration and the Chemical and Mental Health Administrations were reorganized. The Disability Services Division and the Deaf Services Division were combined with chemical and mental health in the new Community Supports Administration and the Continuing Care Administration was renamed the Continuing Care for Older Adults Administration.

Specifically, our staff:

- Lead efforts to shape and implement public policy directed towards prevention, early intervention, and treatment of persons with a mental illness or chemical dependency.
- Administer payment policy and manage grant programs for mental health and chemical dependency services, such as the Consolidated Chemical Dependency Treatment Fund, Minnesota Health Care Programs, Adult Mental Health Grants, Child Mental Health Grants and Chemical Dependency Treatment Support Grants.
- Manage and administer the disability home and community-based services waivers, home care services, intermediate care facilities for people with developmental disabilities, and various grant programs that support people with disabilities living in the community.
- Promote equal access to communication and community resources for Minnesotans who are deaf, deafblind and hard of hearing by delivering direct services through statewide regional offices, the Telephone Equipment Distribution (TED) program and the DHHSD mental health program.
- Manage grant programs for services to adults and children who are deafblind, mentors for families with very young children who have hearing loss, Certified Peer Support Specialists and other mental health services for people with hearing loss who use American Sign Language and have mental health challenges, psychological assessments for children and youth with hearing loss, increasing capacity of interpreting services in Greater Minnesota.
- Facilitate many stakeholder groups; the Governor-appointed Commission of Deaf, DeafBlind and Hard of Hearing Minnesotans, a state agency housed within DHS (http://mn.gov/deaf-commission/);
- Provide housing assistance support and related services to people experiencing homelessness or who are in danger of becoming homeless
- Work to encourage the development of local service capacity, including related professional workforce development activities.
- Train and guide service delivery partners on best practices.
- Provide supervision, guidance, and oversight to service delivery partners including counties, tribes and non-profit providers.
- Partner with stakeholders to improve prevention and early intervention efforts and the service delivery system.
- Secure funding outside of state appropriations and seek such opportunities to leverage goals.

RESULTS

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Percent of children in the child welfare system who received a mental health screening.[1]	56.6%	58.9%	2010 vs. 2011
Quantity	The percent of adults in *Assertive Community Treatment (ACT)* who receive an annual comprehensive preventative physical exam.[2]	26.5%	27.8%	2012 vs. 2013
Result	Past 30 day use of alcohol by youth in communities receiving prevention funding.[3]	24.5%	17.9%	2010 vs. 2013
Result	Percentage of babies born with negative toxicology reports.[4]	84%	82%	2014 vs. 2015
Result	Percent of working age consumers on disability waiver programs with earnings	44.6%	43.7%	Dec. 2013 to Dec. 2015

Performance Measure Notes:

1. With parental consent, counties conduct mental health screenings for children in the child welfare and juvenile justice systems who have not had a recent assessment. The Previous measure is Calendar Year 2010; the Current measure is CY 2011. (Source: Minnesota Department of Human Services Dashboard, http://dashboard.dhs.state.mn.us/)

2. Compares CY 2012 (Previous) and CY 2013 (Current). The measure is based on ACT recipients who are not Medicare eligible and who are enrolled 12 months in MA or Minnesota Care. (Source: Minnesota Department of Human Services Dashboard, http://dashboard.dhs.state.mn.us/)
3. This measure consists of data as reported in the Minnesota Student Survey for 9th grade users. Previous represents calendar year CY 2010 and Current represents CY 2013.
4. The percentage of babies with negative toxicology results during a 12-month period, born to women served by the state Women's Recovery grants. Previous represents FY 2014 and Current represents FY 2015.
5. Measure compares monthly earnings from Dec. 2013 to Dec. 2015 data for all disability waiver programs. "Working age" is age 22-64. Source: DHS Data Warehouse.

M.S. chapter 256 (Human Services) provides authority for many of the agency's general administrative activities. Some of the authority to administer MA is also in that chapter. Additional legal authority to administer MA is in M.S. chapter 256B (Medical Assistance for Needy Persons). For other activities administered under Community Supports, we list legal citations that apply to the program at the end of each budget narrative.

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
1000 - General	4,324	4,289	22,346	28,462	25,173	25,020	31,087	28,734
2000 - Restrict Misc Special Revenue	3,245	5,763	4,748	5,785	6,060	5,717	7,911	7,669
2001 - Other Misc Special Revenue	1,890	1,805	2,807	4,479	3,295	3,295	3,295	3,295
2403 - Gift	10	5	2	26	13	13	13	13
3000 - Federal	5,131	3,900	5,602	10,059	7,607	7,156	7,607	7,156
4800 - Lottery	157	108	114	209	163	163	163	163
Total	**14,756**	**15,870**	**35,618**	**49,020**	**42,311**	**41,364**	**50,076**	**47,030**
Biennial Change				54,013		(964)		12,467
Biennial % Change				176		(1)		15
Governor's Change from Base								13,431
Governor's % Change from Base								16

Expenditures by Category

Compensation	10,447	10,665	26,126	31,170	31,149	30,695	37,657	35,113
Operating Expenses	3,848	4,280	7,738	16,511	10,698	10,520	11,955	11,768
Other Financial Transactions	114	38	290	82	67	67	67	67
Grants, Aids and Subsidies	348	888	1,463	1,257	397	82	397	82
Capital Outlay-Real Property	0	0	1	0	0	0	0	0
Total	**14,756**	**15,870**	**35,618**	**49,020**	**42,311**	**41,364**	**50,076**	**47,030**
Full-Time Equivalents	**119.7**	**119.8**	**268.9**	**327.7**	**327.7**	**327.7**	**345.2**	**351.7**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	668	842	3,298	0	0	0	0
Direct Appropriation	4,734	5,315	7,058	7,373	25,173	25,020	31,087	28,734
Receipts	68	59	59	0	0	0	0	0
Net Transfers	141	(898)	17,685	17,791				
Cancellations	0	14	0	0	0	0	0	0
Expenditures	**4,324**	**4,289**	**22,346**	**28,462**	**25,173**	**25,020**	**31,087**	**28,734**
Balance Forward Out	619	842	3,298	0	0	0	0	0
Biennial Change in Expenditures				42,195		(615)		9,013
Biennial % Change in Expenditures				490		(1)		18
Gov's Exp Change from Base								9,628
Gov's Exp % Change from Base								19
Full-Time Equivalents	34.2	34.0	169.1	212.4	212.4	212.4	225.9	231.4

2000 - Restrict Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	14,194	11,679	9,342	11,578	5,549	9,366	5,549	9,090
Receipts	7,498	9,991	9,554	11,241	11,219	11,219	11,219	11,383
Net Transfers	(6,902)	(6,932)	(2,571)	(11,486)	(1,340)	(1,684)	(1,340)	(1,684)
Expenditures	**3,245**	**5,763**	**4,748**	**5,785**	**6,060**	**5,717**	**7,911**	**7,669**
Balance Forward Out	11,545	8,975	11,578	5,549	9,366	13,183	9,090	12,694
Biennial Change in Expenditures				1,525		1,244		5,047
Biennial % Change in Expenditures				17		12		48
Gov's Exp Change from Base								3,803
Gov's Exp % Change from Base								32
Full-Time Equivalents	28.5	43.3	36.4	22.0	22.0	22.0	26.0	27.0

2001 - Other Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	58	216	122	1,127	171	312	171	312
Receipts	1,777	1,732	1,509	1,824	1,822	1,822	1,822	1,822
Net Transfers	152	(23)	2,303	1,698	1,614	1,614	1,614	1,614
Expenditures	**1,890**	**1,805**	**2,807**	**4,479**	**3,295**	**3,295**	**3,295**	**3,295**

(Dollars in Thousands)

2001 - Other Misc Special Revenue

Balance Forward Out	97	120	1,127	171	312	453	312	453
Biennial Change in Expenditures				3,592		(696)		(696)
Biennial % Change in Expenditures				97		(10)		(10)
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0
Full-Time Equivalents	14.2	13.2	18.6	25.5	25.5	25.5	25.5	25.5

2403 - Gift

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	19	12	12	13	0	0	0	0
Receipts	3	5	4	13	13	13	13	13
Expenditures	**10**	**5**	**2**	**26**	**13**	**13**	**13**	**13**
Balance Forward Out	12	12	13	0	0	0	0	0
Biennial Change in Expenditures				13		(2)		(2)
Biennial % Change in Expenditures				88		(8)		(8)
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

3000 - Federal

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	697	132	125	0	0	0	0	0
Receipts	4,569	3,878	5,477	10,059	7,606	7,155	7,606	7,155
Net Transfers	(21)		0					
Expenditures	**5,131**	**3,900**	**5,602**	**10,059**	**7,607**	**7,156**	**7,607**	**7,156**
Balance Forward Out	115	110	0	0	0	0	0	0
Biennial Change in Expenditures				6,630		(898)		(898)
Biennial % Change in Expenditures				73		(6)		(6)
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0
Full-Time Equivalents	41.3	28.3	43.5	66.3	66.3	66.3	66.3	66.3

4800 - Lottery

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19

(Dollars in Thousands)

4800 - Lottery

Balance Forward In	0	0	0	46	0	0	0	0
Direct Appropriation	157	157	160	163	163	163	163	163
Cancellations	0	49	0	0	0	0	0	0
Expenditures	**157**	**108**	**114**	**209**	**163**	**163**	**163**	**163**
Balance Forward Out	0	0	46	0	0	0	0	0
Biennial Change in Expenditures				58		3		3
Biennial % Change in Expenditures				22		1		1
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0
Full-Time Equivalents	1.5	1.1	1.3	1.5	1.5	1.5	1.5	1.5

Program: Central Office Operations
Activity: Central IT

mn.gov/mnit/about-mnit/offices/

AT A GLANCE

- Maintains over 385 active applications used by over 775,000 citizens, 5000 county, tribal, and state workers, more than 100,000 providers, other client assistors and DHS and MNsure business partners
- Oversees more than 650 IT employees
- Manages over 160 active IT projects
- Coordinates 4 DHS IT Transformation programs:
  - Minnesota Eligibility Technology (METS) System
  - Integrated Service Delivery System (ISDS)
  - Medicaid Management Information System (MMIS) Modernization
  - Direct Care & Treatment System Modernization
- Total all funds spending for this budget activity in FY 2015 was $174 million, which represents 1.1% of the agency budget.

PURPOSE & CONTEXT

The Central IT budget activity funds *MN.IT@DHS & MNsure*, which is embedded within DHS to provide IT resources to support agency business goals, and build and maintain the computer applications that automate agency programs. MN.IT provides high-quality, secure and cost-effective information technology systems for users of DHS social services, health care, and public assistance programs across the state, to help DHS meet their mission to provide essential services to Minnesota's most vulnerable residents.

Please refer to the *Office of MN.IT Services Agency Profile* for more information about the central MN.IT organization.

SERVICES PROVIDED

MN.IT@DHS and MNsure provides the following services for our agency partners:

1. Leadership and planning support that allows us to deliver IT services to DHS in a high-value and cost-effective manner. This includes:
   - Design of and participation in DHS IT governance structures which allocate funding and guide IT program design and sequence/prioritization of getting IT work done
   - Ensure that user experience design, accessibility and plain language are incorporated into DHS technology
2. Program management activities to develop and operate the DHS IT project and portfolio management. This includes:
   - Business analysis
   - Project and portfolio management
   - Quality assurance, and
   - Release management
3. Application development and support to automate and maintain DHS services and operations. This includes:
   - Enterprise architecture assessment
   - Process to determine technology approach(es)
   - Programming and coding, and
   - Ongoing maintenance to help ensure federal/state/industry compliance for DHS IT systems
4. IT services, including all of the computing, telecommunications and wide area network (WAN) services that underlie and support DHS program applications. This includes:
   - Desktop, server and network support
   - Operations support
   - Firewall support & incident management
   - Contact center support
   - Telephony, telepresence support

MN.IT@DHS is funded through a combination of state general fund, health care access fund and dedicated federal revenues administered within the state systems account.

RESULTS

MN.IT contributes to the State's results-based outcome of *efficient and accountable government services* and supports the State's results-based outcomes for Community, Health, and Safety, by providing IT computing and telecom resources to support DHS business goals, and managing the applications that run agency programs.

Type of Measure	***Name of Measure***	***Previous***	***Current***	***Dates***
Quantity	Service availability to IT network, telecom and communication services	NA	99.8%	August, 2016
Quantity	Infrastructure availability	NA	99.7%	August, 2016
Quantity	New projects added to the Project Portfolio	160 projects added in 2015	100 projects added through Aug. 2016	Ongoing
Quantity	Projects completed	96 projects completed in 2015	69 projects completed through Aug. 2016	Ongoing

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MS § 256.014 provides the authority for DHS operation of systems necessary to operate its programs and the creation of the state systems account.

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
2001 - Other Misc Special Revenue	151,670	175,520	209,240	275,796	149,003	148,989	159,501	155,004
Total	**151,670**	**175,520**	**209,240**	**275,796**	**149,003**	**148,989**	**159,501**	**155,004**
Biennial Change				157,846		(187,044)		(170,531)
Biennial % Change				48		(39)		(35)
Governor's Change from Base								16,513
Governor's % Change from Base								6

Expenditures by Category

Compensation	60,528	65,811	27	0	0	0	0	0
Operating Expenses	81,052	104,180	206,977	275,796	149,003	148,989	159,501	155,004
Other Financial Transactions	5,408	3,520	2,120	0	0	0	0	0
Grants, Aids and Subsidies	4,681	122	100	0	0	0	0	0
Capital Outlay-Real Property	0	1,887	16	0	0	0	0	0
Total	**151,670**	**175,520**	**209,240**	**275,796**	**149,003**	**148,989**	**159,501**	**155,004**
Full-Time Equivalents	**542.3**	**572.8**	**0**	**0**	**0**	**0**	**5.3**	**11.2**

(Dollars in Thousands)

2001 - Other Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	15,060	21,644	7,418	4,412	0	0	0	0
Receipts	110,001	159,205	169,639	257,177	132,415	132,077	132,415	132,077
Net Transfers	44,165	25,862	36,596	14,206	16,588	16,912	27,086	22,927
Expenditures	**151,670**	**175,520**	**209,240**	**275,796**	**149,003**	**148,989**	**159,501**	**155,004**
Balance Forward Out	17,555	31,191	4,412	0	0	0	0	0
Biennial Change in Expenditures				157,846		(187,044)		(170,531)
Biennial % Change in Expenditures				48		(39)		(35)
Gov's Exp Change from Base								16,513
Gov's Exp % Change from Base								6
Full-Time Equivalents	542.3	572.8	0	0	0	0	5.3	11.2

Program: Forecasted Programs
Activity: MFIP / DWP

mn.gov/dhs/people-we-serve/children-and-families/economic-assistance/income/programs-and-services/

AT A GLANCE

- In 2015, MFIP and DWP provided assistance for approximately 34,300 low-income families a month, 71 percent of those served are children.
- The average monthly cash payment for an MFIP family was $722, including the food portion of MFIP. The average monthly cash payment for a DWP family was $395.
- All funds spending for the MFIP/DWP activity for FY 2015 was $274 million. This represented 1.8% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

Minnesota Family Investment Program (MFIP) and Diversionary Work Program (DWP) provide temporary financial support to help meet the basic needs of low-income families with children and low-income pregnant women.

Half the parents receiving MFIP or DWP were employed in the three months before they turned to the program for assistance. Common causes for job losses are layoff, reduced hours, birth of a baby by a parent with no leave time, need to care for an ill child or spouse with a disability, or transportation and child care costs that wages do not cover.

The goal of these related programs is to stabilize families and improve economic outcomes through employment. Without these benefits, families have little or no other resources available to help meet their basic needs.

These programs are funded with a combination of state, federal Supplemental Nutrition Assistance Program (SNAP), and federal Temporary Assistance for Needy Families (TANF) funds. Counties and tribes administer the MFIP and DWP programs.

SERVICES PROVIDED

MFIP provides job counseling, cash assistance and food assistance to low-income families with children and to low-income pregnant women. Families receive time limited benefits (60 months or fewer). The amount of benefits is based on family size and other sources of income. Families may request an extension of their benefits if, for example, an eligible adult has a disability or needs to care for a family member with a disability. A family of three - a parent with two children - with no other income can receive $532 in financial assistance and $446 in SNAP benefits per month. The benefits are structured to reward families who work and are gradually reduced as income rises. Parents are required to participate in employment services to develop the skills needed to move into the labor market as soon as possible. Families may also be eligible for child care assistance and for health care coverage under Medical Assistance.

DWP is designed to meet specific crisis situations and help families move to employment rather than go on MFIP. The program includes intensive, up-front services to focus on families' strengths and break down barriers to work. Families can participate in the program for four months within a 12-month period. A family receives cash benefits based on its housing, utility costs and personal needs up to a maximum based on the number of people in the family. Housing and utility costs are paid directly to the landlord or utility company. The maximum that a family of three – a parent with two children –can receive is $532 in financial assistance. Most families are also eligible for SNAP benefits, child care assistance and for health care coverage under Medical Assistance.

Beginning July 1, 2015, families who receive MFIP (with some exemptions) may also be eligible for a housing assistance grant of $110 per month if they do not receive a rental subsidy through the federal Department of Housing and Urban Development.

RESULTS

The two key measures in MFIP are:

- The **Self-Support Index** (S-SI) is a results measure. The S-SI gives the percentage of adults eligible for MFIP or DWP in a quarter who have left assistance or are working at least 30 hours per week three years later. Customized targets are set for each county or tribe using characteristics of the people served and local economic conditions. State law requires the Department of Human Services to use the Self-Support Index to allocate performance bonus funds. The following chart shows that about two-thirds of participants have left MFIP and/or are working at least 30 hours per week three years after a baseline period.

Year ending in March of:	S-SI
2008	71.8%
2009	68.9%
2010	67.0%
2011	65.2%
2012	65.3%
2013	66.9%
2014	68.5%
2015	68.8%
2016	68.0%

- The federal **Work Participation Rate** (WPR) is a measure of quantity. The WPR reflects parents engaging in work and specific work-related activities. We calculate an estimated WPR for counties, county consortiums, and tribes monthly and it is annualized to allocate performance bonus funds. (Beginning in calendar year 2016, the bonus will be based solely on the S-SI.) The following chart shows the WPR for 2008 to 2015.

Federal Fiscal Year	WPR
2008	29.9%
2009	29.8%
2010	40.2%
2011	43.9%
2012	45.3%
2013	45.1%
2014*	46.2%
2015*	37.9%

The state legal authority for the Minnesota Family Investment Program (MFIP) and Diversionary Work Program (DWP) is under M.S. chapter 256J (https://www.revisor.mn.gov/statutes/?id=256J).

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
1000 - General	76,154	75,245	103,453	87,542	88,930	97,851	88,930	97,851
2000 - Restrict Misc Special Revenue	450	316	314	750	750	750	750	750
3000 - Federal	144,520	135,785	135,174	140,609	141,468	143,844	141,468	143,844
3001 - Federal TANF	71,015	63,807	60,572	89,562	92,732	83,513	92,732	83,513
Total	**292,138**	**275,153**	**299,513**	**318,463**	**323,880**	**325,958**	**323,880**	**325,958**
Biennial Change				50,685		31,862		31,862
Biennial % Change				9		5		5
Governor's Change from Base								0
Governor's % Change from Base								0

Expenditures by Category

Operating Expenses	0	0	0	0	0	0	0	0
Other Financial Transactions	580	587	595	800	800	800	800	800
Grants, Aids and Subsidies	291,558	274,566	298,918	317,663	323,080	325,158	323,080	325,158
Total	**292,138**	**275,153**	**299,513**	**318,463**	**323,880**	**325,958**	**323,880**	**325,958**
Full-Time Equivalents	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Direct Appropriation	76,154	75,245	103,453	87,542	88,930	97,851	88,930	97,851
Expenditures	**76,154**	**75,245**	**103,453**	**87,542**	**88,930**	**97,851**	**88,930**	**97,851**
Biennial Change in Expenditures				39,596		(4,214)		(4,214)
Biennial % Change in Expenditures				26		(2)		(2)
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

2000 - Restrict Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	1	1	0	0	0	0	0	0
Receipts	450	315	314	750	750	750	750	750
Expenditures	**450**	**316**	**314**	**750**	**750**	**750**	**750**	**750**
Balance Forward Out	1	0	0	0	0	0	0	0
Biennial Change in Expenditures				299		436		436
Biennial % Change in Expenditures				39		41		41
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

3000 - Federal

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	1	0	9,451	0	0	0	0	0
Receipts	144,519	135,785	125,723	140,609	141,468	143,844	141,468	143,844
Expenditures	**144,520**	**135,785**	**135,174**	**140,609**	**141,468**	**143,844**	**141,468**	**143,844**
Biennial Change in Expenditures				(4,522)		9,529		9,529
Biennial % Change in Expenditures				(2)		3		3
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

3001 - Federal TANF

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19

(Dollars in Thousands)

3001 - Federal TANF

Receipts	71,015	63,807	60,572	89,562	92,732	83,513	92,732	83,513
Expenditures	**71,015**	**63,807**	**60,572**	**89,562**	**92,732**	**83,513**	**92,732**	**83,513**
Biennial Change in Expenditures				15,312		26,111		26,111
Biennial % Change in Expenditures				11		17		17
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

Program: Forecasted Programs
Activity: MFIP Child Care Assistance

mn.gov/dhs/people-we-serve/children-and-families/economic-assistance/child-care/programs-and-services/child-care-assistance.jsp

AT A GLANCE

- In 2015 MFIP Child Care Assistance paid for child care for 15,328 children in 7,588 families in an average month.
- The average monthly assistance per family was $1,486.
- All funds spending for the MFIP Child Care Assistance activity for FY 2015 was $142.0 million. This represented 0.9% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

In order to work, families need safe and reliable child care. The annual cost of full time licensed care for one child can exceed $10,000. Many low-income families struggle to find affordable child care that fits their needs. Minnesota Family Investment Program (MFIP) Child Care Assistance provides financial subsidies to help low-income families pay for child care. To support quality child care experiences and school readiness the program can pay a higher subsidy rate when a child is being cared for in a setting that meets quality standards.

SERVICES PROVIDED

The program provides supports to help improve outcomes for the most at risk children and their families by increasing access to high quality child care.

The following families are eligible to receive MFIP child care assistance or Transition Year child care assistance once they leave MFIP:

- MFIP and Divisionary Work Program (DWP) families who are employed, pursuing employment, or participating in employment, training or social services activities authorized in approved employment plans
- Employed families who are in their first year off MFIP or DWP (this is known as the “transition year”)
- Families in counties with a Basic Sliding Fee (BSF) child care waiting list who have had their transition year extended
- Parents under age 21 who are pursuing a high school or general equivalency diploma (GED), do not receive MFIP benefits, and reside in a county that has a BSF waiting list that includes parents under age 21.

As family income increases, so does the amount of child care expenses paid by the family in the form of copayments. All families receiving child care assistance and earning 75 percent or more of the federal poverty guideline make copayments based on family income. A family of three leaving MFIP and earning 115 percent of the federal poverty level ($23,104) would have a total biweekly child care provider payment of $24 for all children in child care.

The MFIP child care assistance activity is part of the state’s Child Care Assistance Program. Maximum rates in the Child Care Assistance Program are set in state law. Maximum rates are set for each type of care: child care centers, family child care and legal non-licensed child care. Providers are paid at the rate they charge private pay families, up to this limit. The program pays a higher rate to providers who have met quality standards through Parent Aware, are accredited, or hold certain educational credentials.

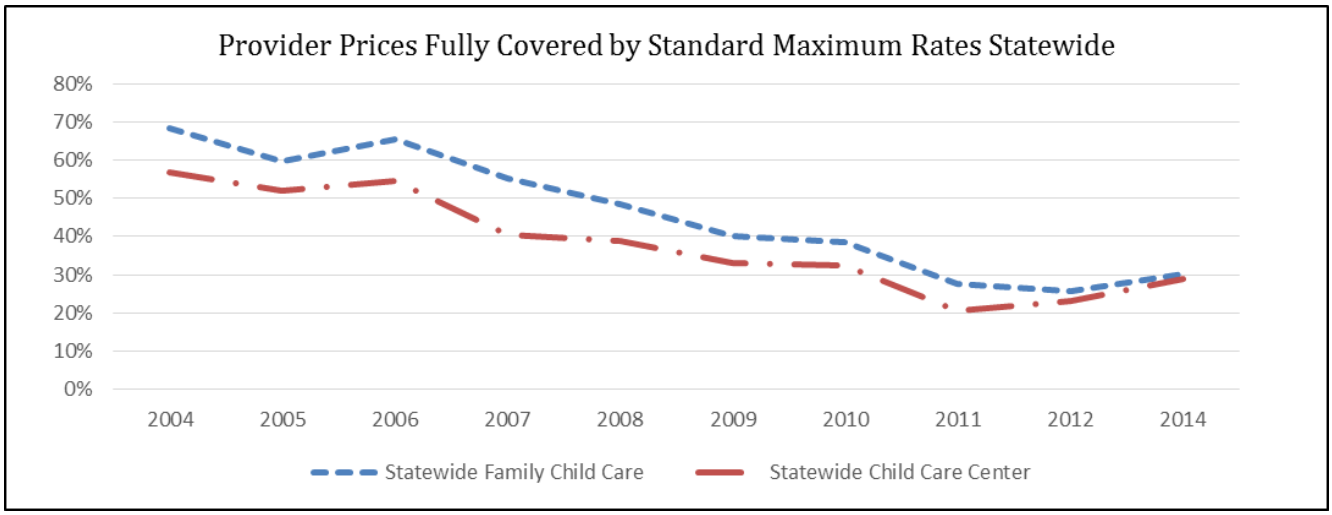
Child care must be provided by a legal child care provider over the age of 18 years. Allowable providers include legal non-licensed family child care, license-exempt centers, licensed family child care and licensed child care centers. Families choose their providers in the private child care market. Counties administer the Child Care Assistance Program.

All families who meet eligibility requirements may receive this help. MFIP child care assistance is funded with state and federal funds that include the federal Child Care and Development Fund and the Temporary Assistance for Needy Families (TANF) fund.

RESULTS

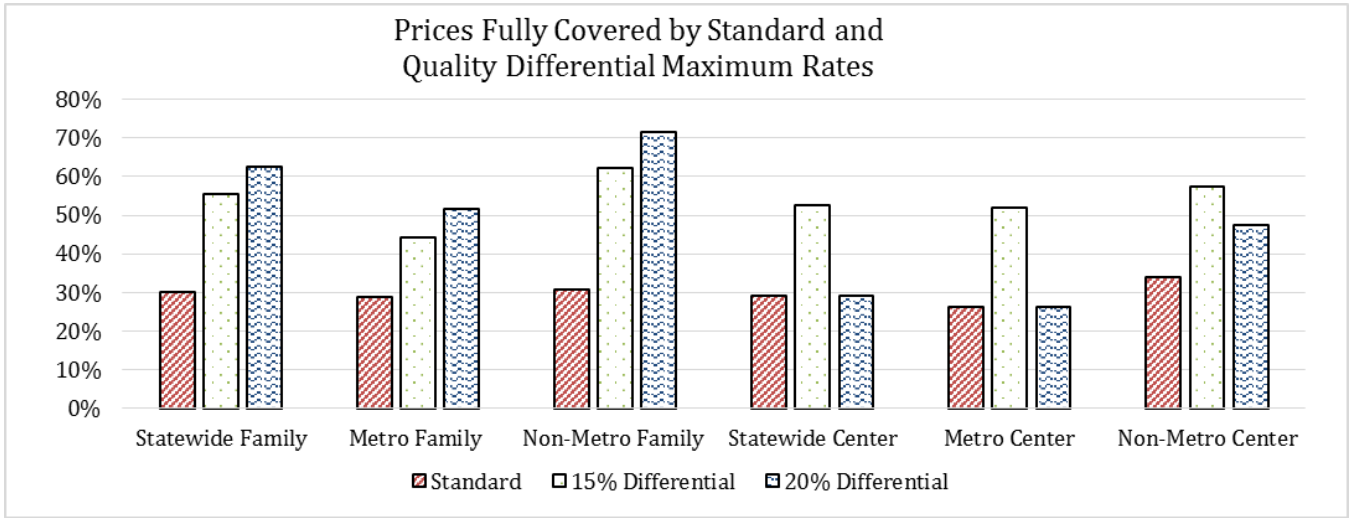
PERCENT OF PROVIDER PRICES FULLY COVERED BY CHILD CARE ASSISTANCE PROGRAM - Maximum rates paid to providers under the Child Care Assistance Program may not cover the full cost of child care. This may be a barrier for some families, if the family cannot find a provider in their community whose prices are covered by the maximum allowed under the program. **The percent of child care provider prices that are fully covered by the Child Care Assistance Program increased when the maximum rates were raised in 2014, but the maximum rate paid remains low compared to prices in the market.**

This quality measure shows approximately 30 percent of all child care providers charge prices that are fully covered by the Child Care Assistance Program maximum rates.



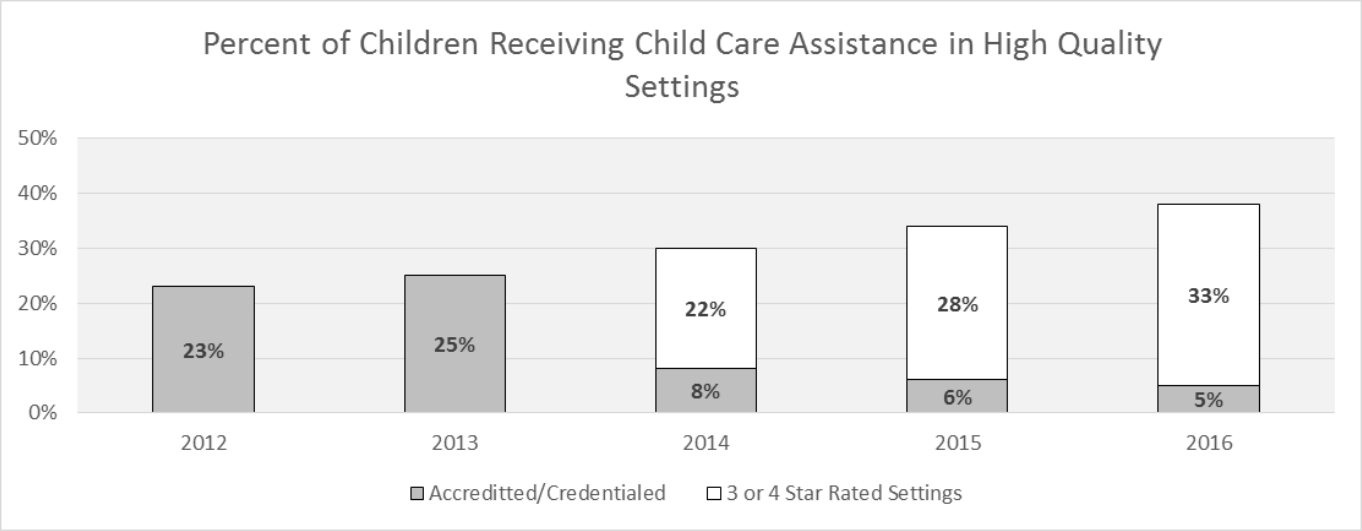
QUALITY DIFFERENTIAL IMPACT - Parent Aware is Minnesota's rating tool for helping parents select high quality child care and early education programs. The Child Care Assistance Program allows up to a 15 percent higher maximum rate to be paid to providers with a Parent Aware 3-star rating, or who hold certain accreditation or education standards established in statute. Up to a 20 percent higher maximum rate can be paid to providers with a 4-star Parent Aware rating.

This quality measure shows that higher maximum rates may increase families' access to high quality providers by allowing the maximum rate paid by the Child Care Assistance Program to fully cover more (or an equivalent proportion) of their prices as compared to the prices charged by all providers. This measure indicates the impact of quality differentials by type of care. It is first presented as a statewide total, and then broken out by metro and non-metro counties.



Specifically, the 20 percent differential allows the prices charged by center based four-star rated metro providers to be fully covered by the maximum subsidy in the same proportion as the prices of all metro center providers. The higher maximum rates offer coverage of the prices charged by all other types of quality providers at higher levels than the standard maximum rates.

INCREASE IN USE OF HIGH QUALITY CARE - Children who participate in high quality early care and education are more likely to experience school success and positive life-long outcomes. **This quality measure shows that the percent of all children receiving child care assistance through providers eligible for the higher subsidy rates for quality has increased from 23 percent in quarter four of 2012 to 38 percent in quarter three of 2016. This represents a 65 percent increase over the 4-year period.**



In 2014 a statute change allowed providers to qualify for the higher maximum subsidy rate through receiving a Parent Aware rating of 3-or-4-Stars. Previously only providers holding certain accreditations and family child care providers meeting certain education standards were eligible. In this figure, child care settings were categorized according to the quality standard they meet to be eligible for the CCAP quality differential.

- In 2012-2013 settings meeting quality standards though accreditations/credentials may also have been highly rated by Parent Aware. In 2014-2015 settings that hold both a 3-or-4 Star Parent Aware rating and an accreditation or educational credential, are included in the Parent Aware rated category.

The data source for the prices charged by providers is a biennial survey of provider prices conducted by the Department. To assess the portion of provider prices fully covered, provider prices are compared to the applicable maximum subsidy rates.

The data source for children in care with provider's eligible for the higher rates for quality is from MEC^2, Minnesota's child care electronic eligibility and payment system.

The legal authority for the MFIP/TY Child Care Assistance program is in M.S. chapter 119B (https://www.revisor.mn.gov/statutes/?id=119B)

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
1000 - General	61,207	90,141	78,221	94,248	108,428	113,247	115,065	132,911
3000 - Federal	67,439	51,853	72,381	70,786	65,584	65,584	65,584	65,584
Total	**128,646**	**141,994**	**150,602**	**165,034**	**174,012**	**178,831**	**180,649**	**198,495**
Biennial Change				44,996		37,206		63,507
Biennial % Change				17		12		20
Governor's Change from Base								26,301
Governor's % Change from Base								7

Expenditures by Category

Operating Expenses	0	2	1	0	0	0	0	0
Grants, Aids and Subsidies	128,645	141,993	150,601	165,034	174,012	178,831	180,649	198,495
Total	**128,646**	**141,994**	**150,602**	**165,034**	**174,012**	**178,831**	**180,649**	**198,495**
Full-Time Equivalents	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	0	0	0	0	0	0	0
Direct Appropriation	61,017	90,141	78,221	94,248	108,428	113,247	115,065	132,911
Net Transfers	190							
Expenditures	**61,207**	**90,141**	**78,221**	**94,248**	**108,428**	**113,247**	**115,065**	**132,911**
Biennial Change in Expenditures				21,121		49,206		75,507
Biennial % Change in Expenditures				14		29		44
Gov's Exp Change from Base								26,301
Gov's Exp % Change from Base								12

3000 - Federal

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	189	383	0	0	0	0	0	0
Receipts	67,250	51,470	72,381	70,787	65,584	65,584	65,584	65,584
Expenditures	**67,439**	**51,853**	**72,381**	**70,786**	**65,584**	**65,584**	**65,584**	**65,584**
Biennial Change in Expenditures				23,875		(12,000)		(12,000)
Biennial % Change in Expenditures				20		(8)		(8)
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

Program: Forecasted Programs
Activity: General Assistance

mn.gov/dhs/people-we-serve/people-with-disabilities/economic-assistance/income/programs-and-services/

AT A GLANCE

- In FY2015, the General Assistance (GA) program supported a monthly average of 23,250 people.
- The typical monthly benefit is $203 for an individual and $260 for a couple.
- All funds spending for General Assistance activity for FY 2015 was $51.4 million, which represented 0.3% of the overall agency budget.

PURPOSE & CONTEXT

General Assistance (GA) is the primary safety net for very low-income people without children who are unable to work and do not have enough money to meet their basic needs. The most common reason people are eligible is illness or incapacity (50 percent). GA helps people meet some of their basic and emergency needs. Without this income support, they would likely fall further into poverty and become homeless.

Many people receive GA while they wait for more stable assistance such as Supplemental Security Income (SSI), a federal income supplement program that helps people who are aged, blind or have a disability and have little or no income. Forty-seven percent of people eligible for GA have signed an Interim Assistance Agreement. That indicates they plan to apply for other income benefits such as SSI or Retirement, Survivors and Disability Income (RSDI).

SERVICES PROVIDED

General Assistance provides state-funded, monthly cash grants to people without children who have a serious illness, disabilities or other issues that limit their ability to work and are unable to fully support themselves. GA's maximum monthly benefit is $203 for a single adult (about 21 percent of the Federal Poverty Guideline of $990 per month for one person) and $260 for a couple. Additional emergency funds may be available if a recipient cannot pay for basic needs and the person's health or safety is at risk. People eligible for GA may also be eligible for health care coverage under Medical Assistance.

The Department of Human Services (DHS) works with the federal Social Security Administration and the state's Disability Linkage Line® to streamline the disability determination process. DHS also connects recipients with resources to help them with the SSI application process. People who become eligible for SSI are no longer eligible for GA. They become eligible for Minnesota Supplemental Aid to supplement their SSI income.

DHS works with counties and tribes to administer the GA program.

RESULTS

GA is a safety net program that helps people achieve better outcomes by stabilizing crisis situations, avoiding homelessness and making connections to other resources.

GA recipients who may be eligible for SSI must apply and sign an Interim Assistance Agreement (IAA). If a person on GA is eligible for SSI, having an IAA in place allows the state to collect federal reimbursement for GA benefits paid while the person's application for SSI was pending. An increase in the percent of GA recipients with a signed IAA shows a better opportunity for stable income for recipients and state savings.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Percent of GA recipients with a signed Interim Assistance Agreement (IAA)	47.4%	43.7%	Dec 2014 Dec 2015

GA is a safety net for people who do not have adequate income or resources to meet their basic needs. It is intended to be short-term while they apply for other benefits, look for employment, or secure other income. It is not intended as a long-term solution to meet a person's basic needs. Data below shows that while around 41 percent of cases are on the program for more than 12 months, only 25 percent of cases remain on the program after two years.

Type of Measure	***Name of Measure***	***Previous***	***Current***	***Dates***
Quantity	Percent of GA cases with more than 12 months of continuous GA usage	45.5%	41.5%	Dec. 2014 Dec. 2015
Quantity	Percent of GA cases with more than 24 months of continuous GA usage	27.5%	25.0%	Dec. 2014 Dec. 2015

One of the goals of the GA program is to help people prepare to obtain permanent work and become self-sufficient. Some features of GA act as work incentives. For example, the GA program allows some earned income to be disregarded when a person's GA eligibility and benefits are calculated. A person can work and still remain on GA if his or her earned income is minimal.

Type of Measure	***Name of Measure***	***Previous***	***Current***	***Dates***
Quantity	Percent of GA cases with earned income	1.7%	3.0%	Dec. 2014 Dec. 2015

The source for these outcomes is the DHS report, December 2015 General Assistance Caseload: Cases and Eligible People (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6128H-ENG)

The legal authority for the General Assistance program is M.S. chapter 256D (https://www.revisor.mn.gov/statutes/?id=256D)

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
1000 - General	51,125	51,436	50,444	52,550	55,536	57,221	55,536	57,221
2000 - Restrict Misc Special Revenue	0	0	0	50	50	50	50	50
Total	**51,125**	**51,436**	**50,444**	**52,600**	**55,586**	**57,271**	**55,586**	**57,271**
Biennial Change				483		9,813		9,813
Biennial % Change				0		10		10
Governor's Change from Base								0
Governor's % Change from Base								0

Expenditures by Category

Grants, Aids and Subsidies	51,125	51,436	50,444	52,600	55,586	57,271	55,586	57,271
Total	**51,125**	**51,436**	**50,444**	**52,600**	**55,586**	**57,271**	**55,586**	**57,271**
Full-Time Equivalents	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	904	0	0	0	0	0	0
Direct Appropriation	52,218	52,726	52,997	52,550	55,536	57,221	55,536	57,221
Net Transfers	(190)	0	0	0	0	0	0	0
Cancellations	904	2,194	2,553	0	0	0	0	0
Expenditures	**51,125**	**51,436**	**50,444**	**52,550**	**55,536**	**57,221**	**55,536**	**57,221**
Biennial Change in Expenditures				433		9,763		9,763
Biennial % Change in Expenditures				0		9		9
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

2000 - Restrict Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Receipts	0	0	0	50	50	50	50	50
Expenditures	0	0	0	**50**	**50**	**50**	**50**	**50**
Biennial Change in Expenditures				50		50		50
Biennial % Change in Expenditures						100		100
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

Program: Forecasted Programs
Activity: MN Supplemental Assistance

mn.gov/dhs/people-we-serve/people-with-disabilities/economic-assistance/income/programs-and-services/

AT A GLANCE

- In FY2015, the Minnesota Supplemental Aid program supported a monthly average of 30,441 people.
- The typical benefit is $81 for an individual and $111 for a couple.
- This supplements a typical monthly federal Supplemental Security Income (SSI) benefit of $733 for an individual living alone.
- All funds spending for Minnesota Supplemental Aid activity for FY 2015 was $37.0 million, which represented 0.24% of the overall agency budget.

PURPOSE & CONTEXT

Minnesota Supplemental Aid (MSA) helps to prevent homelessness and poverty by supplementing the incomes of Minnesotans who are eligible for the federal Supplemental Security Income (SSI) program. It was established in 1974 and federal regulations require payments to be at a minimum of that paid in March 1983. MSA benefits are intended to cover basic daily or special needs. Nearly half of MSA recipients are age 60 or older and 77 percent have a disability.

SERVICES PROVIDED

MSA provides a state-funded monthly cash supplement to help people who are aged, blind or disabled, and who receive SSI benefits. Some recipients who do not receive SSI because their income is too high may still be eligible for MSA if they meet other eligibility criteria.

MSA housing assistance is available to qualified recipients, adding $194 to the MSA benefit to help pay housing costs. To be eligible for housing assistance, applicants must:

- Be under age 65 at the time of application,
- Have total housing costs in excess of 40 percent of their total income,
- Apply for rental assistance if eligible, and
- Be relocating from an institution, or eligible for Medical Assistance personal care attendant services, or receiving waivered services and living in their own place.

MSA may also provide additional payments for other special needs such as special diets and household repairs or furnishings.

The Department of Human Services works with counties, tribes, the Social Security Administration, service providers, and other nonprofit agencies to identify people eligible for the program, and to advise and administer MSA program policy.

RESULTS

People who receive federal Supplemental Security Income are categorically eligible for MSA, but must apply for MSA in order to receive the benefits. The MSA program has had stable enrollment of around 30,000 individuals over time, but the number of adults who receive SSI and yet do not receive MSA is increasing. This indicates some people are not accessing the benefits they are eligible for. The Department of Human Services is working with the Social Security Administration to inform people about this benefit.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Results	Percent of SSI beneficiaries over age 18 who receive MSA	38.3	38.2	Dec. 2014 Dec. 2015

MSA helps provides additional money to help people who qualify and have high housing costs move into affordable housing or be able to afford their current housing costs.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Percent of MSA recipients who receive MSA housing assistance	2.4	2.7	Dec. 2014 Dec. 2015

The MSA and SSI programs support efforts of people who want to work. MSA follows work incentives used by the Social Security Administration to encourage people with disabilities to work. More needs to be done to support them in reaching their employment goals.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Percent of MSA recipients with earned income	2.7	2.7	Dec. 2014 Dec. 2015

The source of the data for the MSA measures is the DHS report, December 2015 Minnesota Supplemental Aid: Cases and Eligible People and the Social Security Administration report on SSI Recipients by State and County 2015 (https://www.ssa.gov/policy/docs/statcomps/ssi_sc/2015/index.html).

The legal authority for the Minnesota Supplemental Aid program is in M.S. chapter 256D: sections 256D.33 (https://www.revisor.mn.gov/statutes/?id=256D.33) to 256D.54 (https://www.revisor.mn.gov/statutes/?id=256D.54).

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
1000 - General	36,479	37,067	37,735	38,938	40,484	41,634	40,484	41,634
2000 - Restrict Misc Special Revenue	0	0	0	5	5	5	5	5
Total	**36,479**	**37,067**	**37,735**	**38,943**	**40,489**	**41,639**	**40,489**	**41,639**
Biennial Change				3,133		5,450		5,450
Biennial % Change				4		7		7
Governor's Change from Base								0
Governor's % Change from Base								0

Expenditures by Category

Grants, Aids and Subsidies	36,479	37,067	37,735	38,943	40,489	41,639	40,489	41,639
Total	**36,479**	**37,067**	**37,735**	**38,943**	**40,489**	**41,639**	**40,489**	**41,639**
Full-Time Equivalents	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	1,477	0	0	0	0	0	0
Direct Appropriation	37,956	38,086	38,055	38,938	40,484	41,634	40,484	41,634
Receipts	0	0	0	0	0	0	0	0
Cancellations	1,477	2,496	320	0	0	0	0	0
Expenditures	**36,479**	**37,067**	**37,735**	**38,938**	**40,484**	**41,634**	**40,484**	**41,634**
Biennial Change in Expenditures				3,128		5,445		5,445
Biennial % Change in Expenditures				4		7		7
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

2000 - Restrict Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Receipts	0	0	0	5	5	5	5	5
Expenditures	0	0	**0**	**5**	**5**	**5**	**5**	**5**
Biennial Change in Expenditures				5		5		5
Biennial % Change in Expenditures						83		83
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

Program: Forecasted Programs
Activity: Group Residential Housing

mn.gov/dhs/people-we-serve/people-with-disabilities/economic-assistance/housing/programs-and-services/grh-housing.jsp

AT A GLANCE

- In 2015, the Group Residential Housing (GRH) program served a monthly average of 19,461 participants.
- The current GRH housing rate limit is $891 per month.
- The average monthly payment per recipient is $605.
- All funds spending for the Group Residential Housing activity for FY 2015 was $141.3 million, which represented 0.9% of the overall agency budget.

PURPOSE & CONTEXT

Group Residential Housing (GRH) is a state-funded income supplement program that pays for room and board in approved locations for adults with low incomes who have a disability or are 65 years or older. Participants must meet a combination of eligibility requirements set by the federal Supplemental Security Income (SSI) program or state General Assistance program to qualify for help. GRH also has income and asset limits.

Seventeen percent of GRH recipients are seniors. Those who are younger than 65 years of age all have a combination of factors that limit their self-sufficiency, including a physical or mental health disability, visual impairment or chemical dependency.

Without GRH, program recipients likely would be in institutional placements or homeless.

SERVICES PROVIDED

The GRH rate is currently $891 per month. This rate is paid for residents in more than 6,280 authorized settings in Minnesota. About 4,381 of those are adult foster care homes. Other settings include board and lodging facilities, supervised living facilities, boarding care homes, supportive housing and other assisted living facilities.

Housing providers receive payments on behalf of eligible recipients. The GRH monthly payment is to pay for rent, utilities, food, household supplies and other items needed to provide room and board to a recipient. A recipient may be required to pay a portion of his or her income directly to housing providers. GRH can pay for additional supportive services in some settings if a recipient is not eligible for home-and community- based waiver services.

County human services agencies process eligibility and payments for people in the program. Counties also manage GRH contracts with housing and service providers.

RESULTS

An increase in the number of GRH recipients who are no longer homeless shows efforts are working to reduce homelessness.

GRH recipients who may be eligible for SSI must apply and sign an Interim Assistance Agreement (IAA). If a person receiving GRH is eligible for SSI, having an IAA in place allows the state to collect federal reimbursement for state payments made while the person's application for SSI was pending. An increase in the percent of GRH recipients with a signed IAA shows a better opportunity for stable income for recipients and state savings.

An increase in the percent of GRH applications processed within 30 days shows people get the help they need more quickly.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Results	Number of GRH recipients moving out of homelessness	1,930	2,267	May 2014, May 2015
Quantity	Percent of GRH recipients with signed Interim Assistance Agreement	14.6%	16.0%	May 2014 May 2015
Quality	Percent of GRH applications processed within 30 days	52%	58%	May 2014 May 2015

The information in these measures comes from MAXIS administrative data.

The legal authority for the Group Residential Housing program is M.S. chapter 256I (https://www.revisor.mn.gov/statutes/?id=256I).

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
1000 - General	137,033	139,863	147,461	158,707	169,261	179,295	167,426	177,460
2000 - Restrict Misc Special Revenue	1,676	1,415	1,999	1,975	1,975	1,975	1,975	1,975
Total	**138,709**	**141,278**	**149,461**	**160,682**	**171,236**	**181,270**	**169,401**	**179,435**
Biennial Change				30,156		42,363		38,693
Biennial % Change				11		14		12
Governor's Change from Base								(3,670)
Governor's % Change from Base								(1)

Expenditures by Category

Grants, Aids and Subsidies	138,709	141,278	149,461	160,682	171,236	181,270	169,401	179,435
Total	**138,709**	**141,278**	**149,461**	**160,682**	**171,236**	**181,270**	**169,401**	**179,435**
Full-Time Equivalents	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	4,355	0	0	0	0	0	0
Direct Appropriation	141,388	143,615	147,652	158,707	169,261	179,295	167,426	177,460
Cancellations	4,355	8,107	191	0	0	0	0	0
Expenditures	**137,033**	**139,863**	**147,461**	**158,707**	**169,261**	**179,295**	**167,426**	**177,460**
Biennial Change in Expenditures				29,272		42,388		38,718
Biennial % Change in Expenditures				11		14		13
Gov's Exp Change from Base								(3,670)
Gov's Exp % Change from Base								(1)

2000 - Restrict Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Receipts	1,676	1,415	1,999	1,975	1,975	1,975	1,975	1,975
Expenditures	**1,676**	**1,415**	**1,999**	**1,975**	**1,975**	**1,975**	**1,975**	**1,975**
Biennial Change in Expenditures				884		(24)		(24)
Biennial % Change in Expenditures				29		(1)		(1)
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

Program: Forecasted Programs
Activity: Northstar Care for Children

mn.gov/dhs/people-we-serve/children-and-families/services/foster-care/
mn.gov/dhs/people-we-serve/children-and-families/services/adoption/

AT A GLANCE

- 13,612 children experienced an out-of-home placement in 2015
- 988 children were either adopted or had a permanent transfer of legal custody to a relative in 2015
- Spending for the North Star Care for Children activity for FY 2015 was $121.8 million

PURPOSE & CONTEXT

Northstar Care for Children is designed to help children who are removed from their homes and supports permanency through adoption or transfer of custody to a relative if the child cannot be safely reunified with parents. Financial support is provided to adoptive and foster parents to encourage permanent placement of children in safe homes. The benefit varies with the child's age, but across the program averages about $12,000 annually per child. Northstar Care for Children consolidates and simplifies administration of three existing programs: Family FosterCare, Kinship Assistance (which replaces Relative Custody Assistance) and Adoption Assistance. Northstar Care for Children will help more children grow up in safe and permanent homes.

SERVICES PROVIDED

The comprehensive, simplified Northstar Care for Children program:

- Combines three child welfare programs — Family Foster Care, Adoption Assistance and Kinship Assistance — into a single program with uniform processes and unified benefits
  - Northstar Foster Care is for family foster care, in which children might become permanent members of families, not for group housing or residential treatment.
  - Northstar Kinship Assistance replaced the previous Relative Custody Assistance, simplifying ongoing requirements for caregivers and bringing in federal Title IV-E foster care funds.
  - Northstar Adoption Assistance turns more decision-making over to adoptive parents that previously required detailed state review and approval.
- Provides a monthly basic benefit based on children's age
- Uses a uniform assessment for all children to determine any needs beyond the basic payment for one of 15 levels of monthly supplemental difficulty of care payments
- Maintains the highest range of the current foster care benefits for children with the highest need
- Grandfathers children in existing programs under their current programs unless specifically transitioned into Northstar Care for Children (the current programs are slowly phased out as children exit them)
- Reduces barriers to permanency by eliminating disparities in benefits across the existing programs
- Reduces racial disparities among the children who remain in long-term foster care

Funding for Northstar Care for Children comes from state general fund appropriations, federal payments for foster care and adoption assistance, and county or tribal spending on foster care. In FY14-15, components of this program were part of the Children Services Grants budget activity. In FY16, the consolidation occurred and the Northstar Care for Children became a forecasted program.

RESULTS

The Department of Human Services (DHS) monitors the performance of counties and tribes in delivering child welfare services, including services provided under Northstar Care for Children. DHS expects to see better outcomes for children under Northstar Care in that a larger portion of children in the system will find permanent homes.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quality	Rate of Relative Care: Percentage of children who are in relative family foster homes or pre-adoptive homes compared to children in all family foster care or pre-adoptive homes	35.6%	50.6%	2012 to 2015
Quality	Placement Stability: Percentage of children who have two or fewer placement settings when they are in foster care for less than 12 months	84.0%	89.5%	2012 to 2015
Quality	Timeliness to Adoption: Percentage of children who achieve adoption within 24 months from their most recent entry into foster care	49.4%	54.2%	2012 to 2015

Performance Measures notes:
The 2012 data for the "Previous" column comes from the archived Child Welfare Data Dashboard. The 2015 data for the "Current" column come from the public MN Child Welfare Data Dashboard.

The DHS Dashboard is posted here - Child Welfare Dashboard (http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_148137) .

Northstar Care for Children is established in M.S. section 256N.20 (https://www.revisor.mn.gov/statutes/?id=256N.20).

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
1000 - General	37,313	38,697	42,689	54,528	80,502	96,392	83,445	111,359
3000 - Federal	31,189	33,967	36,081	37,844	45,187	52,956	45,187	52,956
Total	**68,502**	**72,664**	**78,769**	**92,372**	**125,689**	**149,348**	**128,632**	**164,315**
Biennial Change				29,975		103,896		121,806
Biennial % Change				21		61		71
Governor's Change from Base								17,910
Governor's % Change from Base								7

Expenditures by Category

Operating Expenses	0	0	0	0	0	0	0	0
Other Financial Transactions	2,110	1,587	54	2,000	2,000	2,000	2,000	2,000
Grants, Aids and Subsidies	66,392	71,077	78,715	90,372	123,689	147,348	126,632	162,315
Total	**68,502**	**72,664**	**78,769**	**92,372**	**125,689**	**149,348**	**128,632**	**164,315**
Full-Time Equivalents	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	4,006	743	719	1,082	0	0	0	0
Direct Appropriation	36,560	39,700	43,327	53,446	80,502	96,392	83,445	111,359
Net Transfers	(220)		769					
Cancellations	0	1,026	1,044	0	0	0	0	0
Expenditures	**37,313**	**38,697**	**42,689**	**54,528**	**80,502**	**96,392**	**83,445**	**111,359**
Balance Forward Out	3,033	719	1,082	0	0	0	0	0
Biennial Change in Expenditures				21,206		79,678		97,588
Biennial % Change in Expenditures				28		82		100
Gov's Exp Change from Base								17,910
Gov's Exp % Change from Base								10

3000 - Federal

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	3	0	9	9	0	0	0	0
Receipts	31,186	33,977	36,081	37,835	45,187	52,956	45,187	52,956
Expenditures	**31,189**	**33,967**	**36,081**	**37,844**	**45,187**	**52,956**	**45,187**	**52,956**
Balance Forward Out	0	9	9	0	0	0	0	0
Biennial Change in Expenditures				8,769		24,218		24,218
Biennial % Change in Expenditures				13		33		33
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

Program: Forecasted Programs
Activity: MinnesotaCare

mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/programs-and-services/minnesotacare.jsp

AT A GLANCE

- In FY 2015, MinnesotaCare had an average monthly enrollment of 91,105.
- Beginning January 1, 2015, MinnesotaCare began operating as a Basic Health Plan under the Affordable Care Act.
- 35,202 people received dental services through MinnesotaCare in 2015.
- 13,307 people received behavioral health services through MinnesotaCare in 2015.
- All funds spending for the MinnesotaCare grants activity for FY 2015 was $510 million. This represented 3.3% of the Department of Human Services overall budget.
- The Minnesota state share of total MinnesotaCare program expenditures in FY2015 was $275 million.

PURPOSE & CONTEXT

MinnesotaCare provides comprehensive health care coverage for over 100,000 low-income Minnesotans. MinnesotaCare serves clients who do not have access to affordable health insurance and have higher income levels than those served on the Medical Assistance program. Unlike Medical Assistance, MinnesotaCare requires enrollee premiums and does not include coverage for long term care services or supports.The Minnesota Department of Human Services administers the program and contracts with non-profit health plans to deliver covered services to enrollees through their provider networks.

MinnesotaCare is funded with appropriations from the health care access fund, federal Basic Health Plan funds, and from enrollee premiums. During the 2015 fiscal year, about 54% of the program costs were covered by state funds, 43% from federal funds, and 3% from enrollee premiums.

Changes to MinnesotaCare eligibility requirements and covered services were signed into law in 2013. These changes made the program eligible to receive Basic Health Plan (BHP) funding under the Affordable Care Act (ACA). Minnesota receives BHP funding for MinnesotaCare equal to 95 percent of the federal subsidies that would otherwise be available to eligible people enrolled in private health care coverage through MNsure, the state's health insurance exchange.

Changes to the income eligibility limits resulted in over 110,000 former MinnesotaCare recipients transitioning to coverage under MA in January of 2014. MinnesotaCare is available to:

- non-pregnant adults with household income between 138 and 200% of of federal poverty guidelines (FPG)
- children under 19 with income under 200% FPG who are ineligible for MA due to household composition rules, and
- lawfully present noncitizens with income up to 200% of FPG.

People eligible for Medical Assistance are not eligible for MinnesotaCare.

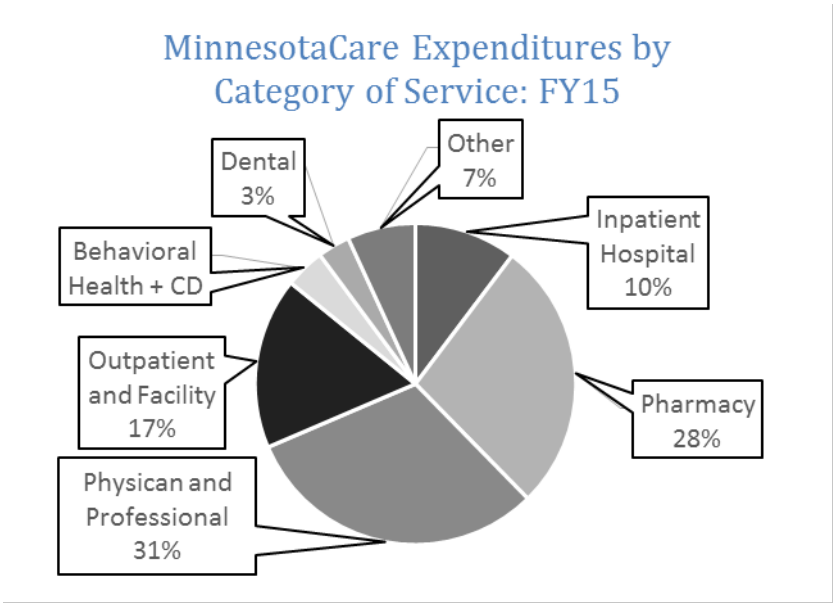
SERVICES PROVIDED

MinnesotaCare covers a broad range of health care services including:

- primary and preventive care,
- inpatient and outpatient hospital care,
- coverage for prescription drugs,
- chemical dependency treatment,
- mental health services, and
- oral health services.

People seeking coverage under MinnesotaCare can apply directly through the MNsure web site or by submitting a paper application to MNsure, to DHS, or to their county human services or tribal office. Applicants are not eligible if they have access

to affordable health insurance coverage through an employer. There are no health condition barriers for eligibility, but applicants must meet income guidelines and pay a premium (if applicable) to receive coverage.[1] Premiums are based on income and are charged for each enrollee, up to a maximum of $80 per month in 2016.



Innovations Underway
DHS works with many stakeholders to determine how we can improve our health care programs. Here is one example of how DHS is working toward program improvements:

Integrated Health Partnerships (IHP)
As part of Minnesota's commitment to deliver quality health care more efficiently, the agency began a new payment model in 2013 that prioritizes quality preventive care and rewards providers for reducing the cost of care for enrollees in MA and MinnesotaCare programs.

The traditional healthcare model pays providers for the volume of care they deliver rather than the quality and effectiveness of the care they provide. The *Integrated Health Partnerships (IHP)* initiative gives participating providers financial incentives to manage the total cost of care through better coordination of medical care and prioritizing quality care. Participating providers that reduce the total cost of care for health care enrollees may be eligible for a share of savings, and providers may also share in the risk if costs are higher than projected. This initiative has resulted in over $150 milllion in lower than expected health care expenditures over three years as providers across the state developed and implemented innovative approaches to improving health care for low income people. A portion of these savings accrue to the state budget. On quality, the results for the provider groups that joined IHP in the first year show that they either outperformed statewide averages for quality metrics such as depression remission and optimal diabetes care, or showed significant improvement.

The IHP, originally known as the Health Care Delivery Systems demonstration, is one of the key components of a $45 million federal State Innovation Model (SIM) grant for health care reforms. The SIM grant provides funding for a joint effort by DHS and the Department of Health to develop new ways of delivering and paying for health care and creating healthy communities using the Minnesota Accountable Health Model. The project began in 2013 with 6 participating providers providing care to 100,000 people in publically funded health care programs. In just three years the project expanded to 19 providers and covers more than 350,000 people in Medical Assistance and MinnesotaCare. This growth puts DHS on track to meet its goal of 500,000 participants in IHP or similar value-based reforms by the end of 2018.

[1] Income eligibility guidelines (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3182-ENG) and estimated premium amounts (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4139A-ENG) by income are available on the DHS web site.

RESULTS

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Result	Percent of Minnesotans without health insurance[1]	8.2%	4.3%	2013 to 2015
Result	Percent of Low Income Minnesotans without Health Insurance[2]	15.9%	8.5%	2013 to 2015
Quantity	Number of MA and MinnesotaCare program enrollees served by an IHP	176,000	350,000	2015 to 2016
Quality	Estimated reduction in health care expenditures (below projections) for providers in Integrated Health Partnership demonstration project[4]	$65.3 million	$76.7 Million	2014 to 2015

Performance Measure Notes:

1. Measure is the percent of Minnesotans that do not have health insurance. Source: Minnesota Health Access Survey, Minnesota Department of Health. Compares 2013 (Previous) and 2015 (Current)
2. Measure is the percentage of uninsured Minnesotans with family income below 200% of poverty. Source: Minnesota Health Access Survey, Minnesota Department of Health. Compares 2013 (Previous) and 2015 (Current)
3. Measure is the number of enrollees served by an IHP provider. Compares 2015 (Previous) and 2016 (Current).
4. Measure is an estimated reduction in annual medical costs below projections for 2014 and 2015 for the providers enrolled in the IHP demonstration. IHP provider contracts require this measure be calculated in the same manner each year. These reductions do not represent lower state spending.

Minnesota Statutes, chapter 256L provides the legal authority to operate the MinnesotaCare program. Many of the covered services, provider rates, and other elements of the MinnesotaCare program overlap with the Medical Assistance program and are detailed in the Medical Assistance statute. The statutory authority for Medical Assistance is located in M.S. chapter 256B.

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
2000 - Restrict Misc Special Revenue	2	0	0	0	0	0	0	0
2360 - Health Care Access	269,525	290,639	144,902	56,171	55,651	55,960	55,638	56,081
3000 - Federal	260,612	219,477	334,558	364,228	399,644	411,176	399,644	411,176
Total	**530,139**	**510,115**	**479,460**	**420,399**	**455,295**	**467,136**	**455,282**	**467,257**
Biennial Change				(140,395)		22,572		22,680
Biennial % Change				(13)		3		3
Governor's Change from Base								108
Governor's % Change from Base								0

Expenditures by Category

Operating Expenses	0	0	0	0	0	0	0	0
Grants, Aids and Subsidies	530,139	510,115	479,460	420,399	455,295	467,136	455,282	467,257
Total	**530,139**	**510,115**	**479,460**	**420,399**	**455,295**	**467,136**	**455,282**	**467,257**
Full-Time Equivalents	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

(Dollars in Thousands)

2000 - Restrict Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	149	155	171	20	0	0	0	0
Receipts	(134)	(140)	(151)	(20)	0	0	0	0
Expenditures	**2**	0	0	0	0	0	0	0
Balance Forward Out	13	15	20	0	0	0	0	0
Biennial Change in Expenditures				(2)				
Biennial % Change in Expenditures				(100)				

2360 - Health Care Access

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	9,080	68	3	0	0	0	0
Direct Appropriation	262,869	267,949	133,293	11,204	12,241	12,917	12,228	13,038
Receipts	15,680	15,634	29,994	44,964	43,410	43,043	43,410	43,043
Net Transfers	0	6,998	0	0	0	0	0	0
Cancellations	9,021	9,021	18,450	0	0	0	0	0
Expenditures	**269,525**	**290,639**	**144,902**	**56,171**	**55,651**	**55,960**	**55,638**	**56,081**
Balance Forward Out	0	0	3	0	0	0	0	0
Biennial Change in Expenditures				(359,091)		(89,461)		(89,353)
Biennial % Change in Expenditures				(64)		(44)		(44)
Gov's Exp Change from Base								108
Gov's Exp % Change from Base								0

3000 - Federal

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	31	66	186	577	55,475	192,259	55,475	192,259
Receipts	260,586	304,504	334,950	419,126	536,428	560,883	536,428	560,883
Expenditures	**260,612**	**219,477**	**334,558**	**364,228**	**399,644**	**411,176**	**399,644**	**411,176**
Balance Forward Out	5	85,094	577	55,475	192,259	341,966	192,259	341,966
Biennial Change in Expenditures				218,698		112,034		112,034
Biennial % Change in Expenditures				46		16		16
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

Program: Forecasted Programs
Activity: Medical Assistance

mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/programs-and-services/medical-assistance.jsp

AT A GLANCE

- In fiscal year 2015, MA served a monthly average of 1,049,819 people. This is 19.1% of the state's population.
- MA provided coverage for 26,673 births in 2015 and pays for about 4 in 10 of all live births in Minnesota
- 199,967 people received mental health services through MA in 2015.
- 432,509 received dental services through MA in 2015.
- In FY2015, coverage for families with children made up 83% of total enrollment, but only 42% of total basic care expenditures.
- In FY 2015, coverage for the elderly and disabled made up 17% of total enrollment, but 58% of total basic care expenditures.
- MA is funded with state general funds, the health care access fund, federal Medicaid funds, and with local shares for a few particular services.
- All funds spending for the Medical Assistance activity for FY 2015 was $10.8 billion. This represented 69.9% of the Department of Human Services overall budget.
- The Minnesota state share of total MA expenditures in FY2015 was $4.2 billion.

PURPOSE & CONTEXT

Medical Assistance (MA) is Minnesota's Medicaid program. MA provides coverage for preventive and primary health care services for low-income Minnesotans. MA differs from the state's other health care program, MinnesotaCare, in that it has lower income eligibility guidelines, does not have premiums, and pays for previously incurred medical bills up to three months prior to the month of application. Additionally, MA can pay for nursing facility care and intermediate care facilities for people with developmental disabilities. It can also cover long term care services and supports for people with disabilities and older adults so that they can continue living in the community.

The Minnesota Department of Human Services (DHS) is the state Medicaid agency and partners with all 87 Minnesota counties to administer the MA program. DHS contracts with both health plans and health care providers across the state to deliver basic health care to MA enrollees.

Minnesota receives federal matching funds for MA. By accepting matching funds, states are subject to federal Medicaid regulations. States have some flexibility in determining what services are covered, what groups are covered, and in setting payment rates to providers.

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. Home and community-based services (HCBS) 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 HCBS to people who may otherwise be institutionalized. Minnesota began serving people under the HCBS waiver in 1984, and these services have facilitated Minnesota's shift away from institutional care.

Minnesota's MA program has expanded since the mid-1980's. The expansions have focused 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 time, a moratorium was placed on nursing facilities and intermediate care facilities for people with developmental disabilities and efforts to develop home and community based alternatives gained momentum.

The most significant recent changes to the Minnesota MA program were enacted by the legislature during the 2013 session and applied to people without an aged, blind, or disabled basis of eligibility. These changes included an elimination of assets tests and an increase to the income eligibility limits for adults without children, parents and relative caretakers, children, and pregnant women. Under the higher income standards, people formerly eligible for MinnesotaCare including pregnant women and children with income up to 275 percent of poverty and adults below 133 percent of poverty became eligible for MA, resulting in over 110,000 former MinnesotaCare recipients transitioning to coverage under MA in January of 2014.

SERVICES PROVIDED

MA enrollees fall under one of five general categories, and receive either long term care services and supports, basic health care, or both long term care and basic care. The five categories include the following:

MA Coverage of Care in Long-Term Care Facilities
MA pays for long-term care services for people who reside in facilities. In FY 2015, this segment of MA funds supported an average of over 16,700 people per month. Total spending on this group was just over $924 million in FY2015, about $442 million of which came from state funds. Care provided under this segment of MA includes 24-hour care and supervision in nursing facilities or intermediate care facilities for persons with developmental disabilities (ICF/DD). It also includes day training and habilitation (DT&H) services for people who live in an ICF/DD.

A nursing facility (also called a nursing home) provides 24-hour care and supervision in a residential facility setting. Nursing facilities provide an all-inclusive package of services that covers: nursing care, help with activities of daily living and other care needs, housing, meals and medication administration. An ICF/DD provides 24-hour care, active treatment, training and supervision to people with developmental disabilities. DT&H services help people living in an ICF/DD develop and maintain life skills, and take part in the community. DT&H services include supervision, training and assistance in self-care, communication, socialization, behavior management, and supported employment and work-related activities, among others.

DHS works with community providers, counties and tribes, and the Department of Health in administering and monitoring services in these long-term care settings. More information is available in a nursing home fact sheet (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-5961-ENG)

To receive MA long-term care services a person must have income and assets that are below allowable limits and have an assessed need for the services.

MA Coverage of Care through Long-Term Care Waivers, Long Term Services and Supports, & Home Care
In Minnesota MA also pays for people to receive long-term care waiver, long-term services and supports, or home care services in their homes and communities. In FY 2015, this segment of MA funds supported an average of nearly 58,000 people per month. Total spending on this group was just under $2.8 billion FY2015, about $1.4 billion came from state funds. Long-term care waivers, also known as Home and Community-Based Services (HCBS) waivers, are an alternative for people who need long-term care services but who do not choose to live in a nursing facility, ICF/DD or hospital. The federal Centers for Medicare and Medicaid Services (CMS) allows states to apply for long-term care waivers which provide different kinds of services that help people live in the community instead of in a facility or institution. These waivers can offer:

- in-home, residential, medical and behavioral supports
- customized day services
- employment supports
- Consumer-Directed Community Supports (a self-directed option)
- caregiver supports
- transitional services to support people to move out of institutions or other congregate settings
- transportation
- home modifications
- case management
- other goods and services

Minnesota operates five home and community-based waivers:

- Brain Injury (BI) – for individuals with a brain injury meeting a nursing facility or neurobehavioral hospital level of care
- Community Alternative Care (CAC) – for individuals with disabilities meeting a hospital level of care
- Community Access for Disability Inclusion (CADI) – for individuals with disabilities meeting a nursing facility level of care
- Developmental Disabilities (DD) – for individuals with developmental disabilities meeting an Intermediate Care Facilities for persons with Developmental Disabilities (ICF/DD) level of care
- Elderly Waiver (EW) – for individuals age 65 and older meeting a nursing facility level of care

Home care services provide a range of medical care and support services in a person's home or community. Services include assessments, home health aide visits, nurse visits, home care nursing, personal care services, home health therapies, and

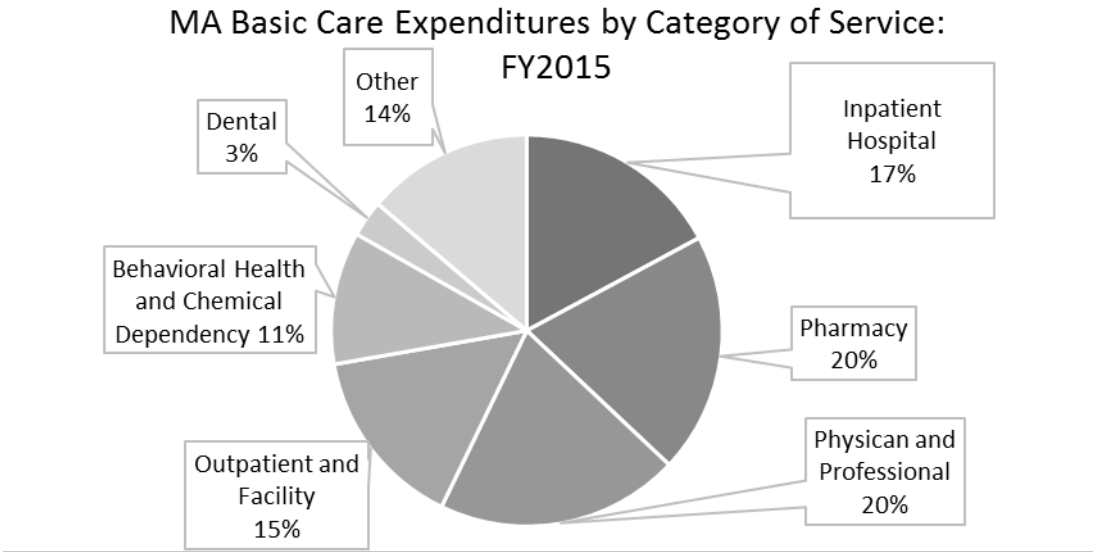
medical supplies and equipment. The agency is developing a new service called Community First Services and Supports (CFSS) that will replace personal care services. CFSS will be more flexible and expand self-directed options.

Medical Assistance Basic Care

The Medical Assistance program also provided comprehensive coverage outside of long-term care to over one million Minnesotans in FY2015. Total spending for basic care services reached about $6.8 billion in FY2015, with $2.6 billion coming from state funds. The enhanced federal share available with the MA expansion in 2014 reduced the share of basic care expenditures to just over 38 percent in FY2015, a decrease from 50 percent in FY2013.

Covered services under MA basic care include:

- primary and preventive care
- inpatient hospital benefits
- mental health and chemical dependency treatment
- medical transportation
- medical equipment
- prescription drugs
- dental care
- coverage for eyeglasses and eye care



MA Coverage of Basic Health Care for Elderly and Disabled

In FY2015, this segment of MA funds supported an average of 181,757 people per month, many of whom are also enrolled in Medicare and so are "dual eligible beneficiaries." Total spending on this group was over $2.35 billion in FY2015, about $1.17 billion of which came from state funds.

People receiving these services are low-income elderly (65 years or older) and people who are blind or have a disability. Their income and assets must be below allowable limits. As MA enrollees they receive health care coverage or financial assistance to help them pay for their Medicare premiums and cost sharing/copayments. This latter approach is often less expensive for the state than if the state provided their health coverage under MA alone.

This segment of the MA program also includes the Medical Assistance for Employed Persons with Disabilities (MA-EPD) program. MA-EPD allows a monthly average of about 9,000 working individuals with disabilities to receive the full MA benefit set. This program encourages people with disabilities to work and enjoy the benefits of being employed. It allows working people with disabilities to qualify for MA without an income limit and under higher asset limits than standard MA. More information on MA-EPD is available in the Medical Assistance for Employed Persons with Disabilities brochure (http://edocs.dhs.state.mn.us/lfserver/public/DHS-2087L-ENG).

MA Coverage of Basic Health Care for Families with Children
In FY 2015, this segment of MA funds supported an average of 668,752 people per month. Total spending on this group was just over $2.72 billion FY2013, about $1.33 billion of which came from state funds. Recipients of this health care coverage include low income pregnant women, children, parents and caretaker relatives. This segment of the MA program also includes funding for the Minnesota Family Planning Program (MFPP) and the MA Breast and Cervical Cancer Treatment program (MABC). MFPP provides coverage of family planning and related health care services for people not currently enrolled in MA or MinnesotaCare. MABC covers treatment costs for breast cancer, cervical cancer or a precancerous cervical condition for women without health insurance.

MA Coverage of Basic Health Care for Adults without Children
In FY2015, this segment of the MA program served an average of 199,310 people per month. Total spending on this group was about $1.7 billion in FY2015, with about $91 million coming from state funds.

A full list of Medical Assistance populations, income and asset limits is in a Minnesota Health Care Programs brochure (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-3182-ENG).

Innovations Underway
DHS works with many stakeholders to determine how we can improve our health care programs. Here are some examples of how DHS is working toward program improvements:

Integrated Health Partnerships (IHP)
As part of Minnesota's commitment to deliver quality health care more efficiently, the agency began a new payment model in 2013 that prioritizes quality preventive care and rewards providers for reducing the cost of care for enrollees in MA and MinnesotaCare programs.

The traditional healthcare model pays providers for the volume of care they deliver rather than the quality and effectiveness of the care they provide. The *Integrated Health Partnerships (IHP)* initiative gives participating providers financial incentives to manage the total cost of care through better coordination of medical care and prioritizing quality care. Participating providers that reduce the total cost of care for health care enrollees may be eligible for a share of savings, and providers may also share in the risk if costs are higher than projected. This initiative resulted in health care spending that was $150 million lower than expected over the last three years, a portion of which accrues to the state, as providers across the state developed and implemented innovative approaches to improving health care for low income people. On quality, the results for the provider groups that joined IHP in the first year show that they either outperformed statewide averages for quality metrics such as depression remission and optimal diabetes care, or showed significant improvement.

The IHP, originally known as the Health Care Delivery Systems demonstration, is one of the key components of a $45 million federal State Innovation Model (SIM) grant for health care reforms. The SIM grant provides funding for a joint effort by DHS and the Department of Health to develop new ways of delivering and paying for health care and creating healthy communities using the Minnesota Accountable Health Model. The project began in 2013 with 6 participating providers providing care to 100,000 people in publically funded health care programs. In just three years the project expanded to 19 providers and covers more than 350,000 people. This growth puts DHS on track to meet its goal of 500,000 participants in IHP or similar value-based reforms by the end of 2018.

Integrated Care Systems Partnerships (Duals Demonstration)
"Dual eligible beneficiaries" are people whose health care is covered by both Medicare and MA. Health care for dual eligible beneficiaries has historically been fragmented, complex, and confusing with Medicare paying for most primary care and Medicaid paying for acute and long-term care. In September 2013, Minnesota began a new project to improve the care experience for dual eligible beneficiaries receiving services through the Minnesota Senior Health Options (MSHO) program. The Integrated Care Systems Partnerships project combines the financing of the managed care organizations operating the Medicare Advantage and Minnesota's MSHO programs to improve coordination between Medicare and Medicaid services and simplify an enrollee's experience. This financing platform allows for new arrangements for provider payment and delivery reforms.

A June 2016 longitudinal analysis comparing recipient outcomes in MSHO compared to duals enrolled in Minnesota Senior Care Plus (MSC+), a non-integrated managed care product, found better results for dual eligibles enrolled in the integrated program. MSHO enrollees were:

- 48% less likely to have a hospital stay, and comparing those in both programs with hospital stays, MSHO enrollees had 26% fewer stays than if in MSC+
- 6% less likely to have an outpatient emergency department visit, and comparing those in both programs with emergency department visits, MSHO enrollees had 38% fewer visits than if in MSC+
- 2.7 times more likely to have a primary care physician visit, but comparing those in both programs with primary care physician visits, MSHO enrollees had 36% fewer visits than MSC+

RESULTS

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quality	Percent of seniors served by home and community-based services[1]	68.4%	71.3%	FY2013 to FY2105
Quality	Percent of people with disabilities served by home and community-based services[2]	93.5%	94.1%	FY2013 to FY2015
Quantity	Percent of Minnesotans without health insurance[3]	8.2%	4.3%	2013 to 2015
Quantity	Percent of Low Income Minnesotans without Health Insurance[4]	15.9%	8.5%	2013 to 2015
Quantity	Number of MA and MinnesotaCare program enrollees served by an IHP[5]	176,000	350,000	2015 to 2016
Quality	Estimated reduction in health care cost (below projections) for providers in Integrated Health Partnership demonstration project[6]	$65.3 million	$76.7 Million	2014 to 2015

Performance Measure Notes:

1. This measure reflects the percentage of older adults receiving publicly-funded long-term care services who receive HCBS services through the Elderly Waiver or Alternative Care program instead of services in nursing homes. Measure compares FY 2013 and FY 2015 data. (Source: DHS Data Warehouse)
2. This is the percent of people with disabilities receiving publicly-funded long-term care services who receive HCBS services through disability waiver or home care programs instead of services in nursing homes or Intermediate Care Facilities. Measure compares FY 2013 and FY 2015 data. (Source: DHS Data Warehouse)
3. Measure is the percent of Minnesotans that do not have health insurance. Source: Minnesota Health Access Survey, Minnesota Department of Health. Compares 2013 (Previous) and 2015 (Current)
4. Measure is the percentage of uninsured Minnesotans with family income below 200% of poverty. Source: Minnesota Health Access Survey, Minnesota Department of Health. Compares 2013 (Previous) and 2015 (Current)
5. Measure is the number of enrollees served by an IHP provider. Compares 2015 (Previous) and 2016 (Current).
6. Measure is an estimated reduction in annual medical costs below projections for 2014 and 2015 for the providers enrolled in the IHP demonstration. IHP provider contracts require this measure be calculated in the same manner each year. The lower health care spending does not result in savings to the state of the same amount.

Minnesota Statutes, chapter 256B provides the legal authority for the Medical Assistance program. An example of legislative directives to improve and innovate in Medical Assistance is M.S. section 256B.021 (Medical Assistance Reform Waiver).

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
1000 - General	4,163,665	4,329,056	4,134,042	4,517,912	5,329,045	5,583,977	4,989,330	5,234,726
2000 - Restrict Misc Special Revenue	85,093	76,701	133,737	72,197	65,180	65,180	65,180	65,180
2360 - Health Care Access	175,744	173,879	588,188	240,720	210,159	224,929	568,159	582,929
3000 - Federal	4,944,101	6,194,121	6,524,854	6,430,196	7,136,720	7,392,458	7,136,720	7,392,458
Total	**9,368,603**	**10,773,758**	**11,380,821**	**11,261,025**	**12,741,104**	**13,266,544**	**12,759,389**	**13,275,293**
Biennial Change				2,499,484		3,365,802		3,392,836
Biennial % Change				12		15		15
Governor's Change from Base								27,034
Governor's % Change from Base								0

Expenditures by Category

Operating Expenses	180,956	178,751	207,404	0	0	0	0	0
Other Financial Transactions	225	330	384	300	300	300	300	300
Grants, Aids and Subsidies	9,187,423	10,594,677	11,173,032	11,260,725	12,740,804	13,266,244	12,759,089	13,274,993
Total	**9,368,603**	**10,773,758**	**11,380,821**	**11,261,025**	**12,741,104**	**13,266,544**	**12,759,389**	**13,275,293**
Full-Time Equivalents	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	108,942	0	0	0	0	0	0
Direct Appropriation	4,291,344	4,357,843	4,173,316	4,545,885	5,358,992	5,610,137	5,019,277	5,260,886
Net Transfers	(18,782)	8,949	5,117	(27,973)	(29,947)	(26,160)	(29,947)	(26,160)
Cancellations	108,897	146,678	44,391	0	0	0	0	0
Expenditures	**4,163,665**	**4,329,056**	**4,134,042**	**4,517,912**	**5,329,045**	**5,583,977**	**4,989,330**	**5,234,726**
Biennial Change in Expenditures				159,233		2,261,068		1,572,102
Biennial % Change in Expenditures				2		26		18
Gov's Exp Change from Base								(688,966)
Gov's Exp % Change from Base								(6)

2000 - Restrict Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	18	68	426	6,941	0	0	0	0
Receipts	85,076	76,724	140,252	65,255	65,180	65,180	65,180	65,180
Expenditures	**85,093**	**76,701**	**133,737**	**72,197**	**65,180**	**65,180**	**65,180**	**65,180**
Balance Forward Out	0	91	6,941	0	0	0	0	0
Biennial Change in Expenditures				44,139		(75,574)		(75,574)
Biennial % Change in Expenditures				27		(37)		(37)
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

2360 - Health Care Access

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	2,111	0	0	0	0	0	0
Direct Appropriation	177,855	173,597	588,190	240,720	210,159	224,929	568,159	582,929
Net Transfers	0							
Cancellations	0	1,828	2	0	0	0	0	0
Expenditures	**175,744**	**173,879**	**588,188**	**240,720**	**210,159**	**224,929**	**568,159**	**582,929**
Balance Forward Out	2,111	0	0	0	0	0	0	0
Biennial Change in Expenditures				479,284		(393,820)		322,180
Biennial % Change in Expenditures				137		(48)		39
Gov's Exp Change from Base								716,000

(Dollars in Thousands)

2360 - Health Care Access

Gov's Exp % Change from Base				165

3000 - Federal

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	4,718	4,292	22,177	17,424	0	0	0	0
Receipts	4,941,974	6,212,099	6,520,101	6,412,772	7,136,720	7,392,458	7,136,720	7,392,458
Expenditures	**4,944,101**	**6,194,121**	**6,524,854**	**6,430,196**	**7,136,720**	**7,392,458**	**7,136,720**	**7,392,458**
Balance Forward Out	2,591	22,271	17,424	0	0	0	0	0
Biennial Change in Expenditures				1,816,828		1,574,128		1,574,128
Biennial % Change in Expenditures				16		12		12
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

Program: Forecasted Programs
Activity: Alternative Care

mn.gov/dhs/people-we-serve/seniors/services/home-community/programs-and-services/alternative-care.jsp
mn.gov/dhs/people-we-serve/seniors/services/home-community/programs-and-services/essential-community-supports.jsp

AT A GLANCE

- In fiscal year 2015, the Alternative Care Program:
  - Served 3,873 people;
  - Averaged 2,724 enrollees each month;
  - Who were provided an average monthly benefit of $849; and
- Enrolled consumers contributed a total of $1.3 million towards their cost of care.
- In November 2013 the program became eligible for federal Medicaid financial participation through an approved waiver.
- Starting in fiscal year 2015, Essential Community Support grants are included as part of the Alternative Care Budget activity. In fiscal year 2015, the program served:
  - Averaged 24 enrollees each month
  - Provided an average monthly benefit of $216.
- All funds spending for the Alternative Care activity for FY 2015 was $28.9 million. This represented 0.2% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

The Alternative Care (AC) Program is a cost-sharing program that provides certain home and community-based services for Minnesotans age 65 and over. Alternative Care services support seniors, their families, caregivers and communities to help seniors to stay in their homes and communities and avoid costly institutionalization.

The program is a cost-effective strategy to prevent or delay people from moving onto Medical Assistance-funded long term care services, such as Elderly Waiver and nursing home care. The program helps prevent the impoverishment of eligible seniors and maximizes the use of their own resources by sharing the cost of care with clients. AC is available to individuals who need the level of care provided in a nursing home but choose instead to receive services in the community, and whose income and assets would be inadequate to fund a nursing home stay for more than 135 days.

SERVICES PROVIDED

Alternative Care (AC) services are used in a person's own home. AC covers the following services: adult day services, caregiver assessment, case management, chore services, companion services, consumer-directed community supports, home health aides, home-delivered meals, homemaker services, environmental accessibility adaptations, nutrition services, personal emergency response system, personal care, respite care, skilled nursing, specialized equipment and supplies, training and support for family caregivers and transportation.

Beginning January 1, 2015, some people who have a lower level of need for long-term care services no longer qualify to have Medical Assistance pay for nursing facility care and community-based alternatives. Those people will instead be served by Essential Community Support grants, which are a new targeted benefit. Essential Community Support grants cover the following services: adult day services, service coordination (case management), chore services, home delivered meals, homemaker services, personal emergency response, caregiver education/training, and community living assistance. People can qualify for up to $424 a month for these services. These grants are included as part of the Alternative Care budget activity.

DHS partners with community providers, counties, tribal health groups and the Department of Health in providing and monitoring services.

The AC program is funded with state and federal money along with monthly fees paid by the person receiving services. Payments made by the state for AC services are also subject to estate recovery. Essential Community Support grants are state funded only.

More information is available on the Alternative Care fact sheet (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4720-ENG).

RESULTS

The agency monitors performance measures that show how this program is working. One key measure is how much people who are eligible for publically funded long-term care services access the services in their homes and community rather than in nursing facilities.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Result	1. Percent of seniors served by home and community-based services	68.4%	71.3%	2013 to 2015
Quantity	2. Percent of long-term care expenditures for seniors spent on home and community-based services	45.1%	51%	2013 to 2015
Quantity	3. Percent of AC spending on Consumer-Directed Community Supports (CDCS)	5.4%	7.5%	2013 to 2015

Performance Notes:

1. Measure one compares FY2013 to FY2015 data. This measure shows the percentage of elderly receiving publicly funded long-term care services who receive HCBS services through the Elderly Waiver, Alternative Care, or home care programs instead of nursing home services. Source: DHS Data Warehouse
2. Measure two compares 2013 to 2015 data. This measure shows the percentage of public long-term care funding for the elderly that is spent on Elderly Waiver, Alternative Care or home care services instead of nursing home services. Source: DHS Data Warehouse.
3. Measure three compares FY2013 to FY2015 data. CDCS gives persons more flexibility and responsibility for directing their services and supports—compared to services provided through the traditional program – including hiring and managing direct care staff. Source: DHS Data Warehouse.

More information is available on the Continuing Care Performance Report (http://www.dhs.state.mn.us/main/dhs16_166609) and the DHS Dashboard (http://dashboard.dhs.state.mn.us/).

The Alternative Care and Essential Community Support programs are authorized by Minnesota Statutes, sections 256B.0913 (https://www.revisor.mn.gov/statutes/?id=256B.0913) and 256B.0922 (https://www.revisor.mn.gov/statutes/?id=256B.0922).

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
1000 - General	17,829	13,253	12,866	43,590	44,250	44,833	44,441	45,133
2000 - Restrict Misc Special Revenue	1,849	1,275	1,266	1,060	962	990	962	990
3000 - Federal	7,079	14,353	13,511	14,738	17,444	20,292	17,444	20,292
Total	**26,757**	**28,881**	**27,643**	**59,388**	**62,656**	**66,115**	**62,847**	**66,415**
Biennial Change				31,393		41,740		42,231
Biennial % Change				56		48		49
Governor's Change from Base								491
Governor's % Change from Base								0

Expenditures by Category

Grants, Aids and Subsidies	26,757	28,881	27,643	59,388	62,656	66,115	62,847	66,415
Total	**26,757**	**28,881**	**27,643**	**59,388**	**62,656**	**66,115**	**62,847**	**66,415**
Full-Time Equivalents	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	26,011	0	0	0	0	0	0
Direct Appropriation	43,840	42,627	43,997	43,590	44,250	44,833	44,441	45,133
Net Transfers		(55,061)	(31,131)					
Cancellations	26,011	324	0	0	0	0	0	0
Expenditures	**17,829**	**13,253**	**12,866**	**43,590**	**44,250**	**44,833**	**44,441**	**45,133**
Biennial Change in Expenditures				25,373		32,627		33,118
Biennial % Change in Expenditures				82		58		59
Gov's Exp Change from Base								491
Gov's Exp % Change from Base								1

2000 - Restrict Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	62	8	139	129	0	0	0	0
Receipts	1,786	1,296	1,256	931	962	990	962	990
Expenditures	**1,849**	**1,275**	**1,266**	**1,060**	**962**	**990**	**962**	**990**
Balance Forward Out	0	29	129	0	0	0	0	0
Biennial Change in Expenditures				(797)		(374)		(374)
Biennial % Change in Expenditures				(26)		(16)		(16)
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

3000 - Federal

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	0	0	1	0	0	0	0
Receipts	7,079	14,353	13,512	14,737	17,444	20,292	17,444	20,292
Expenditures	**7,079**	**14,353**	**13,511**	**14,738**	**17,444**	**20,292**	**17,444**	**20,292**
Balance Forward Out	0	0	1	0	0	0	0	0
Biennial Change in Expenditures				6,816		9,487		9,487
Biennial % Change in Expenditures				32		34		34
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

Program: Forecasted Programs
Activity: Chemical Dependency Treatment Fund

mn.gov/dhs/people-we-serve/children-and-families/health-care/substance-abuse/programs-and-services/

AT A GLANCE

- In the United States, 21.5 million people aged 12 and older had substance use disorders (CY2014).
- Statewide, there were 52,596 admissions for substance use disorder treatment in 2015, which represents a 5% increase over 2013.
- The CD Treatment Fund pays for a little more than 40% of all admissions for substance abuse disorder treatment in Minnesota.
- The percentage of people completing substance use disorder reatment dropped to 50.7% in 2015.
- All funds spending for the CD Treatment Fund activity for FY 2015 was $172 million. This represented 1.1% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

The Chemical Dependency (CD) Treatment Fund activity pays for residential and outpatient substance use disorder (SUD) treatment services for eligible low-income Minnesotans.

People access the SUD treatment services paid by the fund by first being assessed as needing treatment for Substance Use Disorder, and second by meeting financial eligibility guidelines. Financial eligibility standards are similar to those for Medical Assistance, the state's Medicaid program.

Counties and tribes are responsible for providing assessments (known as "Rule 25" assessments) to individuals seeking access to these funds. These assessments not only determine an individual's eligibility for services paid for by the CD Treatment Fund but also determine the appropriate level or intensity of services the person may need based on their condition and circumstances.

SERVICES PROVIDED

The Consolidated Chemical Dependency Treatment Fund (CCDTF) is the single fee-for-service public payment source that funds residential and outpatient substance use disorder treatment services for eligible low-income Minnesotans. The CCDTF combines multiple funding sources – state appropriations, county funding, federal Medicaid funding and the federal Substance Abuse, Prevention and Treatment block grant – into a single fund with common eligibility criteria and a single process for evaluating treatment need and placement options. Federal Medicaid matching funds are collected on eligible treatment services provided to Medical Assistance recipients. Counties also contribute a share toward the cost of treatment. Counties pay 30 percent of the non-federal share of treatment costs for Medical Assistance (MA) recipients and 22.95 percent for non-MA recipients (this amount was reduced to 20.2 percent for FY 2017). The CCDTF pays for services that are part of a licensed residential or non-residential SUD treatment program. The CCDTF ensures that all clients have the same access to high quality, effective treatment programs.

All of these programs provide a continuum of effective, research-based treatment services for individuals who need them. Treatment services include individual and group therapy in outpatient or residential settings, and may also include treatment for a mental illness, other medical services, medication-assisted therapies (with or without adjunct behavioral services), and service coordination.

CD treatment providers use a variety of evidence-based practices, such as the twelve-step facilitation program, cognitive behavioral therapies, specialized behavioral therapy, motivational interviewing and motivational enhancement therapy as methods to ensure success.

RESULTS

Type of Measure	*Name of Measure*	*Previous (CY2013)*	*Current (CY2015)*	*Dates*
Quantity	Number of treatment admissions to substance use disorder treatment[1]	50,124	52,596	2013 to 2015
Result	Percent of persons completing substance use disorder treatment	53.6%	50.7%	2013 to 2015
Result	Change in percent of clients who reported alcohol use within the last 30 days at time of admission and then again at the time of discharge	Admit 41.2% Discharge 13.4%	Admit 37.4% Discharge 11.6%	2013 to 2015 2013 to 2015

Measure Notes:

1. This indicator is from the Drug and Alcohol Abuse Normative Evaluation System (DAANES) in the Performance Measurement & Quality Improvement section in the Alcohol and Drug Abuse Division of the Minnesota Department of Human Services.

Minnesota Statutes chapter 254B (https://www.revisor.mn.gov/statutes/?id=254B) provides the legal authority for the CD Treatment Fund. M.S. section 254B.01, Subd.3 (https://www.revisor.mn.gov/statutes/?id=254B.01) defines chemical dependency services payable by the CD Treatment Fund. This definition applies to a wide variety of services within a planned program of care to treat a person's chemical dependency, or substance use disorder.

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
2000 - Restrict Misc Special Revenue	141,035	171,542	161,379	179,278	179,097	182,334	179,097	180,903
Total	**141,035**	**171,542**	**161,379**	**179,278**	**179,097**	**182,334**	**179,097**	**180,903**
Biennial Change				28,080		20,774		19,343
Biennial % Change				9		6		6
Governor's Change from Base								(1,431)
Governor's % Change from Base								0

Expenditures by Category

Operating Expenses	1	0	0	0	0	0	0	0
Other Financial Transactions	170	173	175	200	200	200	200	200
Grants, Aids and Subsidies	140,864	171,369	161,204	179,078	178,897	182,134	178,897	180,703
Total	**141,035**	**171,542**	**161,379**	**179,278**	**179,097**	**182,334**	**179,097**	**180,903**
Full-Time Equivalents	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Direct Appropriation	85,147	82,684	93,699	115,120	116,213	136,519	116,213	135,079
Net Transfers	(85,147)	(82,684)	(93,699)	(115,120)	(116,213)	(136,519)	(116,213)	(135,079)

2000 - Restrict Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	17,911	5,678	1,620	976	976	976	976	976
Receipts	62,365	72,197	67,036	64,658	63,384	46,315	63,384	46,315
Net Transfers	66,059	94,782	93,699	114,620	115,713	136,019	115,713	134,588
Expenditures	**141,035**	**171,542**	**161,379**	**179,278**	**179,097**	**182,334**	**179,097**	**180,903**
Balance Forward Out	5,300	1,115	976	976	976	976	976	976
Biennial Change in Expenditures				28,080		20,774		19,343
Biennial % Change in Expenditures				9		6		6
Gov's Exp Change from Base								(1,431)
Gov's Exp % Change from Base								0

Program: Grant Programs
Activity: Support Services Grants

www.dhs.state.mn.us/main/id_004112
mn.gov/dhs/people-we-serve/children-and-families/economic-assistance/food-nutrition/programs-and-services/e-and-t.jsp

AT A GLANCE

- Provides MFIP/DWP employment services to approximately 27,000 people per month.
- Provides Supplemental Nutrition Assistance Program employment services to approximately 1,000 people per month.
- All funds spending for the Support Services Grants activity for FY 2015 was $103 million. This represented 0.7% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

The Minnesota Family Investment Program (MFIP) and Diversionary Work Program (DWP) primary focus is on self-sufficiency through employment, by building on job placements in today's economy and focusing on future workforce development.

Support Services Grants cover the cost of services creating pathways to employment for low income families. This is accomplished by addressing barriers, helping stabilize families and adults, and building skills that ensure participants are prepared to find and retain employment.

These grants ensure that a foundation is there to deliver key activities to help families meet their basic needs and achieve their highest potential.

SERVICES PROVIDED

The Support Services Grants activity provides funding for the MFIP Consolidated Fund. Counties and tribes use the MFIP Consolidated Fund to provide an array of employment services including job search, job placement, training and education. The Consolidated Fund also provides other supports such as emergency needs for low-income families with children.

In addition to helping those on MFIP/DWP, the Support Services Grants activity also provides funding for employment supports for adults who receive benefits through the Supplemental Nutrition Assistance Program (SNAP), or the SNAP Employment and Training program.

Services are delivered by Workforce Centers, counties, tribes and community agencies. Service providers evaluate the needs of each participant and develop an individualized employment plan that builds on strengths and addresses areas of need. Services include:

- Referrals to housing, child care, and health care coverage, including any needed chemical and mental health services, to aid in stabilizing families
- Basic education, English proficiency training, skill building and education programs to prepare participants for the labor market
- Job search assistance and job placement services to help participants locate employment that matches their skills and abilities
- Innovative programs to address special populations or needs such as: a single point of contact for teen parents that includes public health home visits, subsidized work experiences, integrated services for families with serious disabilities and support for the FastTRAC program, which links education and credentials to high demand careers.

Support Services Grants also fund a portion of county and tribal costs to administer MFIP and DWP. Support Services Grants are allocated to counties and tribes, and are funded with a combination of state and federal funds, including from the federal Temporary Assistance for Needy Families (TANF) block grant.

RESULTS

The two key measures in MFIP/DWP are:

- The **Self-Support Index** (S-SI), which is a results measure. The S-SI shows the percentage of adults eligible for MFIP or DWP in a quarter who have left assistance or are working at least 30 hours per week three years later. Customized targets are set for each county or tribe using characteristics of the people served and local economic conditions. State

law requires the Department of Human Services to use the Self-Support Index to allocate performance bonus funds. The chart following shows that about two-thirds of participants have left MFIP or DWP and/or are working at least 30 hours per week three years after a baseline period.

Year ending in March of:	S-SI
2008	71.8%
2009	68.9%
2010	67.0%
2011	65.2%
2012	65.3%
2013	66.9%
2014	68.5%
2015	68.8%
2016	68.0%

- The federal Work Participation Rate (WPR), which is a measure of quantity. The WPR shows parents engaging in work and specific work-related activities. We calculate an estimated WPR for counties, county consortiums and tribes monthly, and it is annualized to allocate performance bonus funds. (Beginning in calendar year 2016, the bonus will be based solely on the S-SI.) The chart following shows the WPR for 2008 to 2015.

Federal Fiscal Year	WPR
2008	29.9%
2009	29.8%
2010	40.2%
2011	43.9%
2012	45.3%
2013	45.1%
2014*	46.2%
2015*	37.9%

*State estimate (Federal figures not yet released)

Another employment-related, state-mandated performance measure tracked is:

- **MFIP/DWP Median Placement Wage**, a quality measure that reflects the number of people getting jobs and the median wage. The chart shows the statewide median hourly starting wage. (Tribes are not included.)

Calendar Year	Median Placement Wage Per Hour for MFIP Clients	Median Placement Wage Per Hour for DWP Clients
2008	$8.38	$8.92
2009	$8.50	$9.00
2010	$8.98	$9.19
2011	$8.95	$9.27
2012	$9.00	$9.58
2013	$9.18	$9.84
2014	$9.79	$10.04
2015	$10.15	$10.75

The legal authority for Support Services Grants is M.S. sections 256J.626 (https://www.revisor.mn.gov/statutes/?id=256J.626) and 256D.051 (https://www.revisor.mn.gov/statutes/?id=256D.051)

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
1000 - General	8,784	12,920	15,805	8,715	8,715	8,715	8,715	8,715
2000 - Restrict Misc Special Revenue	0	0	0	741	0	0	0	0
3000 - Federal	11	19	19	4,600	5,600	5,600	5,600	5,600
3001 - Federal TANF	87,533	93,720	92,483	96,311	96,311	96,311	96,311	96,311
Total	**96,328**	**106,659**	**108,307**	**110,367**	**110,626**	**110,626**	**110,626**	**110,626**
Biennial Change				15,687		2,579		2,579
Biennial % Change				8		1		1
Governor's Change from Base								0
Governor's % Change from Base								0

Expenditures by Category

Operating Expenses	700	1,043	1,491	0	0	0	0	0
Other Financial Transactions	2,782	3,670	4,455	0	0	0	0	0
Grants, Aids and Subsidies	92,847	101,945	102,360	110,367	110,626	110,626	110,626	110,626
Total	**96,328**	**106,659**	**108,307**	**110,367**	**110,626**	**110,626**	**110,626**	**110,626**
Full-Time Equivalents	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	0	2,694	0	0	0	0	0
Direct Appropriation	8,915	13,333	13,133	8,715	8,715	8,715	8,715	8,715
Cancellations	131	24	22	0	0	0	0	0
Expenditures	**8,784**	**12,920**	**15,805**	**8,715**	**8,715**	**8,715**	**8,715**	**8,715**
Balance Forward Out	0	389	0	0	0	0	0	0
Biennial Change in Expenditures				2,816		(7,090)		(7,090)
Biennial % Change in Expenditures				13		(29)		(29)
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

2000 - Restrict Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	0	741	741	0	0	0	0
Receipts	0	741	0	0	0	0	0	0
Expenditures	0	0	0	**741**	0	0	0	0
Balance Forward Out	0	741	741	0	0	0	0	0
Biennial Change in Expenditures				741		(741)		(741)
Biennial % Change in Expenditures						(100)		(100)

3000 - Federal

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Receipts	11	19	19	4,600	5,600	5,600	5,600	5,600
Expenditures	**11**	**19**	**19**	**4,600**	**5,600**	**5,600**	**5,600**	**5,600**
Biennial Change in Expenditures				4,589		6,581		6,581
Biennial % Change in Expenditures				15,417		142		142
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

3001 - Federal TANF

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19

(Dollars in Thousands)

3001 - Federal TANF

Balance Forward In	0	0	0	0	0	0	0	0
Receipts	87,533	93,719	92,483	96,311	96,311	96,311	96,311	96,311
Expenditures	**87,533**	**93,720**	**92,483**	**96,311**	**96,311**	**96,311**	**96,311**	**96,311**
Biennial Change in Expenditures				7,540		3,828		3,828
Biennial % Change in Expenditures				4		2		2
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

Program: Grant Programs
Activity: Basic Sliding Fee Child Care Assistance Grants

mn.gov/dhs/people-we-serve/children-and-families/economic-assistance/child-care/programs-and-services/basic-sliding-fee.jsp

AT A GLANCE

- In 2015 Basic Sliding Fee Child Care Assistance paid for child care for 15,267 children in 8,121 families in an average month.
- As of May, 2016 there was a waiting list of 7,420 families eligible for assistance, but who could not be served at the current funding levels.
- The average monthly assistance per family was $1,030.
- All funds spending for the BSF Child Care Assistance Grants activity for FY 2015 was $102 million. This represented 0.7% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

In order to work, families need safe and reliable child care. The annual cost of full time licensed care for one child can exceed $10,000. Many low-income families struggle to find affordable child care that fits their needs. Basic Sliding Fee (BSF) Child Care Assistance provides financial subsidies to help low-income families pay for child care through the Child Care Assistance Program. Families earning no more than 47 percent of the state median income ($36,365 in 2015 for a family of three) are eligible to enter the Basic Sliding Fee program. Families leave the Child Care Assistance Program when their earnings are greater than 67 percent of state median income (in October 2015, that level was set at $51,841 for a family of three) or when their copayment exceeds their cost of care.

SERVICES PROVIDED

BSF child care assistance grants provide support to help improve outcomes for the most at-risk children and their families by increasing access to high quality child care.

Families must be working, looking for work or attending school to be eligible for the Basic Sliding Fee Program. The program helps families pay child care costs on a sliding fee basis. As family income increases, so does the amount of child care expenses (copayment) paid by the family. All families receiving child care assistance and earning 75 percent or more of the federal poverty guideline make copayments based on their income. A family of three earning 55 percent of the state median income ($42,555) would have a total biweekly copayment of $138 for all children in care.

The BSF child care assistance grants activity is part of the state's Child Care Assistance Program. Maximum rates for provider payment in the Child Care Assistance Program are set in state law. Maximum rates are set for each type of care: child care centers, family child care and legal non-licensed child care. Providers are paid at the rate they charge in the private child care market, up to this limit. The program pays a higher rate to providers who have met quality standards through Parent Aware, are accredited, or hold certain educational credentials.

Child care must be provided by a legal child care provider over the age of 18 years. Allowable providers include legal non-licensed family child care, license-exempt centers, licensed family child care and licensed child care centers. Families choose their providers in the private child care market. Counties administer the Child Care Assistance Program.

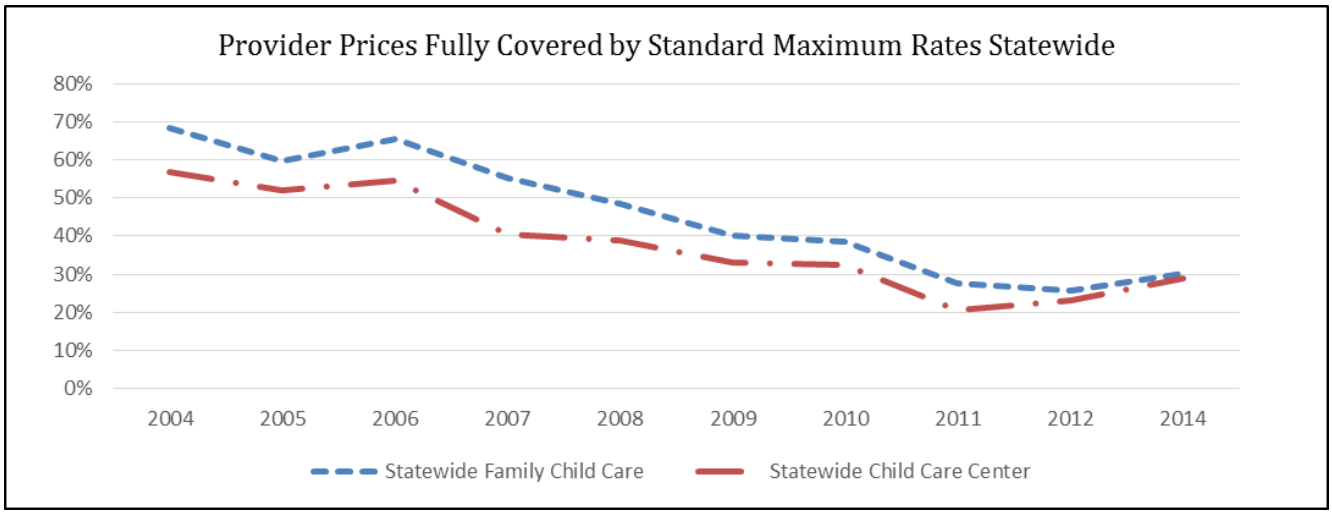
BSF funding is a capped allocation. It includes a combination of state funds and federal Child Care and Development and Temporary Assistance for Needy Families funding. The agency allocates funding to counties, who administer the program. Because the funding is capped, not everyone who is eligible for the program may be served. As of May, 2016, there was a waiting list for BSF child care assistance of 7,420 families.

RESULTS

Percent of Provider Prices Fully Covered by CCAP - Maximum rates paid to providers under the Child Care Assistance Program may not cover the full cost of child care. This may be a barrier for some families if they cannot find a provider in their

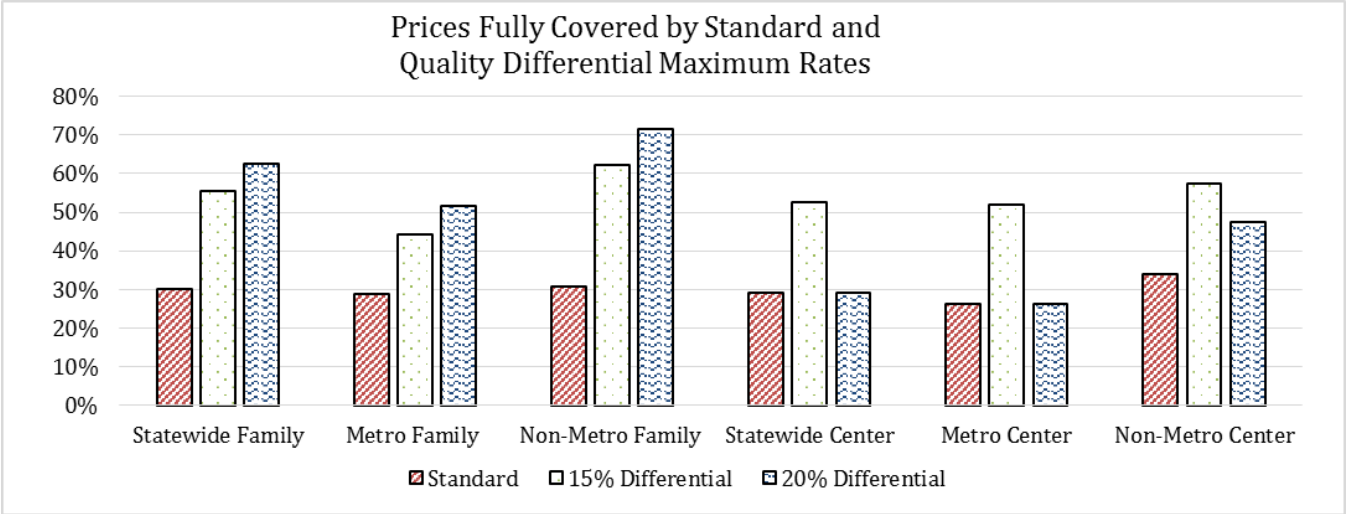
community whose prices are covered by the maximum allowed under the program. The percent of child care providers who charge prices that are fully covered by the Child Care Assistance Program increased when the maximum rates were raised in 2014, but the maximum rate paid remains low compared to prices in the market.

This quality measure shows approximately 30% of all child care providers charge prices that are fully covered by the Child Care Assistance Program maximum rates.



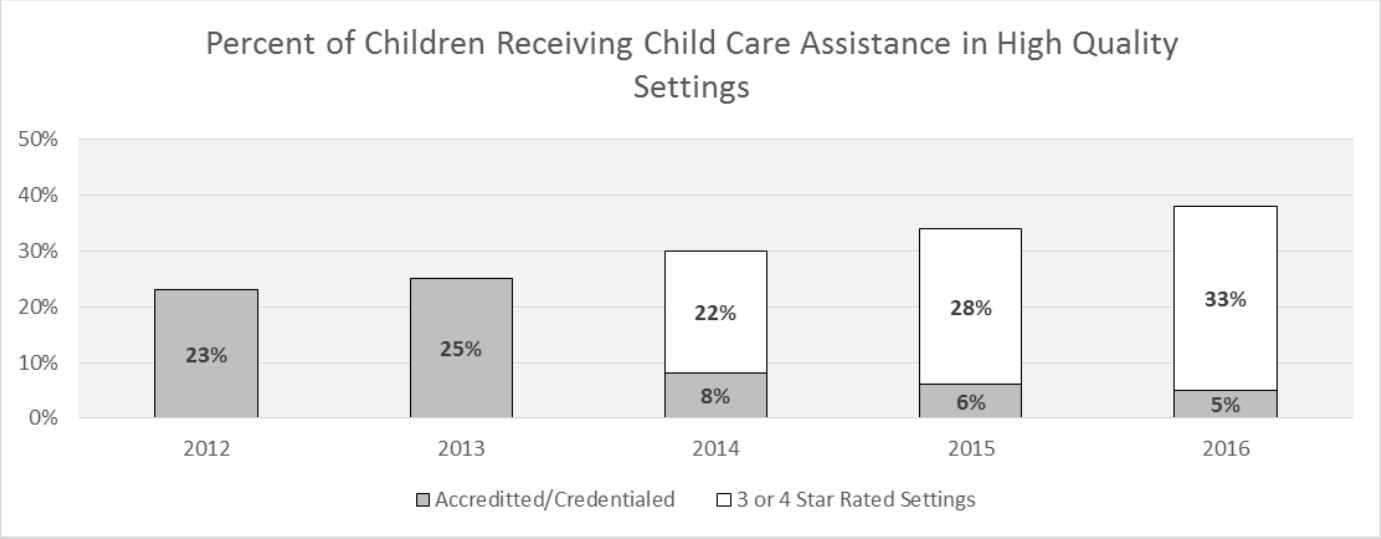
Quality Differential Impact - Parent Aware is Minnesota's rating tool for helping parents select high quality child care and early education programs. The Child Care Assistance Program allows up to a 15 percent higher maximum rate to be paid to providers with a Parent Aware 3-star rating, or who hold certain accreditation or education standards established in statute. Up to a 20 percent higher maximum rate can be paid to providers with a 4-star Parent Aware rating.

This quality measure shows that higher maximum rates may increase families' access to high quality providers by allowing the maximum rate paid by the Child Care Assistance Program to fully cover more (or an equivalent proportion) of their prices as compared to the prices charged by all providers. This measure indicates the impact of quality differentials by type of care. It is first presented as a statewide total, and then broken out by metro and non-metro counties.



Specifically, the 20 percent differential allows the prices charged by center based four-star rated metro providers to be fully covered by the maximum subsidy in the same proportion as the prices of all metro center providers. The higher maximum rates offer coverage of the prices charged by all other types of quality providers at higher levels than the standard maximum rates.

Use of High Quality Care - Children who participate in high quality early care and education are more likely to experience school success and positive life-long outcomes. This quality measure shows that the percent of all children receiving child care assistance through providers eligible for the higher subsidy rates for quality has increased from 23 percent in quarter four of 2012 to 38 percent in quarter three of 2016. This represents a 65 percent increase over the 4-year period.



In 2014 a statute change allowed providers to qualify for the higher maximum subsidy rate through receiving a Parent Aware rating of 3-or-4-Stars. Previously only providers holding certain accreditations and family child care providers meeting certain education standards were eligible. In this figure, child care settings were categorized according to the quality standard they meet to be eligible for the CCAP quality differential.

- In 2012-2013 settings meeting quality standards though accreditations/credentials may also have been highly rated by Parent Aware. In 2014-2015 settings that hold both a 3-or-4 Star Parent Aware rating and an accreditation or educational credential, are included in the Parent Aware rated category.

The data source for the prices charged by providers is a biennial survey of provider prices conducted by the Department. To assess the portion of provider prices fully covered, provider prices are compared to the applicable maximum subsidy rates.

The data source for children in care with provider's eligible of the higher rates for quality is from MEC2, Minnesota's child care electronic eligibility and payment system.

The legal authority for the Basic Sliding Fee (BSF) Child Care Assistance program is in M.S. chapter 119B. (https://www.revisor.mn.gov/statutes/?id=119B)

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
1000 - General	36,836	42,318	48,439	51,559	52,369	52,380	55,877	63,098
3000 - Federal	47,437	59,682	47,187	53,051	50,328	50,328	50,328	50,328
Total	**84,273**	**102,000**	**95,626**	**104,610**	**102,697**	**102,708**	**106,205**	**113,426**
Biennial Change				13,963		5,168		19,394
Biennial % Change				7		3		10
Governor's Change from Base								14,226
Governor's % Change from Base								7

Expenditures by Category

Grants, Aids and Subsidies	84,273	102,000	95,626	104,610	102,697	102,708	106,205	113,426
Total	**84,273**	**102,000**	**95,626**	**104,610**	**102,697**	**102,708**	**106,205**	**113,426**
Full-Time Equivalents	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Direct Appropriation	36,836	42,318	48,439	51,559	52,369	52,380	55,877	63,098
Expenditures	**36,836**	**42,318**	**48,439**	**51,559**	**52,369**	**52,380**	**55,877**	**63,098**
Biennial Change in Expenditures				20,844		4,751		18,977
Biennial % Change in Expenditures				26		5		19
Gov's Exp Change from Base								14,226
Gov's Exp % Change from Base								14

3000 - Federal

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	1,318	67	3	16	0	0	0	0
Receipts	46,173	59,615	47,201	53,035	50,328	50,328	50,328	50,328
Expenditures	**47,437**	**59,682**	**47,187**	**53,051**	**50,328**	**50,328**	**50,328**	**50,328**
Balance Forward Out	54	0	16	0	0	0	0	0
Biennial Change in Expenditures				(6,881)		417		417
Biennial % Change in Expenditures				(6)		0		0
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

Program: Grant Programs
Activity: Child Care Development Grants

mn.gov/dhs/people-we-serve/children-and-families/services/child-care/

AT A GLANCE

- As of July 2016, 2,644 child care and early education programs have a Parent Aware rating.
- 1,880 family child care providers and 6,993 child care center staff are active users on Develop, an on-line tool to help individuals search for training and track their training and education.
- 1,954 individuals received coaching and support services to increase quality of care to children in FY16.
- All funds spending for the Child Care Development Grants activity for FY 2015 was $13.4 million. This represented less than 0.1% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

Child Care Development Grants are used for services that promote children's development and learning.

It is important that all children and their families have access to high quality child care and early education programs. The first few years of children's lives are key to their intellectual, emotional and social development. Everyone wants to know that children are being well cared for while family members are at work or school. High quality child care that is available and affordable is important to children's safety and healthy development, and to families' self-sufficiency.

Child Care Development Grants fund support services and initiatives that increase the availability of quality care and education in Minnesota.

These grants also support Parent Aware, Minnesota's Quality Rating and Improvement System. Parent Aware offers tools and resources that help families access quality child care and early education that will prepare them for school and for life. It also provides resources to help child care programs improve their practices.

SERVICES PROVIDED

The Department of Human Services (DHS) works with public and private agencies, as well as individuals to promote school readiness through education and training. Child Care Development Grants are used to support services that improve the quality of early childhood and school- age care, and increase access to high quality care, especially for high-needs children. This grant activity also supports consumer education services for parents searching for child care. Services support:

- Information for parents searching for quality child care and early education for their children through Parent Aware, an online search tool (Parent Aware website, http://parentaware.org/), and other parent education services provided by Child Care Aware of Minnesota
- Grants, financial supports and other incentives for child care programs to improve quality, including for those participating in the voluntary Parent Aware Quality Rating and Improvement System
- Training, coaching, consultation and other workforce supports for early childhood and school-age care providers to increase their knowledge and skills in child development, instructional practices and ways to meet the needs of individual children
- Reimbursement to child care programs and providers to cover some of the fees charged to complete a nationally recognized child care accreditation program

Child Care Development Grants are funded primarily with federal Child Care and Development block grant funds and some state funds.

RESULTS

Use of High Quality Child Care - Children who participate in high quality child care and early education are more likely to experience school success and positive life-long outcomes. This measure shows that the percent of all children receiving child

care assistance through providers eligible for the higher subsidy rates for quality has increased from 23 percent in quarter four of 2012 to 38 percent in quarter three of 2016. This represents a 65 percent increase over the 4-year period.

Number of Programs Rated by Parent Aware – Parent Aware improves children's outcomes by improving families' access to high quality child care. This measure shows that the percentage of child care and early education programs with a Parent Aware rating increased from 2015 to 2016.

Provider Education Levels – Child care and early education professionals with degrees or credentials are needed to provide the kind of early learning opportunities that will make a difference for children's outcomes. This measure shows that the number of early childhood educators who earned a degree or credential in Minnesota increased from 947 in 2014 to 1,136 in 2015.

Searches for Quality Care Through Parent Aware - A new and improved website for parents was launched in FY2015 to better meet parents' needs in choosing child care. After this launch, the website experienced a large increase in visitors in a short period of time.

Type of Measure	***Description***	***Previous***	***Current***	***Dates***
Result	***Percent of children receiving child care assistance in high quality settings***[1]	***23%***	***38%***	2012 & 2016
Quantity	Percent of child care and early education programs with a Parent Aware rating[2]	17%	22%	2015 & 2016
Quantity	Number of early childhood educators who earned a degree or credential in the past year[3]	947	1,136	2014 & 2015
Quantity	Number of unique visitors on Parent Aware.org[4]	36,641 visitors	199,791 visitors	2015 & 2016

Performance Measures notes:

1. Data is from the Department of Human Services (DHS) and includes the number of children receiving child care assistance served in high quality settings that were accredited or credentialed in 2012 (Q4), and the number of children receiving child care assistance served in high quality settings that were accredited or credentialed (5%) in 2016 (Q3) or in 3 or 4 Star Rated programs (33%) in 2016 (Q3).
2. Data is from DHS and includes licensed child care programs (Centers and Family Child Care), Head Start sites, and school-based pre-kindergarten sites.
3. Data is from DHS, the Minnesota Association for the Education of Young Children, the National Council for Professional Recognition, and the Integrated Postsecondary Education Data System. The following credentials and degrees were included: Minnesota Child Care Credential, Minnesota Director's Credential, National Child Development Associate, Higher Education Diploma or Credential, Associate's Degree, and Bachelor's Degree.
4. Data is collected via Google Analytics reports from Parent Aware.org.

The legal authority for the Child Care Development Grant activities is M.S. chapter 119B (https://www.revisor.mn.gov/statutes/?id=119B).

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
1000 - General	1,553	1,711	2,600	5,347	2,962	2,962	2,962	2,962
2000 - Restrict Misc Special Revenue	0	27	0	7	0	0	0	0
2001 - Other Misc Special Revenue	2,032	3,330	3,694	3,548	0	0	0	0
3000 - Federal	10,045	9,282	9,301	9,282	9,282	9,282	9,282	9,282
Total	**13,630**	**14,350**	**15,594**	**18,184**	**12,244**	**12,244**	**12,244**	**12,244**
Biennial Change				5,798		(9,290)		(9,290)
Biennial % Change				21		(28)		(28)
Governor's Change from Base								0
Governor's % Change from Base								0

Expenditures by Category

Operating Expenses	488	0	137	7	0	0	0	0
Other Financial Transactions	0	0	137	0	0	0	0	0
Grants, Aids and Subsidies	13,142	14,350	15,320	18,177	12,244	12,244	12,244	12,244
Total	**13,630**	**14,350**	**15,594**	**18,184**	**12,244**	**12,244**	**12,244**	**12,244**
Full-Time Equivalents	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Direct Appropriation	1,612	1,737	1,737	1,737	1,737	1,737	1,737	1,737
Net Transfers			863	3,610	1,225	1,225	1,225	1,225
Cancellations	59	26	0	0	0	0	0	0
Expenditures	**1,553**	**1,711**	**2,600**	**5,347**	**2,962**	**2,962**	**2,962**	**2,962**
Biennial Change in Expenditures				4,683		(2,023)		(2,023)
Biennial % Change in Expenditures				143		(25)		(25)
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

2000 - Restrict Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	33	33	7	7	0	0	0	0
Net Transfers		2						
Expenditures	0	**27**	0	**7**	0	0	0	0
Balance Forward Out	33	7	7	0	0	0	0	0
Biennial Change in Expenditures				(20)		(7)		(7)
Biennial % Change in Expenditures				(74)		(100)		(100)

2001 - Other Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	0	14	0	0	0	0	0
Receipts	2,032	3,330	3,680	5,030	0	0	0	0
Net Transfers				(1,482)	0	0	0	0
Expenditures	**2,032**	**3,330**	**3,694**	**3,548**	0	0	0	0
Biennial Change in Expenditures				1,880		(7,242)		(7,242)
Biennial % Change in Expenditures				35		(100)		(100)

3000 - Federal

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	627	0	19	0	0	0	0	0

(Dollars in Thousands)

3000 - Federal

Receipts	9,418	9,282	9,282	9,282	9,282	9,282	9,282	9,282
Expenditures	**10,045**	**9,282**	**9,301**	**9,282**	**9,282**	**9,282**	**9,282**	**9,282**
Biennial Change in Expenditures				(744)		(19)		(19)
Biennial % Change in Expenditures				(4)		0		0
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

Program: Grant Programs
Activity: Child Support Enforcement Grants

mn.gov/dhs/people-we-serve/children-and-families/services/child-support/

AT A GLANCE

- County and state child support offices provide services to more than 360,000 custodial and non-custodial parents and their 250,000 children.
- In 2015, the child support program collected and disbursed $609 million in child support.
- Access and visitation funds served 437 families in 2015.
- All Funds spending for the Child Support Enforcement Grants Activity for FY 2015 was $1.7 million dollars. This represented less than 0.01% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

Every child needs financial and emotional support, and every child has the right to support from both parents. Minnesota's child support program benefits children by enforcing parental responsibility for their support.

The State of Minnesota collected $609 million in child support in FY2015. Of that collected, 96% went to families and the remaining 4% reimbursed public assistance dollars. The MN child support program plays an active role in reducing the reliance on other state income maintenance programs given the significant amount of child support that is collected and sent directly to families.

Child support represents a high proportion of income for low income custodial parents. Twenty-nine percent of custodial parent families eligible for child support have income below the federal poverty level. For low-income families who receive child support, the average amount received represents 52 percent of their income. Eighty-two percent of custodial parents who are eligible for child support are women, 79 percent are 30 years-old or older, and 57 percent have just one eligible child.

Child Support Enforcement Grants help strengthen families by providing financial supports. Child support helps families become self-sufficient.

SERVICES PROVIDED

Under state direction and supervision, child support activities are administered by counties and tribes. Staff provides assistance for custodial parents in obtaining basic support, medical support and child care support for children, through locating parents and establishing paternity and support obligations. Without this assistance, many families would not have the financial resources to remain self-sufficient.

The following activities help to support and stabilize families:

- Establish paternity through genetic testing, Recognition of Parentage or other means;
- Establish and modify court orders for child support, medical support and child care support, based on statutory guidelines;
- Enforce court orders to assure payment through remedies established in federal regulation and state law, such as income withholding, driver's license suspension and passport denial; and,
- Collect and process payments from employers, parents, counties and other states, and issue support funds to families.

Additional grants provide federal funding to improve non-custodial parents' access to their children. Funding is a mix of federal funds, state general funds and fees.

RESULTS

The federal government funds state child support programs in part through performance incentives. These are calculated by measuring the state's performance in core activities: Paternity establishment, order establishment, collection of current support, collection of arrears (past due support) and program cost effectiveness. States are ranked by their scores on the measures and

earn higher incentives as performance increases. Each percentage measurement has a threshold of 80 percent to earn the maximum incentive for that measure. To maximize the incentive for cost-effectiveness, states must collect $5.00 for every dollar spent on the child support program.

Minnesota's child support performance has increased in all measures over the last five years. Minnesota ranks among the top five states on child support collections measures. In 2015, Minnesota earned $12 million dollars in federal incentives. The federal incentives are passed on to counties to help cover their administrative costs of the program.

Type of Measure	Performance Measures1	FFY 2015	FFY 2014	FFY 2013	FFY 2012	FFY 2011
Quantity	Paternities established: percent of children born outside marriage for whom paternity was established in open child support cases for the year	99%	100%	102%	102%	101%
Quantity	Orders established: percent of cases open at the end of the year with orders established	88%	88%	86%	86%	86%
Quantity	Collections on current support: percent of cases with current support due within the year that had a collection on current support	73%	72%	71%	71%	70%
Quantity	Collections on arrears: percent of cases with arrears due within the year that had a collection on arrears	72%	70%	70%	70%	70%
Quality	Cost effectiveness: dollars collected per dollar spent	$3.54	$3.58	$3.63	$3.51	$3.59

Performance Measures notes:

1. Federal performance measures are listed in the 2015 Minnesota Child Support Performance Report (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4252P-ENG).
2. FFY = federal fiscal year
3. Paternities established can be higher than 100 percent because the results include children born in prior years for whom paternity has been established in that year.

The legal authority for Child Support Enforcement Grants comes from federal and state laws.

Federal law 42 U.S.C. secs. 651-669b requires that states establish a child support program and gives general guidelines for administering the program. (Title 42 651) (http://www.gpo.gov/fdsys/pkg/USCODE-2012-title42/pdf/USCODE-2012-title42-chap7-subchapIV-partD.pdf)

State law:
Requires a person receiving public assistance to assign child support rights to the state and cooperate with child support services (M.S. sec. 256.741, https://www.revisor.mn.gov/statutes/?id=256.741)
Provides legal authority to establish child support (M.S. sec. 256.87, https://www.revisor.mn.gov/statutes/?id=256.87) and to establish paternity (M.S. sec. 257.57, https://www.revisor.mn.gov/statutes/?id=257.57)
Provides legal authority to set and collect fees for child support services (M.S. sec. 518A.51, https://www.revisor.mn.gov/statutes/?id=518A.51), and requires the state to establish a central collections unit (M.S. sec. 518A.56, https://www.revisor.mn.gov/statutes/?id=518A.56).

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
2000 - Restrict Misc Special Revenue	1,457	1,492	1,543	1,543	1,543	1,543	1,543	1,543
2001 - Other Misc Special Revenue	124	98	-5	153	50	50	50	50
3000 - Federal	134	168	188	312	138	138	138	138
Total	**1,715**	**1,758**	**1,726**	**2,008**	**1,731**	**1,731**	**1,731**	**1,731**
Biennial Change				261		(272)		(272)
Biennial % Change				8		(7)		(7)
Governor's Change from Base								0
Governor's % Change from Base								0

Expenditures by Category

Operating Expenses	-360	-292	-305	138	138	138	138	138
Grants, Aids and Subsidies	2,075	2,050	2,031	1,870	1,593	1,593	1,593	1,593
Total	**1,715**	**1,758**	**1,726**	**2,008**	**1,731**	**1,731**	**1,731**	**1,731**
Full-Time Equivalents	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Direct Appropriation	50	50	50	50	50	50	50	50
Net Transfers	(50)	(50)	(50)	(50)	(50)	(50)	(50)	(50)

2000 - Restrict Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	0	0	0	0	0	0	0
Receipts	1,491	1,526	1,577	1,543	1,543	1,543	1,543	1,543
Net Transfers	(34)	(34)	(34)					
Expenditures	**1,457**	**1,492**	**1,543**	**1,543**	**1,543**	**1,543**	**1,543**	**1,543**
Balance Forward Out	0	0	0	0	0	0	0	0
Biennial Change in Expenditures				137		0		0
Biennial % Change in Expenditures				5		0		0
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

2001 - Other Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	119	46	48	103	0	0	0	0
Net Transfers	50	100	50	50	50	50	50	50
Expenditures	**124**	**98**	**(5)**	**153**	**50**	**50**	**50**	**50**
Balance Forward Out	46	48	103	0	0	0	0	0
Biennial Change in Expenditures				(74)		(48)		(48)
Biennial % Change in Expenditures				(33)		(32)		(32)
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

3000 - Federal

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Receipts	134	168	188	312	138	138	138	138
Expenditures	**134**	**168**	**188**	**312**	**138**	**138**	**138**	**138**

3000 - Federal

Biennial Change in Expenditures	198	(224)	(224)
Biennial % Change in Expenditures	65	(45)	(45)
Gov's Exp Change from Base			0
Gov's Exp % Change from Base			0

AT A GLANCE

In 2015:

- 24,690 reports of child abuse and neglect were assessed involving 35,767 children
- Of these, 6,146 children were determined to be victims of child maltreatment
- 13,612 children experienced an out-of-home placement
- All funds spending for the Children's Services Grants activity for FY 2015 was $98.4 million. This represented 0.64% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

Having strong families and communities is an effective first line of defense for keeping children safe, especially in times of stress. Children who have been abused and neglected are more likely to perform poorly in school, get involved in criminal activities and abuse or neglect their own children. Programs and services that cultivate the factors shared by strong families and communities actually minimize long-term intervention costs for crime, corrections, truancy, hospitalization, special education and mental health care. Research provides compelling evidence that strength-based child welfare interventions such as those funded with Children's Services Grants, result in safer children and more stable families. Without these services, children and families remain at risk.

SERVICES PROVIDED

The Children's Services Grants activity funds child welfare services around the state, including Indian child welfare services, child protection, homeless youth services, and child abuse and neglect services through counties, tribes, and community- based providers. Grants provide supports to help keep more children out of foster care and safely with their families, and to decrease the disproportionate number of children of color in out-of-home placements. Most recently these grants have been used to:

- Reform the child welfare system to focus on ensuring children's safety while supporting families
- Improve the Minnesota Child Welfare Training System
- Work with tribes to design and develop tribal approaches that ensure child safety and permanency
- Transfer responsibilities from counties to tribes to deliver a full continuum of child welfare services to American Indian children and families on two reservations
- Expand the Parent Support Outreach Program (PSOP https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4472A-ENG) by doubling the number of counties in the program.

These services are essential in keeping children safe and families stable. Children's Services Grants include state and federal funding for child welfare services.

RESULTS

The Department of Human Services monitors the performance of counties and tribes in delivering child welfare services. Minnesota outcomes match or exceed most federal standards. Efforts to engage families early and collaboratively with evidence-based interventions have resulted in improving safety and timely permanency outcomes.

Type of Measure	*Description of Measure*	*2010*	*2011*	*2012*	*2013*	*2014*	*2015*
Quality	Percent of children not experiencing repeated abuse or neglect within six months of a prior report	95.1%	95.6%	97.5%	97.2%	96.7%	97.0%
Quality	Percent of children reunified with parents or living with relatives in fewer than 12 months from latest removal from home	84.5%	85.7%	85.9%	85.1%	86.2%	83.9%
Quality	Percent of children adopted in fewer than 24 months from latest removal from home	48.2%	48.1%	49.4%	54.7%	59.9%	54.2%

Performance Measures notes:

All measures are from Minnesota's Child Welfare Reports, 2010-2015. Child Protection statistical reports are posted on the DHS Child Protection Publications page (http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_003712).

Also see the DHS Child Welfare Dashboard (http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_148137).

Several state statutes provide the legal authority for the Children's Services Grants activity:

Provisions for reasonable efforts, Interstate Compact on Placement of Children and Minnesota Indian Preservation Act are in M.S. chapter 260 (https://www.revisor.mn.gov/statutes/?id=260)
Provisions for juvenile protection are in M.S. chapter 260C (https://www.revisor.mn.gov/statutes/?id=260C)
Provisions for voluntary foster care for treatment are in M.S. chapter 260D (https://www.revisor.mn.gov/statutes/?id=260D)
Reporting of Maltreatment of minors is under M.S. section 626.556 (https://www.revisor.mn.gov/statutes/?id=626.55

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
1000 - General	11,309	11,733	36,669	37,983	37,183	37,183	38,483	37,683
2000 - Restrict Misc Special Revenue	560	264	335	550	475	475	475	475
2001 - Other Misc Special Revenue	2,115	2,763	2,181	2,858	2,858	2,858	2,858	2,858
2403 - Gift	15	14	11	39	24	24	24	24
3000 - Federal	7,882	13,030	11,030	15,819	15,527	15,377	15,527	15,377
3001 - Federal TANF	140	140	140	140	140	140	140	140
Total	**22,021**	**27,944**	**50,365**	**57,389**	**56,207**	**56,057**	**57,507**	**56,557**
Biennial Change				57,789		4,511		6,311
Biennial % Change				116		4		6
Governor's Change from Base								1,800
Governor's % Change from Base								2

Expenditures by Category

Operating Expenses	651	944	899	611	536	536	536	536
Other Financial Transactions	5,781	7,189	6,318	975	75	75	1,375	575
Grants, Aids and Subsidies	15,589	19,811	43,148	55,803	55,597	55,447	55,597	55,447
Total	**22,021**	**27,944**	**50,365**	**57,389**	**56,207**	**56,057**	**57,507**	**56,557**
Full-Time Equivalents	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Direct Appropriation	13,200	13,258	39,015	39,465	38,665	38,665	39,965	39,165
Net Transfers	(1,262)	(1,482)	(2,251)	(1,482)	(1,482)	(1,482)	(1,482)	(1,482)
Cancellations	629	43	95	0	0	0	0	0
Expenditures	**11,309**	**11,733**	**36,669**	**37,983**	**37,183**	**37,183**	**38,483**	**37,683**
Biennial Change in Expenditures				51,610		(286)		1,514
Biennial % Change in Expenditures				224		0		2
Gov's Exp Change from Base								1,800
Gov's Exp % Change from Base								2

2000 - Restrict Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	360	398	555	778	744	770	744	770
Receipts	71	(58)	0	0	0	0	0	0
Net Transfers	526	478	557	516	501	501	501	501
Expenditures	**560**	**264**	**335**	**550**	**475**	**475**	**475**	**475**
Balance Forward Out	397	555	778	744	770	796	770	796
Biennial Change in Expenditures				61		65		65
Biennial % Change in Expenditures				7		7		7
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

2001 - Other Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	1,247	1,869	1,846	1,531	1,410	956	1,410	956
Receipts	1,163	1,115	1,284	2,103	2,070	2,412	2,070	2,412
Net Transfers	1,416	928	582	634	334	334	334	334
Expenditures	**2,115**	**2,763**	**2,181**	**2,858**	**2,858**	**2,858**	**2,858**	**2,858**
Balance Forward Out	1,711	1,149	1,531	1,410	956	844	956	844
Biennial Change in Expenditures				161		677		677
Biennial % Change in Expenditures				3		13		13
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

(Dollars in Thousands)

2001 - Other Misc Special Revenue

2403 - Gift

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	20	12	16	15	0	0	0	0
Receipts	8	18	9	24	24	24	24	24
Expenditures	**15**	**14**	**11**	**39**	**24**	**24**	**24**	**24**
Balance Forward Out	12	16	15	0	0	0	0	0
Biennial Change in Expenditures				20		(2)		(2)
Biennial % Change in Expenditures				69		(3)		(3)
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

3000 - Federal

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	229	22	143	0	0	0	0	0
Receipts	7,653	13,007	10,886	15,819	15,528	15,378	15,528	15,378
Expenditures	**7,882**	**13,030**	**11,030**	**15,819**	**15,527**	**15,377**	**15,527**	**15,377**
Biennial Change in Expenditures				5,938		4,056		4,056
Biennial % Change in Expenditures				28		15		15
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

3001 - Federal TANF

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Receipts	140	140	140	140	140	140	140	140
Expenditures	**140**	**140**	**140**	**140**	**140**	**140**	**140**	**140**
Biennial Change in Expenditures				0		0		0
Biennial % Change in Expenditures				0		0		0
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

Program: Grant Programs
Activity: Child & Community Service Grants

Child Protection:
(http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_000152)
Adult Protective Services Unit:
(http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_005710)

AT A GLANCE

- Child and Community Services Grants serve more than 213,000 Minnesotans annually. In 2015:
- 24,690 reports of child abuse and neglect were assessed involving 35,767 children
- 988 children were either adopted or had a permanent transfer of legal custody to a relative
- 34,662 reports of suspected maltreatment of a vulnerable adult were received, screened and dispatched
- 13,275 reports of suspected maltreatment of a vulnerable adult were assessed by a county
- 5,132 reports of suspected maltreatment of a vulnerable adult were investigated by a county
- All funds spending for the Children & Community Services activity for FY 2015 was $86.3 million. This represented 0.6% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

Under the state Vulnerable Children and Adult Act, Child and Community Services Grants provide funding to support core safety services for vulnerable children and adults, including response to reports of maltreatment, assessments of safety and risk, case management and other supportive services that help keep children and adults safely in their own homes.

The grants provide funding that support counties' administrative responsibility for child protection services and foster care. The funding also helps counties to purchase or provide these services for children, vulnerable adults and families.

SERVICES PROVIDED

Funding through these grants provides core safety services that focus on preventing or remedying vulnerable adult maltreatment and child neglect, preserving and rehabilitating families, and providing for community-based care. Services include:

- Response to reports of child and adult maltreatment, and assessment of safety and risk of harm
- Adoption and foster care supports for children
- Case management and counseling.

Children and Community Services Grants provide child protection services to help keep more children out of foster care and safely with their families, and to decrease the disproportionate number of children of color in out-of-home placements. They help ensure that vulnerable children and adults are better protected and receive support services in their communities.

Allocated to counties through the state's Vulnerable Children and Adult Act, these grants include state funds and the federal Social Services Block Grant.

This budget activity also includes a smaller set of grant funds that support initiatives by the White Earth and Red Lake Nations to operate their own human services systems.

RESULTS

The Department of Human Services monitors the performance of counties in delivering child welfare and adult protective services. Minnesota outcomes match or exceed most federal child welfare standards. Efforts to engage families early and

collaboratively with evidence-based interventions have resulted in improving safety and timely permanency outcomes for children.

Type of Measure	*Name of Measure*	*2010*	*2011*	*2012*	*2013*	*2014*	*2015*
Quality	Percent of children not experiencing repeated abuse or neglect within six months of a prior report	95.1%	95.6%	97.5%	97.2%	96.7%	97.0%
Quality	Percent of children reunified with parents or living with relatives in fewer than 12 months from latest removal from home	84.5%	85.7%	85.9%	85.1%	86.2%	83.9%
Quality	Percent of children adopted in fewer than 24 months from latest removal from home	48.2%	48.1%	49.4%	54.7%	59.9%	54.2%
Quantity	Timeliness of vulnerable adult maltreatment reports forwarded to the lead agency within two working days	92.7%	92.3%	94.4%	94.0%	97.8%	NA

Performance Measures notes

Measures for children in the above table are from Minnesota's Child Welfare Reports, 2010-2015. Child Protection statistical reports are posted on the DHS Child Protection Publications page (http://www.dhs.state.mn.us/main/id_003712). Also see the DHS Child Welfare Data Dashboard (www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_148137).

Measures for adults are from the Minnesota Department of Human Services Dashboard: http://dashboard.dhs.state.mn.us/measure01-2-4.aspx (http://dashboard.dhs.state.mn.us/measure01-2-4.aspx).

The legal authority for the Vulnerable Children and Adult Act is in M.S. chapter 256M (https://www.revisor.mn.gov/statutes/?id=256M). This Act establishes a fund to address the needs of vulnerable children and adults in each county under a service plan agreed to by each county board and the commissioner of human services.

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
1000 - General	53,301	56,301	56,301	58,201	58,201	58,201	58,201	58,201
3000 - Federal	30,201	30,029	30,322	30,738	30,737	30,737	30,737	30,737
Total	**83,502**	**86,330**	**86,623**	**88,939**	**88,938**	**88,938**	**88,938**	**88,938**
Biennial Change				5,730		2,314		2,314
Biennial % Change				3		1		1
Governor's Change from Base								0
Governor's % Change from Base								0

Expenditures by Category

Operating Expenses	-2	0	0	0	0	0	0	0
Other Financial Transactions	0	0	0	1,900	1,900	1,900	1,900	1,900
Grants, Aids and Subsidies	83,503	86,330	86,623	87,039	87,038	87,038	87,038	87,038
Total	**83,502**	**86,330**	**86,623**	**88,939**	**88,938**	**88,938**	**88,938**	**88,938**
Full-Time Equivalents	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Direct Appropriation	53,301	56,301	56,301	58,201	58,201	58,201	58,201	58,201
Expenditures	**53,301**	**56,301**	**56,301**	**58,201**	**58,201**	**58,201**	**58,201**	**58,201**
Biennial Change in Expenditures				4,900		1,900		1,900
Biennial % Change in Expenditures				4		2		2
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

3000 - Federal

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	2,267	0	0	0	0	0	0	0
Receipts	27,934	30,029	30,322	30,738	30,737	30,737	30,737	30,737
Expenditures	**30,201**	**30,029**	**30,322**	**30,738**	**30,737**	**30,737**	**30,737**	**30,737**
Biennial Change in Expenditures				830		414		414
Biennial % Change in Expenditures				1		1		1
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

Program: Grant Programs
Activity: Child & Economic Support Grants

SNAP (http://mn.gov/dhs/people-we-serve/children-and-families/economic-assistance/food-nutrition/programs-and-services/supplemental-nutrition-assistance-program.jsp)
Activity Website: Economic Opportunity (http://www.dhs.state.mn.us/main/id_002550)

AT A GLANCE

Annually:

- More than 466,000 Minnesotans receive help through the Supplemental Nutrition Assistance Program (SNAP) every month; the average monthly benefit is $109 per person.
- More than 17,700 people receive emergency shelter and services with state and federal funds.
- More than 2,900 individuals in 1,300 households receive transitional housing services and more than 2,699 individuals at risk of or experiencing long-term homelessness receive supportive services.

Also:

- Since 2000, Family Assets for Independence in Minnesota (FAIM) has helped people save nearly $2.9 million and acquire over 2,100 long-term financial assets.
- All funds spending for the Child & Economic Support Grants activity for FY 2015 was $516 million. This represented 3.4% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

People living in poverty often face numerous barriers and have complex needs. Through the Children and Economic Support Grants activity the Department of Human Services funds efforts to stabilize both short-term crises and long term strategies to help people leave poverty and sustain financial security for themselves and their families.

Through this budget activity we administer nearly 200 grants annually to more than 100 organizations to help people in poverty meet their basic needs for food, clothing and shelter. Funds are also used to help people get the skills, knowledge and motivation to become more self-reliant. Without these funds, more people would be hungry, homeless and poor.

The largest part of this budget activity is federal funding for the Supplemental Nutrition Assistance Program (SNAP). Outreach and nutrition education are conducted under this activity. These efforts help keep more people fed and healthy, and increase nutrition assistance participation.

SERVICES PROVIDED

Children and Economic Support Grants fund food, housing, poverty reduction, and financial capability services for low-income families and individuals. Services include:

- Help for low income persons to purchase food and associated outreach and education activities funded through the federal SNAP program.
- Help under the Minnesota Food Assistance Program (MFAP) for legal non-citizens who do not qualify for federal SNAP due to citizenship status
- Funding for food banks, food shelves and on-site meal programs
- Help for homeless individuals and families to find safe and stable housing
- Supportive services for people who experience long-term homelessness
- Emergency shelter and essential services for homeless adults, children, and youth
- Specialized emergency shelter and services for youth who have been victims of sex trafficking
- Funding, training, and technical assistance to counties and tribes for services to reduce barriers for long-term homeless adults, youth and families.

These grants also support:

- Programs administered by regional Community Action Agencies that help low-income people become more economically secure
- Financial capability services through the Family Assets for Independence in Minnesota (FAIM) and related financial education initiatives.

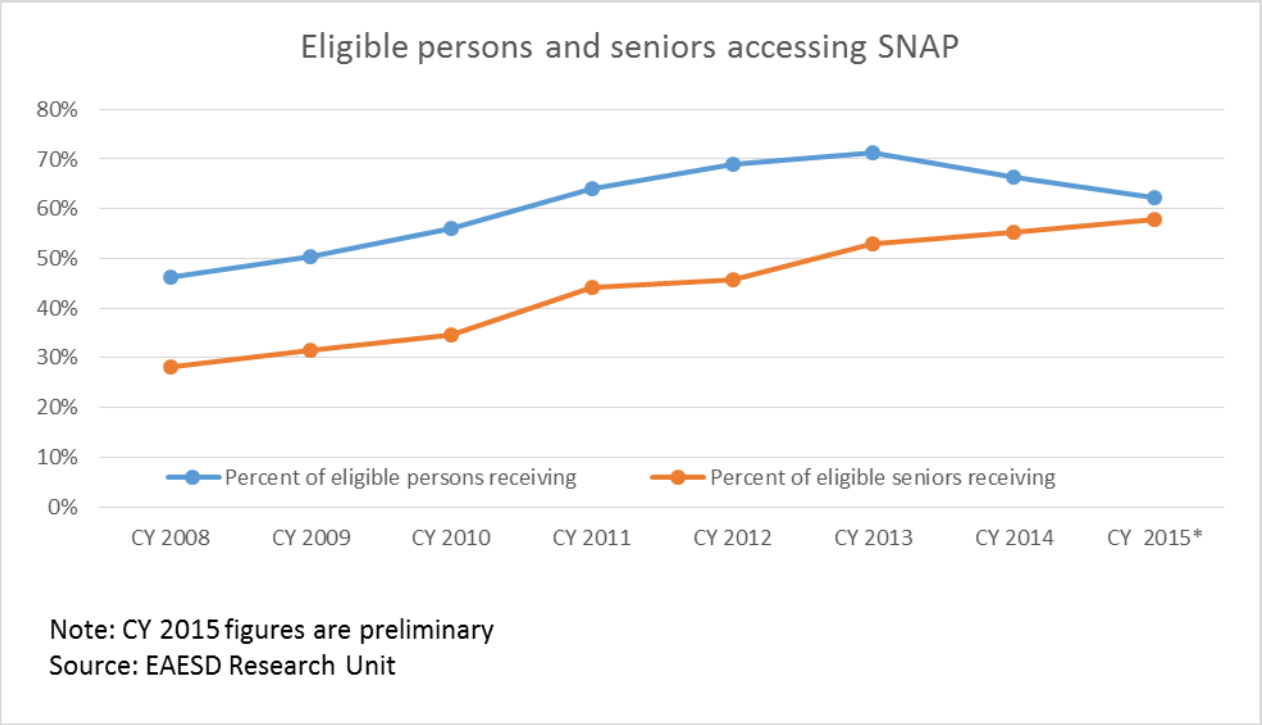
In addition to the federal funding for SNAP, other funding sources include state grants and federal grants from the U.S. Departments of Agriculture (USDA), Health and Human Services (HHS), Housing and Urban Development (HUD) as well as private foundations.

RESULTS

Several programs, such as SNAP, emergency food help, and MFAP, help people with their food needs.

SNAP Participation Rate

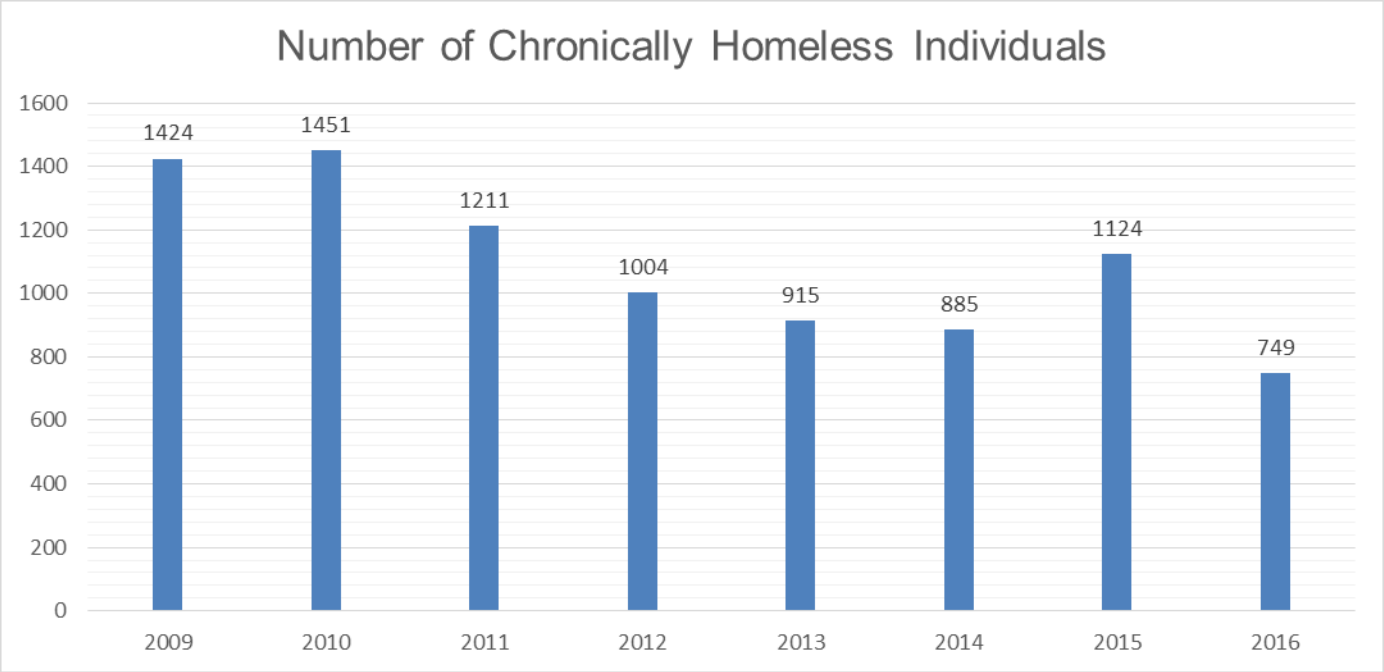
The quality measure below shows participation in SNAP as a percent of those eligible for the program.



Data for CY 2015 from the Economic Assistance & Employment Services Division at the Department of Human Services.

Reducing the number of people who are chronically homeless

This quantity measure shows that the number of chronically homeless individuals has declined by 38 percent since 2009. The Long- term Homeless Supportive Services Fund assists long term and chronically homeless people to obtain and remain in housing. Reduction of the number of chronically homeless people is a goal of the *2014 Plan to End Homelessness in Minnesota*.



The legal authority for the Children and Economic Support Grants activities comes from:

Minnesota Food Assistance Program, M.S. sec. 256D.053 (https://www.revisor.mn.gov/statutes/?id=256D.053)
Community Action Programs, M.S. secs. 256E.30 to 256E.32 (https://www.revisor.mn.gov/statutes/?id=256E.30)
Transitional Housing Programs, M.S. sec. 256E.33 (https://www.revisor.mn.gov/statutes/?id=256E.33)
Minnesota Food Shelf Program, M.S. sec. 256E.34 (https://www.revisor.mn.gov/statutes/?id=256E.34)
Family Assets for Independence in Minnesota (FAIM), M.S. sec. 256E.35 (https://www.revisor.mn.gov/statutes/?id=256E.35)
Emergency Services Grants, M.S. sec. 256E.36 (https://www.revisor.mn.gov/statutes/?id=256E.36)
Homeless Youth Act, M.S. sec. 256K.45 (https://www.revisor.mn.gov/statutes/?id=256k.45)

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
1000 - General	20,772	22,096	25,406	27,306	28,350	28,560	32,430	32,640
2000 - Restrict Misc Special Revenue	436	424	130	159	143	143	143	143
2001 - Other Misc Special Revenue	14	0	0	0	0	0	0	0
3000 - Federal	561,863	499,100	472,200	490,989	481,840	481,840	481,840	481,840
Total	**583,084**	**521,620**	**497,735**	**518,454**	**510,333**	**510,543**	**514,413**	**514,623**
Biennial Change				(88,516)		4,688		12,848
Biennial % Change				(8)		0		1
Governor's Change from Base								8,160
Governor's % Change from Base								1

Expenditures by Category

Operating Expenses	65	70	30	11	5	5	5	5
Other Financial Transactions	702	811	1,254	0	0	0	0	0
Grants, Aids and Subsidies	582,317	520,739	496,451	518,443	510,328	510,538	514,408	514,618
Total	**583,084**	**521,620**	**497,735**	**518,454**	**510,333**	**510,543**	**514,413**	**514,623**
Full-Time Equivalents	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	42	0	274	0	0	0	0
Direct Appropriation	21,047	22,620	26,778	27,032	28,350	28,560	32,430	32,640
Net Transfers	0	0	0	0	0	0	0	0
Cancellations	233	566	1,098	0	0	0	0	0
Expenditures	**20,772**	**22,096**	**25,406**	**27,306**	**28,350**	**28,560**	**32,430**	**32,640**
Balance Forward Out	42	0	274	0	0	0	0	0
Biennial Change in Expenditures				9,843		4,198		12,358
Biennial % Change in Expenditures				23		8		23
Gov's Exp Change from Base								8,160
Gov's Exp % Change from Base								14

2000 - Restrict Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	264	276	125	79	77	77	77	77
Receipts	270	252	(231)	19	3	3	3	3
Net Transfers	165	(46)	314	139	140	140	140	140
Expenditures	**436**	**424**	**130**	**159**	**143**	**143**	**143**	**143**
Balance Forward Out	263	57	79	77	77	77	77	77
Biennial Change in Expenditures				(571)		(2)		(2)
Biennial % Change in Expenditures				(66)		(1)		(1)
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

2001 - Other Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	14	0	0	0	0	0	0	0
Expenditures	**14**	0	0	0	0	0	0	0
Biennial Change in Expenditures				(14)				
Biennial % Change in Expenditures				(100)				

(Dollars in Thousands)

3000 - Federal

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	30,181	1,330	38	1	0	0	0	0
Receipts	531,683	497,770	472,161	490,988	481,840	481,840	481,840	481,840
Expenditures	**561,863**	**499,100**	**472,200**	**490,989**	**481,840**	**481,840**	**481,840**	**481,840**
Balance Forward Out	1	0	1	0	0	0	0	0
Biennial Change in Expenditures				(97,774)		492		492
Biennial % Change in Expenditures				(9)		0		0
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

Program: Grant Programs
Activity: Refugee Services Grants

mn.gov/dhs/people-we-serve/children-and-families/services/refugee-assistance/

AT A GLANCE

- In 2015, an average of 475 people per month received employment and social services through Refugee Services grants
- The average monthly cost per recipient in 2015 was $366 for employment-related services such as assessment, employment development planning, supported job search, placement and follow-up services.
- All funds spending for the Refugee Services Grants activity for FY 2015 was $4.8 million. This represented 0.03% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

Refugees have had to flee their country of origin and are unable to return because of a well-founded fear of persecution. When no other options exist, the United States, as well as most Western nations, provides refugees an opportunity for permanent resettlement. Most refugees resettled in Minnesota over the last decade have been from Somalia, Burma, Laos, Ethiopia, Liberia, Bhutan, Iraq and Moldova.

Refugee Services Grants provide assistance to refugees, asylees and victims of human trafficking to resettle in Minnesota. These federally-funded grants are provided to state and local agencies, including county and voluntary resettlement agencies, school districts and community agencies to enhance human, health, educational, employment and training services. Absent these services, fewer refugees will find work and more will lack the medical, social and financial supports necessary to resettle successfully.

SERVICES PROVIDED

The Department of Human Services (DHS) refugee Resettlement Programs Office works with many others to support the effective resettlement of refugees in Minnesota by coordinating services to help refugees transition to life in the United States. These services may include: resettlement and placement; food, cash and health care assistance; employment services; or social services.

Most refugees who resettle in Minnesota are members of families with minor children who qualify for the same cash (Minnesota Family Investment Program) and health care programs available to state residents who have low incomes. Refugees who do not qualify for one or both of these programs can apply for Refugee Cash Assistance (RCA) and Refugee Medical Assistance (RMA). These programs are available for the first eight months after refugees arrive in Minnesota. Applications for these programs are taken at county human services agencies and at voluntary resettlement agencies for refugees in the Twin Cities metro area and Olmsted County. The Resettlement Programs Office works to ensure existing systems and supports Minnesota residents, including refugees, are eligible for are also accessible to residents with refugee status.

In addition, Refugee Services Grants support limited supplemental services for refugees, including:

- Supported employment services and transportation
- Case management services
- Information and referral
- Translation and interpreter services
- Citizenship and naturalization preparation services
- Refugee student services
- Health screening coordination

Grants are used to supplement existing services to better meet the needs of refugees through local community partners, counties, and refugee communities to ensure refugees and their families are healthy, stable and live and work in strong, welcoming communities. The activity is funded with federal grants from the United States Department of Health and Human Services.

RESULTS

The DHS Resettlement Programs Office uses several client outcome indicators to measure performance and determine the effectiveness of our grant management activity.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Results	Percent of refugees employed within the same year of enrollment	66%	68%	Sept.2013 Sept 2015
Quantity	Percent of refugees receiving health screening within 90 days of arrival	96%	97%	Sept.2013 Sept 2015
Result	Job retention rate within 90 days	82%	75%	Sept.2013 Sept 2015
Quantity	Average hourly wage	$9.15	$9.99	Sept.2013 Sept 2015

Performance Measure Note: The average hourly wage is the average wage over the previous year for all participants.

The legal authority for the Refugee Services Grants activities comes from federal law: 45 CFR 400

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
3000 - Federal	6,232	4,958	6,351	7,232	6,739	6,739	6,739	6,739
Total	**6,232**	**4,958**	**6,351**	**7,232**	**6,739**	**6,739**	**6,739**	**6,739**
Biennial Change				2,393		(105)		(105)
Biennial % Change				21		(1)		(1)
Governor's Change from Base								0
Governor's % Change from Base								0

Expenditures by Category

Operating Expenses	334	223	365	365	403	403	403	403
Grants, Aids and Subsidies	5,898	4,735	5,986	6,867	6,336	6,336	6,336	6,336
Total	**6,232**	**4,958**	**6,351**	**7,232**	**6,739**	**6,739**	**6,739**	**6,739**
Full-Time Equivalents	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

(Dollars in Thousands)

3000 - Federal

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	82	0	1	0	0	0	0	0
Receipts	6,150	4,958	6,351	7,232	6,739	6,739	6,739	6,739
Expenditures	**6,232**	**4,958**	**6,351**	**7,232**	**6,739**	**6,739**	**6,739**	**6,739**
Biennial Change in Expenditures				2,393		(105)		(105)
Biennial % Change in Expenditures				21		(1)		(1)
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

Program: Grants Program
Activity: Health Care Grants

AT A GLANCE

- There are currently 973 navigators and in person assisters available state-wide to aid people in obtaining health care coverage.
- Navigators and in person assisters provided application assistance to nearly 41,000 individuals or families in FY2015
- 85 of Minnesota's 87 counties collect and track Child and Teen Check-up immunization data with the help of grant funds from this activity.
- All funds spending for the Health Care Grants activity for FY 2015 was $56.4 million. This represents 0.4% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

Health Care Grants activity funding provides supports, infrastructure investments and outreach. These grants benefit enrollees in Minnesota Health Care Programs (Medical Assistance (MA) and MinnesotaCare) and some uninsured or underinsured individuals. These grants have historically targeted projects or work that supplements the direct health care services funded under the MA or MinnesotaCare programs.

Some grants in this budget activity augment the agency's own operational efforts. In doing so, we engage experts outside of the Department of Human Services (DHS) to help ensure that eligible Minnesotans are enrolled in the appropriate health care program, and that those enrolled, especially our youngest and/or most vulnerable or hard to reach, receive the needed health care for which they are eligible.

SERVICES PROVIDED

The particular set of active health care grants in this budget activity administered by DHS can change over time depending on the length of the funding or project. Health care grants may be for one year or may be ongoing. Grantees can range from providers, counties, or community organizations.

Funding is generally dedicated to a specific project, demonstration or function as directed by legislation. The grants currently funded under this budget activity include:

- *In Person Assister and Minnesota Community Application Agent (MNCAA) Programs*. These funds provide incentive payments to entities assisting people applying to and enrolling in MinnesotaCare and Medical Assistance.
- *Emergency Medical Assistance Referral and Assistance Grants:* These grants fund organizations to provide immigration legal assistance to people with emergency medical conditions whose immigration status is a barrier to Medical Assistance or MinnesotaCare eligibility. Between July of 2013 and December 2014 these funds supported legal assistance to nearly 300 people receiving care through Emergency Medical Assistance (EMA). 90 of these individuals became eligible or are expected to become eligible for MA or MinnesotaCare because of changes in their immigration status.
- *Immunization Registry Grants.* Provides administrative funds for counties to support immunization registries
- *Child and Teen Checkup Grants:* Provides funding to counties for outreach and education to children on Medical Assistance related to Child and Teen Checkup services.
- *Diabetes Prevention Program Grants.* Funds incentives for Minnesota Health Care Program recipients participating in the diabetes prevention program, a multi-year evidence-based program supported by the Centers for Disease Control and Prevention.
- *Minnesota Medicaid Electronic Health Record (EHR) Incentive Program.* Distributes federal funds to eligible providers and hospitals. These funds incent providers to purchase and use a certified EHR, with the goal of improving the patient experience of health care and population health, at a reduced cost to providing care.

Health Care Grants are funded with appropriations from the state general fund, health care access fund and with federal funds.

RESULTS

The Health Care Grants activity contributes to the statewide goal of reducing the percentage of Minnesotans that do not have health insurance. DHS collects information on the number of successful applications completed by application agents under the MNCAA and In Person Assister programs.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Enrollees receiving support from MNCAAs/In Person Assisters[1]	21,179	40,922	4/2013-3/2014 and 7/2014-6/2015
Quantity	Number of MA recipients receiving disease management services through the Minnesota Diabetes Prevention Program (MN MIPCD)[2]	565	1,111	6/2014 and 12/2015
Quantity	Number of clinics participating as partners in the Minnesota Diabetes Prevention Program (MN MMIPCD)	13	13	6/2014 and 12/2015

1. Measure is the number of MNCAAs and In Person Assisters receiving incentive payments as reported by MNsure and DHS staff.
2. Measure is the number of MA recipients currently receiving incentives for participating in disease management for pre-diabetes as reported by DHS staff in June 2014 and December 2015. The Minnesota Diabetes Prevention program study concluded in December 2015.
3. Measure is the number of clinics offering the curriculum and providing disease management services to MA recipients through the Minnesota Diabetes Prevention Program as reported by DHS staff in both June 2014 and December 2015. The Minnesota Diabetes Prevention Program study concluded in December 2015. Results of the study are forthcoming.

Minnesota Statutes section 256.962 provides the authority to provide incentives for application assistance under the MNCAA program.

Minnesota Statutes section 256B.021 is the legal authority for grants related to reforms in the Medical Assistance program.

Minnesota Statutes section 62V.05 provides authority for the In Person Assister program.

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
1000 - General	95	185	207	2,482	4,119	3,711	4,244	3,961
2360 - Health Care Access	316	698	1,322	3,465	3,465	3,465	3,465	3,465
3000 - Federal	73,440	57,677	37,912	92,068	92,021	91,975	92,021	91,975
Total	**73,851**	**58,560**	**39,442**	**98,015**	**99,605**	**99,151**	**99,730**	**99,401**
Biennial Change				5,046		61,299		61,674
Biennial % Change				4		45		45
Governor's Change from Base								375
Governor's % Change from Base								0

Expenditures by Category

Operating Expenses	2,445	1,990	2,006	5,393	5,346	5,300	5,346	5,300
Grants, Aids and Subsidies	71,406	56,570	37,435	92,622	94,259	93,851	94,384	94,101
Total	**73,851**	**58,560**	**39,442**	**98,015**	**99,605**	**99,151**	**99,730**	**99,401**
Full-Time Equivalents	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Direct Appropriation	190	190	536	2,482	4,119	3,711	4,244	3,961
Cancellations	95	5	329	0	0	0	0	0
Expenditures	**95**	**185**	**207**	**2,482**	**4,119**	**3,711**	**4,244**	**3,961**
Biennial Change in Expenditures				2,409		5,141		5,516
Biennial % Change in Expenditures				861		191		205
Gov's Exp Change from Base								375
Gov's Exp % Change from Base								5

2360 - Health Care Access

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Direct Appropriation	190	190	3,341	3,465	3,465	3,465	3,465	3,465
Net Transfers	2,038	4,188						
Cancellations	1,912	3,680	2,019	0	0	0	0	0
Expenditures	**316**	**698**	**1,322**	**3,465**	**3,465**	**3,465**	**3,465**	**3,465**
Biennial Change in Expenditures				3,773		2,143		2,143
Biennial % Change in Expenditures				372		45		45
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

3000 - Federal

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	63	19	0	0	0	0	0
Receipts	73,440	57,613	37,894	92,069	92,021	91,975	92,021	91,975
Expenditures	**73,440**	**57,677**	**37,912**	**92,068**	**92,021**	**91,975**	**92,021**	**91,975**
Biennial Change in Expenditures				(1,136)		54,015		54,015
Biennial % Change in Expenditures				(1)		42		42
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

AT A GLANCE

- The HCBS Incentive pool will serve an estimated 250 people when fully implemented in FY2018.
- $1,344,000 in Incentive Pool funds to be distributed in FY2017 to support increased innovation in HCBS programs.
- The Other Long Term Care grants budget activity was established in FY2016. The total projected expenditures for FY2016 is $1.1 million.[1]

PURPOSE & CONTEXT

The purpose of other long term care grants is to serve more people in community-based settings and to encourage creativity in how services are delivered for people with disabilities, mental illness, and seniors.

Currently, there are three grants that are included in Other Long Term Care Grants, which will expand as more cross-population grants are developed. The HCBS Incentive pool grant incentivizes providers to innovate in achieving integrated competitive employment, living in the most integrated setting, and other outcomes. The Incentive pool will begin distributing funds in late 2016. And there are two Money Follows the Person (MFP) grants: the Rebalancing Demonstration grant and the Tribal grant.[2]

SERVICES PROVIDED

- The Home and Community-Based Service (HCBS) incentive pool provides incentives to providers, service recipients, and other entities for innovation in achieving outcomes identified in the Olmstead plan, including integrated, competitive employment and living in the most integrated setting in the community. The funds will be distributed in late 2016 via a request for proposal (RFP) process. There are three ways the money will be distributed:
  1. Large grants. These grants incent innovation in HCBS services by using pay for performance ideas and models that utilize outcome-based payments. For the purpose of this RFP, outcome-based payments consist of financial incentives based on the outcomes proposed, produced and achieved.
  2. Micro grants. The micro grant program will provide modest amounts of money to people with disabilities so they can accomplish their own goals and aspirations. The funds complement and supplement what can already be paid for through other sources of funds and have a lasting and ongoing impact for the micro-grant recipient.
  3. Small grants. This is for grants of under $50,000 per year for 1-3 years. We want to solicit participation from all kinds of groups, not just waiver services providers. This could include individuals, small groups, sole proprietors, small businesses, etc.
- Under the Money Follows the Person (MFP) Rebalancing Demonstration grant, rebalancing funds may be used by the state to invest in or support activities that will promote improvements to the state's delivery of long term services and supports and move the state toward more integrated and inclusive community based service delivery systems. States that receive MFP awards are eligible for enhanced federal financial participation (FFP) which is deposited into the rebalancing account. This funding is in the special revenue fund. Investments will be paid out of this account starting in FY 17.
- Funds under the Money Follows the Person Tribal Initiative (TI) will be used to improve access to community-based long term care services and supports (CB-LTSS) for American Indians and Alaska Natives (AI/AN) who have been in an institutional setting for over 90 days. In addition, the TI may be used to advance the development of an infrastructure required to implement CB-LTSS for AI/AN using a single, or a variety of applicable Medicaid authorities. Funding is intended to support the planning and development of:
  1. An in-state Medicaid program CB-LTSS (as an alternative to institutional care) tailored for AI/ANs who are presently receiving services in an institution; and

2. A service delivery structure that includes a set of administrative functions delegated by the state Medicaid agency to Tribes or Tribal organizations (T/TOs), such as enabling tribe(s) to design an effective program or package of Medicaid CB- LTSS, and operating day to day functions pertaining to the LTSS program(s).

The TI may be used to cover costs necessary to plan and implement activities consistent with the objectives of this funding and within Federal grant regulations. The funds are subject to all the terms and conditions of the MFP Program. TI is funded through a federal grant.

RESULTS

The agency monitors data, reviews counties, and administers surveys to consumers to evaluate services. Minnesota has seen continuous improvement in the number of people with disabilities served by community-based rather than institution-based services.

More information is also available on the DHS dashboard (http://dashboard.dhs.state.mn.us/) and the Continuing Care Performance Report (http://mn.gov/dhs/partners-and-providers/continuing-care/data-measures/public-planning-performance-reporting/performance-reports.jsp).

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Result	1. Percent of working age consumers on disability waiver programs with earnings	44.6%	43.7%	Dec. 2013 to Dec. 2015
Result	2. Percent of people with disabilities who receive home and community-based services in their own home.	53.1%	53.7%	2013 to 2015

Performance Measures Notes:

1. Measure compares monthly earnings from Dec. 2013 to Dec. 2015 data for all disability waiver programs. "Working age" is age 22-64. Source: DHS Data Warehouse.
2. Measure is people who are age 0 to 64. Compares FY 2013 (Previous) to FY2015 data (Current). Source: DHS Data Warehouse.

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[1]Transition grants were transferred from Disability grants in FY16-17. These grants will be transferred to Adult Mental Health Grants budget activity starting in FY2018.

[2]The Money Follows the Person grant accounts were under the Disability Grants budget activity in FY16-17. These grants will be transferred to Other Long Term Care Grant accounts starting in FY2018.

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
1000 - General	0	0	0	1,344	1,500	1,925	1,500	1,925
2000 - Restrict Misc Special Revenue	0	0	0	1,468	1,305	1,127	1,305	1,127
Total	**0**	**0**	**0**	**2,812**	**2,805**	**3,052**	**2,805**	**3,052**
Biennial Change				2,812		3,045		3,045
Biennial % Change						108		108
Governor's Change from Base								0
Governor's % Change from Base								0

Expenditures by Category

Grants, Aids and Subsidies	0	0	0	2,812	2,805	3,052	2,805	3,052
Total	**0**	**0**	**0**	**2,812**	**2,805**	**3,052**	**2,805**	**3,052**
Total Agency Expenditures	0	0	0	2,812	2,805	3,052	2,805	3,052
Expenditures Less Internal Billing	**0**	**0**	**0**	**2,812**	**2,805**	**3,052**	**2,805**	**3,052**
Full-Time Equivalents	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Direct Appropriation	0	0	0	1,344	1,500	1,925	1,500	1,925
Expenditures	0	0	0	**1,344**	**1,500**	**1,925**	**1,500**	**1,925**
Biennial Change in Expenditures				1,344		2,081		2,081
Biennial % Change in Expenditures						155		155
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

2000 - Restrict Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	0	0	600	0	0	0	0
Net Transfers			600	868	1,305	1,127	1,305	1,127
Expenditures	0	0	0	**1,468**	**1,305**	**1,127**	**1,305**	**1,127**
Balance Forward Out	0	0	600	0	0	0	0	0
Biennial Change in Expenditures				1,468		964		964
Biennial % Change in Expenditures						66		66
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

Program: Grant Programs
Activity: Aging & Adult Services Grants

mn.gov/dhs/people-we-serve/seniors/

AT A GLANCE

- Provides congregate dining to 38,000 people and home delivered meals to 12,000 people.
- Supports more than 17,000 older volunteers per year who provide services through the Retired and Senior Volunteer Program (RSVP), Foster Grandparents, and Senior Companions.
- Provides comprehensive assistance and individualized help to more than 125,000 individuals through over 277,000 calls in 2015 through the Senior LinkAge Line®.
- Funds home and community-based service options for more than 11,000 people and increased capacity by 8,700 volunteers through the Community Service/Services Development (Live Well at Home) grant program.
- All funds spending for the Aging & Adult Services Grants activity was $44.9 million in FY2015. This represented 0.3% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

The purpose of Aging and Adult Services Grants is to provide non-medical social services and supports for older Minnesotans and their families to allow older adults to stay in their own homes and avoid institutionalization.

These funds increase the number and kind of service options for older Minnesotans in both urban and rural communities. This gives greater opportunity for Minnesotans to age at home. Several of the state grant programs are coordinated with the services provided under the federal Older Americans Act (OAA). Federal OAA funds in Minnesota are administered through the Minnesota Board on Aging. These funds provide core social services to at-risk older adults and their family caregivers who are not yet eligible for public programs. Services are targeted to people with the greatest social and economic need.

SERVICES PROVIDED

Aging and Adult Services Grants promote affordable services that are both dependable and sustainable. These grants are often used along with local private money, including donations. Aging and Adult Services grants provide:

- Nutritional services including congregate meals, home-delivered meals, and grocery delivery.
- Increased service options for older Minnesotans through service development activities funded by the Community Service/Community Services Development (CS/SD), Family Caregiver Support, and ElderCare Development Partnership (EDP) grant programs. Those services include: transportation, help with chores, help with activities of daily living, evidence-based health promotion, chronic disease management, falls prevention services, respite and other supportive services to family caregivers, and other services that help people stay in their own homes.
- Support to older volunteers who provide services through the Retired and Senior Volunteer Program, Foster Grandparent, and Senior Companion programs.
- Comprehensive and individualized help through the Senior LinkAge Line®. The Senior LinkAge Line® trains long-term care options counselors that assist individuals to find community resources and financing options for beneficiaries of all ages.
- Information about community-based resources and customized long-term care planning tools through www.minnesotahelp.info, (http://www.minnesotahelp.info/) a web-based database of over 45,000 services.
- Long-term care options counseling services provided by the Senior LinkAge Line®, known as Return to Community, that help people successfully remain in their homes after discharge from a nursing home. Since the launch of this service in 2010 and through 2015, over 14,000 consumers have been contacted for discharge support. Of those 14,000, direct assistance was provided to over 3,400 older adults at their request to return home and nearly 1,100 are receiving five years of follow up at home.

- Home and community-based services quality information which includes a tool to help people who need long term services and supports and their caregivers find and locate services. The tool includes 340 features about services. In addition, consumer reviews are being piloted for assisted living providers, supported employment and independent living services.
- Core Service grants to nonprofit home and community based service providers who provide in-home and community-based services to older adults. These grants expand the number of organizations that can be supported, which increases the number of individuals served.

The Agency administers these grants in partnership with regional Area Agencies on Aging, counties, tribes, and community providers.

RESULTS

Minnesota has seen improvement in the number of seniors served by community-based rather than institution-based services. The percent of seniors served in the community has remained steady or improved over the past five years. Through our partners, we surveyed users of the Senior LinkAge Line® and found a consistent proportion of people would recommend Senior LinkAge Line® services to others.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Result	1. Percent of seniors served by home and community-based services	59.3%	68.4%	2008 to 2013
Quality	2. Percent of consumers who would recommend the Senior LinkAge Line® to others	93%	94%	2007 to 2015
Quantity	3. Number of people who have moved from nursing homes back to the community through the Return to Community Initiative to date	1,054	2,896	Q2 2010 to Q4 2015
Result	4. Percent of family caregivers who report that the caregiver support services helped them provide care for a longer period of time	93%	95%	2009 to 2013

Results Notes:

1. Measure 1 compares FY2008 to FY2013. This measure shows the percentage of elderly receiving publicly-funded long-term care services who receive HCBS services through the Elderly Waiver, Alternative Care, or home care programs instead of nursing home services. (Source: February 2014 Forecast)
2. Measure 2 compares 2007 data to 2015 data (Source: Consumer Surveys, Web Referral database)
3. Measure 3 compares cumulative quarter 2 CY2010 data to quarter 4 CY2015 data (Source: Return to Community Database)
4. Measure 4 compares CY 2009 to CY 2013 data, as measured by an annual survey of family caregivers receiving Older Americans Act-funded caregiver support services. (Source: Minnesota Board on Aging Caregiver Outcomes Survey)

M.S. sections 256B.0917 (https://www.revisor.mn.gov/statutes/?id=256B.0917) and 256B.0922 (https://www.revisor.mn.gov/statutes/?id=256B.0922) provide the legal authority for Aging and Adult Services Grants. M.S. section 256.975 (https://www.revisor.mn.gov/statutes/?id=256.975) created the Minnesota Board on Aging.

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
1000 - General	20,071	23,367	26,411	28,162	28,597	28,162	31,339	32,594
2000 - Restrict Misc Special Revenue	181	0	0	0	0	0	0	0
2001 - Other Misc Special Revenue	245	0	130	0	0	0	0	0
3000 - Federal	26,157	23,589	21,508	25,438	24,814	23,934	24,814	23,934
Total	**46,654**	**46,956**	**48,048**	**53,600**	**53,411**	**52,096**	**56,153**	**56,528**
Biennial Change				8,038		3,859		11,033
Biennial % Change				9		4		11
Governor's Change from Base								7,174
Governor's % Change from Base								7

Expenditures by Category

Compensation	-12	0	0	0	0	0	0	0
Operating Expenses	2	-1	-159	0	0	0	0	0
Other Financial Transactions	201	4	216	0	0	0	0	0
Grants, Aids and Subsidies	46,463	46,953	47,991	53,600	53,411	52,096	56,153	56,528
Total	**46,654**	**46,956**	**48,048**	**53,600**	**53,411**	**52,096**	**56,153**	**56,528**
Full-Time Equivalents	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Direct Appropriation	20,074	23,896	28,463	28,162	28,597	28,162	31,339	32,594
Cancellations	3	529	2,052	0	0	0	0	0
Expenditures	**20,071**	**23,367**	**26,411**	**28,162**	**28,597**	**28,162**	**31,339**	**32,594**
Biennial Change in Expenditures				11,135		2,186		9,360
Biennial % Change in Expenditures				26		4		17
Gov's Exp Change from Base								7,174
Gov's Exp % Change from Base								13

2000 - Restrict Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	20	0	153	94	0	0	0	0
Receipts	161	153	155	0	0	0	0	0
Net Transfers			(214)	(94)	0	0	0	0
Expenditures	**181**	**0**	0	0	0	0	0	0
Balance Forward Out	0	153	94	0	0	0	0	0
Biennial Change in Expenditures				(181)		0		0
Biennial % Change in Expenditures				(100)		0		0
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

2001 - Other Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Receipts	245	0	130	0	0	0	0	0
Expenditures	**245**	0	**130**	0	0	0	0	0
Biennial Change in Expenditures				(115)		(130)		(130)
Biennial % Change in Expenditures				(47)		(100)		(100)

3000 - Federal

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	23	16	0	0	0	0	0

(Dollars in Thousands)

3000 - Federal

Receipts	26,160	23,566	21,491	25,438	24,814	23,934	24,814	23,934
Expenditures	**26,157**	**23,589**	**21,508**	**25,438**	**24,814**	**23,934**	**24,814**	**23,934**
Balance Forward Out	2	0	0	0	0	0	0	0
Biennial Change in Expenditures				(2,801)		1,802		1,802
Biennial % Change in Expenditures				(6)		4		4
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

Program: Grant Programs
Activity: Deaf & Hard of Hearing Grants

mn.gov/dhs/people-we-serve/adults/services/deaf-hard-of-hearing/programs-services/

AT A GLANCE

- Deaf and Hard of Hearing Grants supported 585 people in state fiscal year 2015. An unknown additional number benefitted from grant funded real-time TV news captioning services provided statewide.
- 21% of participants in deafblind programs chose the consumer-directed services option in FY 2015.
- Certified Peer Support Specialists worked with 22 people in FY 2015 who are deaf and have a serious mental illness.
- 35 families who have a young child with hearing loss participated in the Deaf & Hard of Hearing Role Model and Deaf Mentor Family programs in FY 2015.
- All funds spending for the Deaf and Hard of Hearing Grants activity for FY 2015 was $2 million. This represented 0.01% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

Three out of every 1,000 newborns have hearing loss. One-third of people between ages 65-74 have hearing loss and nearly half of those over age 75 have hearing loss.

National research estimates 20% of the population has some degree of hearing loss. In Minnesota, this means approximately 1 million people are likely to have some degree of hearing loss. Of those, about 11% are deaf and as many as 1,640 individuals are deafblind.

Deaf and Hard of Hearing Services grants help Minnesotans of all ages who are deaf, deafblind and hard of hearing with services and supports they need to live independently and be involved in their families and communities.

The Deaf and Hard of Hearing Services Division (DHHSD) administers these grants.

SERVICES PROVIDED

Deaf and Hard of Hearing Grant programs include:

- Sign language interpreter-related services that allow Minnesotans who are deaf, hard of hearing, and deafblind to access every day activities and core services such as medical care, mental health services, human services, the judicial system, and self-help; This activity includes a pilot program to increase the number of interpreters in Greater Minnesota available to provide community interpreting services.
- Deafblind grants to support adults who are both deaf and blind so they can live independently and stay in their own homes. Supports include service providers fluent in American Sign Language and trained in specialized communication methods and assistive technology; consumers have an option for consumer-directed services.
- Services for children who are deafblind to provide experiential learning and language development through service providers called interveners.
- Specialized mental health programs for adults and for children and youth that provide linguistically and culturally appropriate services including home-based outreach, inpatient therapy, outpatient therapy, family counseling, psychological assessments and educational opportunities for families, schools, and mental health providers.
- Certified Peer Support Specialists for individuals who are deaf and have a serious mental illness.
- Mentors who work with families that have children with hearing loss to develop the family's communication competence, including an option to have an American Sign Language mentor or a hard of hearing role model.
- Real-time television captioning grants that allow consumers statewide who are deaf, deafblind, hard of hearing or late deafened to have equal access to their community and statewide live news programming.

We partner with statewide community providers, mental health professionals, local television stations and the Department of Commerce to provide services.

Deaf and Hard of Hearing grants are primarily funded by the state general fund. In addition, the Telecommunications Access Minnesota (TAM) funds collected by the Department of Commerce provide grants for real-time television captioning of local news programs.

RESULTS

People served in deaf and hard of hearing grant-funded programs fill out surveys to measure satisfaction with the quality and timeliness of services. Over the last three years, they have reported a high level of satisfaction with the quality of services. In Deaf and Hard of Hearing grant-funded mental health programs, the percent of clients who have completed or are making good progress on their treatment goals remains consistently above 80%. The vast majority of families with children who are deafblind report noticeable improvement in their child's progress in communication, social development and community integration as a result of the services they receive.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quality	1. Percent of consumers in DHHS grant-funded programs who are satisfied with quality of services they received	94%	98%	2012 to 2015
Quality	2. Percent of consumers in DHHS grant-funded programs who are satisfied with timeliness of the services they received	89%	86%	2012 to 2015
Quality	3. Percent of clients in DHHS grant-funded mental health programs who completed or are making good progress on their treatment plan goals	89%	84%	2012 to 2015
Quality	4. Percent of parents in DHHS grant-funded programs who observed progress in the communication ability, community integration and social development of their child who is deafblind.	81%	80%	2012 to 2015

Performance Notes:

- Data source: Consumer satisfaction surveys and grantee reports.
- More information on measures one and two is available on the CCA Performance Reports (https://mn.gov/dhs/partners-and-providers/continuing-care/data-measures/public-planning-performance-reporting/performance-reports.jsp).

M.S. sections 256.01, subd. 2 (https://www.revisor.mn.gov/statutes/?id=256.01), 256C.233 (https://www.revisor.mn.gov/statutes/?id=256C.233), 256C.25 (https://www.revisor.mn.gov/statutes/?id=256C.25), and 256C.261 (https://www.revisor.mn.gov/statutes/?id=256C.261) provide the legal authority for Deaf and Hard of Hearing grants.

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
1000 - General	1,763	1,848	2,225	2,375	1,875	1,875	2,675	2,675
2001 - Other Misc Special Revenue	269	266	240	269	240	240	240	240
2403 - Gift	0	0	0	13	13	13	13	13
3000 - Federal	96	0	75	75	75	75	75	75
Total	**2,128**	**2,114**	**2,540**	**2,732**	**2,203**	**2,203**	**3,003**	**3,003**
Biennial Change				1,030		(866)		734
Biennial % Change				24		(16)		14
Governor's Change from Base								1,600
Governor's % Change from Base								36

Expenditures by Category

Operating Expenses	82	55	19	15	13	13	13	13
Grants, Aids and Subsidies	2,046	2,059	2,522	2,717	2,190	2,190	2,990	2,990
Total	**2,128**	**2,114**	**2,540**	**2,732**	**2,203**	**2,203**	**3,003**	**3,003**
Full-Time Equivalents	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Direct Appropriation	1,771	1,866	2,225	2,375	1,875	1,875	2,675	2,675
Cancellations	8	18	0	0	0	0	0	0
Expenditures	**1,763**	**1,848**	**2,225**	**2,375**	**1,875**	**1,875**	**2,675**	**2,675**
Biennial Change in Expenditures				989		(850)		750
Biennial % Change in Expenditures				27		(18)		16
Gov's Exp Change from Base								1,600
Gov's Exp % Change from Base								43

2001 - Other Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	2	2	12	15	13	42	13	42
Receipts	300	300	276	300	300	300	300	300
Net Transfers	(31)	(31)	(33)	(33)	(31)	(31)	(31)	(31)
Expenditures	**269**	**266**	**240**	**269**	**240**	**240**	**240**	**240**
Balance Forward Out	2	5	15	13	42	71	42	71
Biennial Change in Expenditures				(26)		(29)		(29)
Biennial % Change in Expenditures				(5)		(6)		(6)
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

2403 - Gift

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Receipts	0	0	0	13	13	13	13	13
Expenditures	0	0	0	**13**	**13**	**13**	**13**	**13**
Biennial Change in Expenditures				13		13		13
Biennial % Change in Expenditures						100		100
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

3000 - Federal

	Actual	Actual	Actual	Estimate	Forecast Base	Governor's Recommendation

(Dollars in Thousands)

3000 - Federal

	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Receipts	96	0	75	75	75	75	75	75
Expenditures	**96**	0	**75**	**75**	**75**	**75**	**75**	**75**
Biennial Change in Expenditures				54		0		0
Biennial % Change in Expenditures				56		0		0
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

Program: Grant Programs
Activity: Disabilities Grants

mn.gov/dhs/people-we-serve/people-with-disabilities/services/home-community/a-z/index.jsp

AT A GLANCE

- The Family Support Grant served 1,628 people in FY2015.
- The Consumer Support Grant supported 2,612 people in FY2015.
- Semi-independent living services served 1,552 people in FY2015.
- HIV/AIDS programs help 2,647 people living with HIV/AIDS.
- The Disability Linkage Line served 30,511 people in FY2015, had 86,054 contacts with consumers, and participated in 146 educational events.
- All funds spending for the Disabilities Grants activity for FY 2015 was $48 million. This represented 0.31% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

The US Census Bureau estimates that nearly 550,000 or 10.3 percent of Minnesotans have a disability or disabling condition.

Disabilities Grants provide services and supports to help Minnesotans with disabilities remain in their communities and avoid institutionalization. This work is done by counties, tribes, families and local providers.

These funds increase the number and kinds of service options for people with disabilities and their families; help people with HIV/AIDS with medical expenses; provide information and assistance on disability programs and services; and support county and tribal service infrastructure.

More information about Disabilities Grants and the number of people served is available in a Disabilities Grants fact sheet (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6575-ENG).

SERVICES PROVIDED

Disabilities Grant programs include:

- The Family Support Grant (FSG) which provides cash to families to offset the higher-than-average cost of raising a child with a disability.
- The Consumer Support Grant (CSG) which is an alternative to home care paid through the state plan, which helps people purchase home care, adaptive aids, home modifications, respite care, and other help with the tasks of daily living. This program will be sunsetted when Community First Services and Supports (CFSS) replaces the services provided by CSG.
- Semi-Independent Living Services (SILS) grants which help adults with developmental disabilities, who do not require an institutional level of care, live in the community. The funding is used 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 use of transportation.
- HIV/AIDS programs which help people living with HIV/AIDS pay premiums to maintain private insurance, co-payments for HIV-related medications, mental health services, dental services, nutritional supplements, and case management.
- Housing Access Services grants have been used to support a non-profit organization to help individuals who are eligible for home care, other state plan services, or waiver services, to move out of licensed settings or family homes and into their own homes. Since the fall of 2009 more than 1,700 people have used Housing Access Services to move from licensed or unlicensed settings to homes of their own that are not owned, leased, or controlled by disability services providers.
- The Disability Linkage Line (DLL) which provides one-to-one assistance to make it easier for people with disabilities to understand their options, find solutions, and engage in possibilities.

- Local planning grants to assist counties and tribes in development of community alternatives to corporate foster care settings. This funding is being used to implement specific county plans to address the needs of people with disabilities in their communities.
- Transition Initiatives to Waivered Services for Certain Populations grants provide help pay for specialized services that are needed by individuals transitioning back to the community from state institutions, once the person has met their treatment goals and no longer require the level of treatment and supervision provided at these facilities[1].
- Day Training and Habilitation (DT&H) grants which are allocated to counties. These grants help counties purchase services that help people living in an Intermediate Care Facility for persons with Developmental Disabilities to develop and maintain life skills and participate in community activities.
- State Quality Council and Region 10 grants fund state and regional quality councils. The State and Regional Quality Councils, in collaboration with DHS exist to support a system of quality assurance and improvement in the provision of person directed services for people with disabilities.
- Work Empower grants help people with disabilities maintain or increase stability and employment; increase access to and utilization of appropriate services across systems; reduce use of inappropriate services; improve physical / mental health status; increase earnings; and achieve personal goals.
- Autism grants which increase the network of respite service providers with training or experience to successfully serve adults and children with autism spectrum disorder (ASD). These grants are available until June 30, 2017.

The Disabilities Grants activity is funded by the state's general fund, federal funds and special revenue funds. The HIV/AIDS programs receive federal funds from the Ryan White Care Act and also rebate funding from pharmaceutical companies for drugs and insurance.

RESULTS

The agency monitors data, reviews counties and tribes, and administers surveys to consumers to evaluate services. Minnesota has seen continuous improvement in the number of people with disabilities served by community-based rather than institution-based services.

The agency tracks the percent of people with disabilities who receive home and community-based services in their own home instead of in a congregate residential setting, such as foster care. There is now a reduced reliance on corporate foster care.

More information is also available on the DHS dashboard (http://dashboard.dhs.state.mn.us/) and the Continuing Care Performance Report (http://www.dhs.state.mn.us/main/dhs16_166609).

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Result	1. Percent of people with disabilities who receive home and community-based services at home.	53.1%	53.7%	2013 to 2015
Quantity	2. Number of people that Housing Access Services has helped move to a home of their own each year.	14	297	2009 to 2013
Quality	3. Percent of consumers who would recommend the Disability Linkage Line (DLL) to others.	99%	98%	2008 to 2015

Performance Measures Notes:

1. Measure is people who are age 0 to 64. Compares FY 2013 (Previous) to FY2015 data (Current). Source: DHS Data Warehouse
2. Compares calendar year 2009 (Previous) to CY 2013 (Current). Since the program began, Housing Access Services has moved over 1,000 people with disabilities into homes of their own. Source: DHS Grant reports.
3. Compares CY 2008 data (Previous) to CY 2015 data (Current). Source: DLL Customer Satisfaction Surveys.

M.S. sections 252.275 (https://www.revisor.mn.gov/statutes/?id=252.275); 252.32 (https://www.revisor.mn.gov/statutes/?id=252.32); 256.01, subds. 19, 20, and 24 (https://www.revisor.mn.gov/statutes/?id=256.01); 256.476 (https://www.revisor.mn.gov/statutes/?id=256.476); and 256B.0658 (https://www.revisor.mn.gov/statutes/?id=256b.0658) provide the legal authority for Disabilities Grants.

[1]In FY 16, most of the funding for transition grants was transferred to the Other Long Term Care budget activity. In FY 18, these grants will be transferred to the Adult Mental Health budget activity.

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
1000 - General	33,972	38,312	42,355	49,201	48,591	45,190	49,191	48,540
2000 - Restrict Misc Special Revenue	3,665	4,508	3,199	7,810	9,430	9,430	9,430	9,430
2001 - Other Misc Special Revenue	0	0	12	76	0	0	0	0
3000 - Federal	7,241	5,690	7,940	11,138	9,251	6,776	9,251	6,776
Total	**44,878**	**48,509**	**53,505**	**68,225**	**67,271**	**61,396**	**67,871**	**64,746**
Biennial Change				28,343		6,937		10,887
Biennial % Change				30		6		9
Governor's Change from Base								3,950
Governor's % Change from Base								3

Expenditures by Category

Operating Expenses	407	759	1,126	1,933	1,768	1,768	1,768	1,768
Other Financial Transactions	0	0	0	75	75	75	75	75
Grants, Aids and Subsidies	44,470	47,750	52,380	66,217	65,428	59,553	66,028	62,903
Total	**44,878**	**48,509**	**53,505**	**68,225**	**67,271**	**61,396**	**67,871**	**64,746**
Full-Time Equivalents	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	0	2,500	1,550	0	0	0	0
Direct Appropriation	18,780	20,874	20,820	20,858	20,772	20,772	21,372	24,122
Net Transfers	18,782	23,967	25,357	26,793	27,819	24,418	27,819	24,418
Cancellations	3,590	4,029	4,772	0	0	0	0	0
Expenditures	**33,972**	**38,312**	**42,355**	**49,201**	**48,591**	**45,190**	**49,191**	**48,540**
Balance Forward Out	0	2,500	1,550	0	0	0	0	0
Biennial Change in Expenditures				19,272		2,225		6,175
Biennial % Change in Expenditures				27		2		7
Gov's Exp Change from Base								3,950
Gov's Exp % Change from Base								4

2000 - Restrict Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	9,812	15,574	16,499	17,184	23,724	18,575	23,724	18,575
Receipts	9,425	5,120	3,884	7,290	5,083	5,083	5,083	5,083
Net Transfers				7,060	(802)	(753)	(802)	(753)
Expenditures	**3,665**	**4,508**	**3,199**	**7,810**	**9,430**	**9,430**	**9,430**	**9,430**
Balance Forward Out	15,573	16,187	17,184	23,724	18,575	13,475	18,575	13,475
Biennial Change in Expenditures				2,837		7,851		7,851
Biennial % Change in Expenditures				35		71		71
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

2001 - Other Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Receipts	0	0	12	76	0	0	0	0
Expenditures	0	0	**12**	**76**	0	0	0	0
Biennial Change in Expenditures				88		(88)		(88)
Biennial % Change in Expenditures						(100)		(100)

(Dollars in Thousands)

3000 - Federal

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	293	322	7	5	0	0	0	0
Receipts	6,926	5,369	7,937	11,133	9,251	6,776	9,251	6,776
Net Transfers	21							
Expenditures	**7,241**	**5,690**	**7,940**	**11,138**	**9,251**	**6,776**	**9,251**	**6,776**
Balance Forward Out	0	0	5	0	0	0	0	0
Biennial Change in Expenditures				6,147		(3,051)		(3,051)
Biennial % Change in Expenditures				48		(16)		(16)
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

Program: Grant Program
Activity: Adult Mental Health Grants

mn.gov/dhs/people-we-serve/adults/health-care/mental-health/index.jsp

AT A GLANCE

- Approximately 226,805 adults in Minnesota have a serious mental illness
- Provided Projects for Assistance in Transition from Homelessness PATH services to 665 homeless persons and 507 persons at imminent risk of homeless, and provided homeless outreach services to another 2,025 people in CY 2015
- Provided Crisis Housing Assistance to prevent homelessness of 238 people in facility based treatment in CY 2015
- Provided Intensive Residential Treatment (IRTS) to 1,947 people in CY 2015
- Provided Assertive Community Treatment to 1,991 people in CY 2015
- Provided Crisis Services to 13,449 people in response to crisis episodes in CY 2015
- All funds spending for the Adult Mental Health Grants activity for FY 2015 was $74.9 million.[1] This represented 0.5% of the Department of Human Services overall budget

PURPOSE & CONTEXT

The Adult Mental Health Grants support services for adults with mental illness and are administered by the Mental Health Division of the Community Supports Administration, using both federal and state funds. These funds, combined with county dollars, are used to identify and meet the local service need by developing and providing a range of mental health services in the community. Adult Mental Health Grants support the mission of the Minnesota Comprehensive Adult Mental Health Act by supporting community mental health system infrastructure and services. The grants are used in conjunction with healthcare coverage and other funding sources to support individuals in independent living through community-based service and treatment options. Services are delivered using best practice and evidence-based practice models that are person-centered and effective.

SERVICES PROVIDED

Adult Mental Health Grants support a broad range of vital community service needs. The grants provide funding for infrastructure, community services, supports, and coordination activities not covered by Medical Assistance, and/or for persons who are uninsured or under-insured by public or private health plans. These grants are delivered in a number of ways. Some are block grants to counties who have flexibility use the funding for a number of services. Others are grants to counties, mental health providers, and other organizations for specific services, projects, and programs. Services include, but are not limited to the following:

Transitions to Community Initiative - This initiative reduces the time that individuals remain at the Anoka Metro Regional Treatment Center (AMRTC) or the Minnesota Security Hospital (MSH) once they no longer need hospital care. By providing funding to cover community-based services and address the unique discharge barriers faced by some individuals, the initiative promotes recovery, allows individuals to move to integrated settings of their choice as outlined in the Minnesota Olmstead Plan, and opens up beds at AMRTC and MSH for other individuals who need them.

Targeted Case Management – These activities coordinate services and help adults with serious and persistent mental illness gain access to needed medical, social, educational, vocational services. These activities include developing a functional assessment, an individual community support plan, and ensuing coordination of services and monitoring of service delivery.

[1] Total expenditures for FY 2015 include Compulsive Gambling grants, which, effective July 1, 2017, are administered under the CD Treatment Support Grants Budget Activity.

Assertive Community Treatment (ACT) – These intensive, non-residential mental health services are provided by a multidisciplinary staff using a team model. The team includes, at a minimum, a psychiatrist, mental health professional, registered nurse, vocational and substance abuse specialists. ACT services are available 24 hours a day. ACT teams assume full responsibility for the individual's mental health treatment. This service keeps people in the community and preventing hospitalization.

Adult Rehabilitative Mental Health Services (ARMHS) - ARMHS Services are services that enable a recipient to develop, retain and enhance their mental stability and functioning by providing education on medication management, basic social and living skills, household management, employment-related skills, and assist transitioning to community living.

Adult Outpatient Medication Management - Provides for prescriptions, medication education, and reviews to help individuals manage their symptoms.

Basic Living /Social Skills and Community Intervention - Basic living /social skills and community intervention services provided to help individuals live safely and inclusively in the community.

Project for Assistance in Transition from Homelessness (PATH) - PATH is a federal program with a state match to provide homeless outreach, service coordination, and related services designed to find and engage persons with serious mental illness who are homeless or at imminent risk of becoming homeless in services, basic needs, resources, and housing.

Crisis Housing – This program provides direct payments for rent, mortgage, and utility costs, to assist persons with retaining their housing while getting needed facility based treatment. The program prevents homelessness while the individual uses their income to pay for treatment or loses income while getting needed treatment.

Housing with Supports - These grants fund the development of permanent supportive housing for persons with serious mental illness, by providing options that assist individuals who need housing with linked supports to help maintain an individual's mental health and housing stability while living in the community.

Crisis Response Services – Provides an array of services from mobile crisis response teams to crisis stabilization beds and aftercare services. Mobile crisis teams respond to an individual's call for help in their home, place of employment, or possibly to an emergency department in a hospital in cases where they are experiencing a severe mental health problem that requires immediate assistance. Many components of crisis services are not reimbursable under Medicaid, such as telephone contacts with a person in crisis, linkage and coordination, benefits assistance, and post-hospital transition services. Ancillary services that are not able to be billed to MA are being provided through grant funding.

Culturally specific services – These grants expand capacity for ethnically and culturally-specific, trauma-informed, adult mental health services within target cultural and ethnic minority communities in Minnesota.

Individual Placement Supports (IPS) - Supported Employment - Counties use adult mental health grants to fund evidence-based practices such as the IPS model of supported employment to improve the ability of adults with serious and persistent mental illness to find and maintain competitive employment. These grants extend and support the work done by the Department of Employment and Economic Development.

Minnesota Center for Chemical and Mental Health (MNCAMH) - These grants fund training and technical assistance from the Minnesota Center for Chemical and Mental Health (MNCAMH), a program of the University of Minnesota drawing from the strengths of the School of Social Work, the College of Continuing Education, and the Department of Psychiatry. MNCAMH is a center of excellence for workforce training created to advance the professional development of the treatment services workforce on research informed practices for recovery-oriented systems of care.

Certified Peer Specialist (CPS) Implementation and Training - Selected and qualified individuals with a lived experience of mental illness are trained to work as Certified Peer Specialists in Assertive Community Treatment (ACT), Adult Rehabilitative Mental Health Services (ARMHS), Crisis Response Services and Intensive Residential Treatment services.

RESULTS

Transitions to Community - Between July 1, 2013 and February 29, 2016:

- 130 individuals received support through the Transition to Community program.
- 99 individuals were discharged as of February 29, 2016, 65 from AMRTC and 34 from MSH.
- Technical assistance was provided by DHS staff to navigate discharge options for 247 individuals.

Assertive Community Treatment (ACT), Adult Rehabilitative Mental Health Services (ARMHS), and Crisis Response

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Result	Percent of Adults with serious mental illness served by **ACT and ARMHS** who remain in the community six months after discharge from an inpatient psychiatric setting.[1]	75%	74.4%	2012 - 2014
Result	Reduction in inpatient days for persons served in **Assertive Community Treatment** (ACT)[2]	54%	46%	FY 2012-FY 2013
Quantity	Number of Adults with Serious Mental Illness who received **Adult Rehabilitative Mental Health Services** (ARMHS).[3]	17,452	19,149	2013 - 2015
Quantity	Number of episodes for which **Mental Health Crisis Services were provided**	NA	13,449	2015
Result	Percent of people needing hospitalization after receiving **crisis service interventions**	NA	14%	2015

Measure Notes:

1. Previous measures Calendar Year 2012 and Current measures CY 2014. The measure looks at a readmission to any psychiatric inpatient care unit (either State Operated or Community) within six months of discharge from a psychiatric inpatient care unit.
2. Previous measure is the percent reduction in mental health inpatient days for ACT clients admitted in FY 2012. Current measure is the percent reduction in mental health inpatient days for ACT clients admitted in FY 2014. The percent reduction compares the year before starting program with the year after starting the program. The department goal is to reduce the need for hospitalization and keep persons served in the community.
3. Previous measures Calendar Year 2013 and Current measures Calendar Year 2015 number of individuals receiving adult rehabilitative mental health services (ARMHS).

MS § 256E.12, 245.4661, and 245.70 provide the authority for the grants in this budget activity.

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
1000 - General	70,178	68,740	71,521	73,769	79,802	79,802	82,622	82,622
2360 - Health Care Access	750	60	973	2,473	750	750	750	750
3000 - Federal	6,543	5,249	8,515	13,899	8,754	6,617	8,754	6,617
Total	**77,471**	**74,049**	**81,009**	**90,141**	**89,306**	**87,169**	**92,126**	**89,989**
Biennial Change				19,630		5,325		10,965
Biennial % Change				13		3		6
Governor's Change from Base								5,640
Governor's % Change from Base								3

Expenditures by Category

Operating Expenses	1,918	2,516	2,208	140	140	140	140	140
Other Financial Transactions	1,460	2,102	2,146	0	0	0	0	0
Grants, Aids and Subsidies	74,093	69,431	76,655	90,001	89,166	87,029	91,986	89,849
Total	**77,471**	**74,049**	**81,009**	**90,141**	**89,306**	**87,169**	**92,126**	**89,989**
Full-Time Equivalents	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Direct Appropriation	70,597	68,783	71,543	73,169	79,802	79,802	82,622	82,622
Net Transfers	600	600	600	600				
Cancellations	1,019	643	622	0	0	0	0	0
Expenditures	**70,178**	**68,740**	**71,521**	**73,769**	**79,802**	**79,802**	**82,622**	**82,622**
Biennial Change in Expenditures				6,372		14,314		19,954
Biennial % Change in Expenditures				5		10		14
Gov's Exp Change from Base								5,640
Gov's Exp % Change from Base								4

2360 - Health Care Access

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Direct Appropriation	750	750	1,575	2,473	750	750	750	750
Cancellations	0	690	602	0	0	0	0	0
Expenditures	**750**	**60**	**973**	**2,473**	**750**	**750**	**750**	**750**
Biennial Change in Expenditures				2,636		(1,946)		(1,946)
Biennial % Change in Expenditures				325		(56)		(56)
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

3000 - Federal

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	0	12	0	0	0	0	0
Receipts	6,543	5,249	8,503	13,899	8,754	6,617	8,754	6,617
Expenditures	**6,543**	**5,249**	**8,515**	**13,899**	**8,754**	**6,617**	**8,754**	**6,617**
Biennial Change in Expenditures				10,622		(7,043)		(7,043)
Biennial % Change in Expenditures				90		(31)		(31)
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

Program: Grant Programs
Activity: Children's Mental Health Grants

mn.gov/dhs/people-we-serve/children-and-families/health-care/mental-health/

AT A GLANCE

- An estimated 105,000 children and youth in Minnesota (from birth to age 21) need treatment for serious emotional disturbance.
- Each year about 67,000 children and youth receive publicly funded mental health services in Minnesota.
- Approximately 9,300 children and youth received mental health screenings in the child welfare and system in 2015.
- 9% of school-age children and 5% of preschool children in Minnesota have a mental health concern that become longer lasting and interferes significantly with child's functioning at home and in school.
- All funds spending for the Child Mental Grants activity for FY 2015 was $19.9 million. This represented 0.13% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

Children's Mental Health Grants are administered by the Mental Health Division of the Community Supports Administration, which receives both federal and state funding, to support services for children with mental illness. These grants fund community, school, and home-based clinic-based children's mental health services provided by non-profit agencies, schools, Medicaid-enrolled mental health clinics, tribes, counties, and culturally specific agencies.

SERVICES PROVIDED

Children's mental health grants promote integration of mental health services into the state's overall healthcare system by:

- filling gaps in the continuum of services and supports, especially those not covered in the broader Minnesota Health Care Programs benefits set;
- paying for necessary ancillary services, supports, and coordination activities that are not eligible for federal Medicaid reimbursement;
- covering treatment and supports for children who remain uninsured or under-insured by private health plans; and
- building statewide service delivery capacity in workforce-shortage areas, where key services are not available regardless of insurance coverage.
- expanding access to direct treatment by providing care in community, school, home, and clinic-based children's mental health settings,
- providing coordination of mental and chemical health services with physical healthcare, services for persons with disabilities, and county social services
- training providers on evidence-based practices,
- funding measurement of treatment outcomes
- developing a new levels of care for children and youth with complex mental health conditions
- developing a new model to service youth with first episode psychosis

Partners are essential in order to develop and maintain a dynamic and competent mental health service delivery system. For children, coordination of care must include other child-serving sectors of the public and private health and human service systems of Minnesota—such as:

- primary health care,
- day care,
- substance abuse treatment,
- schools,
- public health,
- child welfare,
- juvenile justice,
- tribes,

- health plans;
- counties,
- adult transition services, and
- services to parents designed to prevent traumatic events in a child's life and to build or repair the crucial parent-child attachment bond.

RESULTS

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Service Utilization Rate (per 10,000)	422	450	2013-2015
Quality	Percent of children in the child welfare system who received a mental health screening	57%	64%	2012-2015

Measure Notes:

- Service Utilization Rate: An indicator of service access, this indicator counts the number of children (under age 18) receiving any mental health service from the publicly financed health care system, per 10,000 children in the general child population, which compares calendar year (CY) 2013 (Previous) and CY 2015 (Current). The utilization rate is not an indicator of need for services, because the incidence of emotional disturbance is far higher than the rate at which children access treatment.
- Percent of children receiving a mental health screening: This activity funds screenings for children in the child welfare system. Counties conduct mental health screenings for children in the child welfare system who have not had a recent assessment. The previous measure is CY 2012; the current measure is CY 2015.

Minnesota Statutes, section 245.4889 (https://www.revisor.mn.gov/statutes/?id=245.4889) provides the legal authority for Children's Mental Health grants.

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
1000 - General	17,994	20,549	20,163	24,346	20,761	20,826	20,761	20,826
3000 - Federal	0	0	0	0	1,915	2,553	1,915	2,553
Total	**17,994**	**20,549**	**20,163**	**24,346**	**22,676**	**23,379**	**22,676**	**23,379**
Biennial Change				5,966		1,546		1,546
Biennial % Change				15		3		3
Governor's Change from Base								0
Governor's % Change from Base								0

Expenditures by Category

Operating Expenses	48	63	47	80	80	80	80	80
Other Financial Transactions	253	185	427	0	0	0	0	0
Grants, Aids and Subsidies	17,694	20,301	19,690	24,266	22,596	23,299	22,596	23,299
Total	**17,994**	**20,549**	**20,163**	**24,346**	**22,676**	**23,379**	**22,676**	**23,379**
Full-Time Equivalents	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Direct Appropriation	18,246	20,636	23,386	24,346	20,761	20,826	20,761	20,826
Cancellations	252	87	3,223	0	0	0	0	0
Expenditures	**17,994**	**20,549**	**20,163**	**24,346**	**20,761**	**20,826**	**20,761**	**20,826**
Biennial Change in Expenditures				5,966		(2,922)		(2,922)
Biennial % Change in Expenditures				15		(7)		(7)
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

3000 - Federal

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Receipts	0	0	0	0	1,915	2,553	1,915	2,553
Expenditures	0	0	0	0	**1,915**	**2,553**	**1,915**	**2,553**
Biennial Change in Expenditures						4,468		4,468
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

mn.gov/dhs/people-we-serve/adults/health-care/substance-abuse/

AT A GLANCE

- In the United States, 21.5 million persons, aged 12 and older had substance use disorders (CY2014 data).
- 52,596 persons in Minnesota received treatment for substance use disorder in CY2015.
- 50.7% completed substance use disorder treatment in 2015.
- Compulsive gambling helpline receives about 1,000 calls each year for information or referrals to treatment.
- All funds spending for the CD Treatment Support and Primary Prevention grant activity for FY 2015 was $16.8 million. This represented 0.1% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

The CD Treatment Support and Primary Prevention Grants activity uses both federal and state funding to supporting state-wide prevention, intervention, recovery maintenance, case management and treatment support services for persons with alcohol, or drug addiction. Treatment support services include subsidized housing, transportation, child care, parenting education.

This activity also houses the state Compulsive Gambling Treatment Program, which funds statewide prevention, intervention, treatment and recovery services for individuals and families impacted by problem gambling through evidence based practices, education, supports and protective financial resources

SERVICES PROVIDED

CD Treatment Support and Primary Prevention Grants provide:

- Community drug and alcohol abuse prevention, intervention, and case management services for communities of color, the elderly, disabled, individuals with a mental illness and substance use disorder, individuals experiencing chronic homelessness, and people involved in the criminal justice system;
- Treatment supports specifically targeted to women, women with children, the elderly, and other diverse populations;
- A statewide prevention resource center that provides education and capacity building on the misuse of alcohol and other drugs. Education includes delivering information and training to counties, tribes, local communities, and other organizations;
- Community-based Planning and Implementation grants that use a public health approach to preventing alcohol use problems among young people;
- Regional Prevention Coordinators across MN to provide substance use prevention TA and training locally to prevention professionals in MN; and
- A tobacco merchant education training and educational compliance check project, as well as funding for Synar inspectors, who conduct random inspections of tobacco retailers.

Additional information is in the March 2013 report, *Minnesota's Model of Care for Substance Use Disorder* (http://www.dhs.state.mn.us/main/groups/disabilities/documents/pub/dhs16_195241.pdf).

Most of the funding for CD Treatment Support and Prevention Grants comes from the U.S. Dept. of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) Block Grant. Additional funding comes from the SAMHSA Strategic Prevention Framework Partnerships for Success grant focusing on the prevention of alcohol and marijuana use/abuse on college campuses. State appropriations provide additional funding for drug and alcohol abuse prevention, treatment support and recovery maintenance services for Native Americans.

The state's Compulsive Gambling Program provides:

- public awareness campaigns to promote information and awareness about problem gambling;
- a statewide helpline phone and text line and problem gambling awareness resources and supports;
- funding for problem gambling assessments, outpatient and residential treatment of problem gambling and gambling addiction;
- conduct compulsive gambling assessments of offenders under section 609.115, subdivision 9
- training for gambling treatment providers and other behavioral health service providers; and
- research that evaluates awareness, prevention, education, treatment service and recovery supports related to problem gambling and gambling addiction.

Public awareness campaigns target Minnesotans statewide, with specific initiatives aimed at young adults, women, military and veterans, and diverse race and ethnic communities that experience higher rates of problem gambling. The Compulsive Gambling statewide helpline, http://www.getgamblinghelp.com/about-us/, ((1-800-333-HOPE or text HOPE to 61222) generally receives about one thousand calls requesting information, supports or referrals for treatment services each year. The Compulsive Gambling Treatment program provides funding for approximately 700 people per year for outpatient treatment services. An average of approximately 177 people receive residential treatment each year.

The Compulsive Gambling Treatment program is largely funded by a portion of state lottery proceeds, and a dedicated one-half of one percent of the revenue from the state tax on lawful gambling proceeds.

The Congratulate and Educate tobacco merchant education and educational compliance check project funds local law enforcement and public health departments to conduct educational undercover buy checks and provide publications Congratulate and Educate Project: The Congratulate and Educate Project was activated in 2014 in partnership with local Sheriff and Police Departments and County Public Health agencies. The project is designed to promote community policing and to both congratulate clerks who pass an educational tobacco compliance inspection (do not sell to the minor) and to provide education to clerks and owners about youth access tobacco laws and consequences.

The Alcohol and Drug Abuse Division oversees the Synar Program which is funded by the federal Substance Abuse Prevention and Treatment Block Grant. Synar conducts annual inspections of randomly selected tobacco retailers in Minnesota to determine the State's Retailor Violation Rate. Synar requirements include the facilitation of the annual Tobacco Enforcement Survey (TES), the coverage study which is required every three years and the Annual Synar Report which is a required deliverable under the terms and conditions of the Federal Block Grant Award.

The Alcohol and Drug Abuse Division, a division of the agency's Community Supports Administration, administers the programs and grants within the CD Treatment Support Grants activity.

RESULTS

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Result	Past 30-day use of alcohol by 9th grade youth in communities that received a Planning & Implementation (P&I) grant for prevention work in 2006	35.5%	14.0%	2004 vs 2013
Result	Babies born with negative toxicology results	81%	84%	2013 vs. 2014

Additional Measurement Efforts: The Minnesota Student Survey (MSS) is one viable data source to understand the prevalence of problem gambling among youth and adolescents. Program staff partnered with University of Minnesota researchers to ensure the inclusion of gambling specific questions in the 2016 MSS. Data from the 2016 survey will establish baseline measures for at-risk gambling among youth and adolescents.

Measure Notes:

- The Past 30 day use of alcohol measure consists of data as reported in the Minnesota Student Survey (http://www.health.state.mn.us/divs/chs/mss/) for 9th grade students who self-report on their use of alcohol in the last 30 days. Previous represents calendar year CY 2004 and Current represents CY 2013.
- P&I grant communities were 8 percentage points above the MN State average in 2004 and were below the MN State average in 2013. The MN State average was 27.6% in 2004 and 14.7% in 2013. Minnesota communities that received Primary Prevention Planning and Implementation grants saw a 60.6% reduction in the measure of past 30-day use of alcohol use by 9th grade youth between 2004 and 2013. The rest of the state saw a 46.7% reduction in that measure over the same 2004 and 2013 period. This is a statistically significant difference.
- The Babies born with negative toxicology measure is the percentage of babies with negative toxicology results during a 12-month period, born to women served by the state Women's Recovery grants. Previous represents FY 2013 and Current represents FY 2014.

Minnesota Statutes, chapters 254A (https://www.revisor.mn.gov/statutes/?id=254A), 254B (https://www.revisor.mn.gov/statutes/?id=254B) and 256, (https://www.revisor.mn.gov/statutes/?id=256) and sections 245.98 (http://www.revisor.mn.gov/statutes/?id=245.98) and 297.E02, subd. 3 (https://www.revisor.mn.gov/statutes/?id=297E.02) provide the legal authority for CD Treatment Support and Primary Prevention Grants.

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
1000 - General	1,803	1,622	2,203	2,829	2,728	2,748	2,728	2,748
2000 - Restrict Misc Special Revenue	504	476	247	500	500	500	19,925	19,925
2001 - Other Misc Special Revenue	451	650	0	450	340	340	340	340
3000 - Federal	14,116	15,488	13,901	14,472	22,863	15,513	22,863	15,513
4800 - Lottery	1,340	1,469	1,400	1,733	1,733	1,733	1,733	1,733
Total	**18,212**	**19,706**	**17,750**	**19,984**	**28,164**	**20,834**	**47,589**	**40,259**
Biennial Change				(184)		11,263		50,113
Biennial % Change				0		30		133
Governor's Change from Base								38,850
Governor's % Change from Base								79

Expenditures by Category

Operating Expenses	722	176	175	268	963	963	963	963
Other Financial Transactions	2,001	1,856	1,860	826	927	927	927	927
Grants, Aids and Subsidies	15,489	17,674	15,715	18,890	26,274	18,944	45,699	38,369
Total	**18,212**	**19,706**	**17,750**	**19,984**	**28,164**	**20,834**	**47,589**	**40,259**
Full-Time Equivalents	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	363	546	961	673	0	0	0	0
Direct Appropriation	1,641	1,641	1,561	2,156	2,728	2,748	2,728	2,748
Receipts	367	431	504	0	0	0	0	0
Cancellations	22	43	150	0	0	0	0	0
Expenditures	**1,803**	**1,622**	**2,203**	**2,829**	**2,728**	**2,748**	**2,728**	**2,748**
Balance Forward Out	546	953	673	0	0	0	0	0
Biennial Change in Expenditures				1,607		444		444
Biennial % Change in Expenditures				47		9		9
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

2000 - Restrict Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	396	0	0	0	0	0	0
Receipts	0	0	247	0	0	0	0	0
Net Transfers	900	80		500	500	500	500	500
Expenditures	**504**	**476**	**247**	**500**	**500**	**500**	**19,925**	**19,925**
Balance Forward Out	396	0	0	0	0	0	0	0
Biennial Change in Expenditures				(233)		253		39,103
Biennial % Change in Expenditures				(24)		34		5,233
Gov's Exp Change from Base								38,850
Gov's Exp % Change from Base								3,885

2001 - Other Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	1,061	950	640	450	0	0	0	0
Net Transfers	340	340	(190)	0	340	340	340	340
Expenditures	**451**	**650**	0	**450**	**340**	**340**	**340**	**340**
Balance Forward Out	950	640	450	0	0	0	0	0
Biennial Change in Expenditures				(651)		230		230
Biennial % Change in Expenditures				(59)		51		51
Gov's Exp Change from Base								0

(Dollars in Thousands)

2001 - Other Misc Special Revenue

Gov's Exp % Change from Base				0

3000 - Federal

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	710	624	13,612	0	0	0	0	0
Receipts	13,406	15,927	289	14,471	22,863	15,513	22,863	15,513
Expenditures	**14,116**	**15,488**	**13,901**	**14,472**	**22,863**	**15,513**	**22,863**	**15,513**
Balance Forward Out	0	1,062	0	0	0	0	0	0
Biennial Change in Expenditures				(1,231)		10,003		10,003
Biennial % Change in Expenditures				(4)		35		35
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

4800 - Lottery

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Direct Appropriation	1,733	1,733	1,733	1,733	1,733	1,733	1,733	1,733
Cancellations	393	264	333	0	0	0	0	0
Expenditures	**1,340**	**1,469**	**1,400**	**1,733**	**1,733**	**1,733**	**1,733**	**1,733**
Biennial Change in Expenditures				324		333		333
Biennial % Change in Expenditures				12		11		11
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

Program: Direct Care and Treatment
Activity: Mental Health and Substance Abuse Treatment Services

http://mn.gov/dhs/people-we-serve/adults/services/direct-care-treatment/index.jsp

AT A GLANCE

- Mental illness affects one in five families.
- The US spends more than $100 billion a year on untreated mental illness.
- DCT provided mental health inpatient and residential services to approximately 1,300 people in FY2015.
- 1,454 clients were served in the Community Addition Recovery Enterprise (C.A.R.E.) program during FY2015.
- The structure of budget activities within Direct Care and Treatment has been changed significantly with the FY2018-19 biennium. The overall level of spending in DCT was $ 418.1 million in FY2015, which represents 2.7% of the Department's all funds spending.

PURPOSE & CONTEXT

- As part of the Department of Human Services Direct Care and Treatment (DCT) Administration, Mental Health and Substance Abuse Treatment Services (MHSATS) provides specialized treatment and support services to individuals with mental illness, chemical dependencies/substance abuse and other complex conditions.
- The Department of Human Service's goal is to serve people with disabilities by providing access to care close to their home community and natural supports. DCT provides services to individuals with the goal of allowing them to move through the system and back to the community.
- The 2016 Legislature appropriated $20.8 million for FY2017 to increase staffing levels within the Community Behavioral Health Hospitals (CBHHs) and Anoka Metro Regional Treatment Center.

SERVICES PROVIDED

The following services are funded with general fund appropriations:

- Adult in-patient services at the Anoka Metro Regional Treatment Center (AMRTC)
- Adult in-patient services at the Community Behavioral Health Hospitals (CBHHs) located in Alexandria, Annandale, Baxter, Bemidji, Fergus Falls, Rochester and St. Peter[1]
- Child & Adolescent Behavior Health in-patient Services (CABHS) in Willmar
- Minnesota Specialty Health System – providing Intensive Residential Treatment Services (IRTS) for adults in Brainerd, St. Paul, Wadena and Willmar

Services funded with other revenues:

- Community Addiction Recovery Enterprise (C.A.R.E.) – provides inpatient and outpatient treatment to persons with chemical dependency or substance abuse problems. C.A.R.E. programs operate in Anoka, Brainerd, Carlton, Fergus Falls, St. Peter, and Willmar.

All services:

- are person-centered, focusing on the needs of the individual,
- are provided in a safe environment at the appropriate level of care and,
- allow individuals to move through treatment and back to the most integrated setting possible.

To assure a successful community transition, we use key strategies such as:

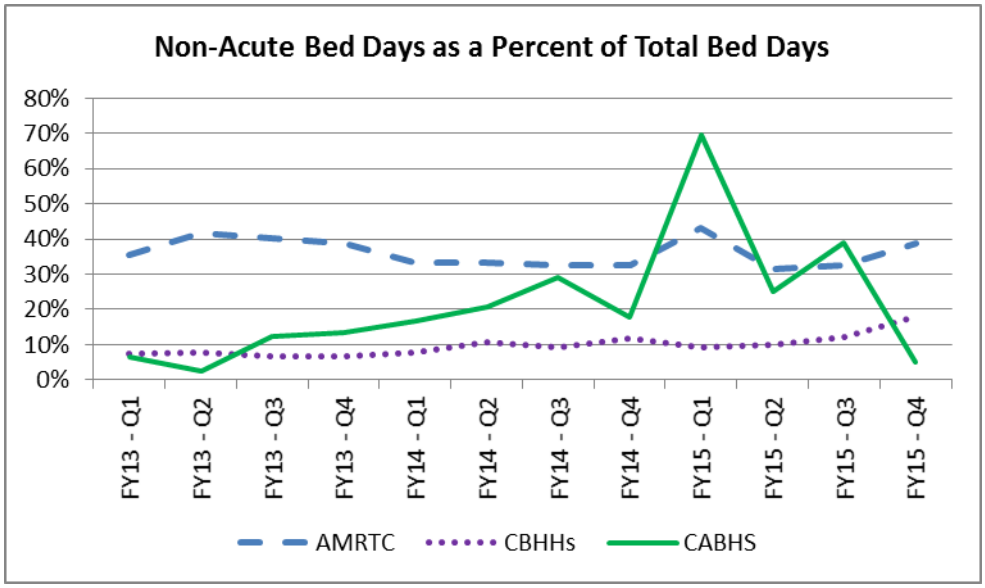
- Prompt psychiatric follow-up upon people's return to a community setting and,
- Reducing the number of medications necessary to control the individual's symptoms.

[1] The St. Peter CBHH is scheduled to close in the fall of 2016. This was part of the 2016 legislative package approved for DCT.

We also reach out to partner with community providers to remove the barriers that limit successful transitions back to the community.

RESULTS

We measure non-acute bed days. A non-acute bed day is a day spent in the hospital when the client no longer needs that level of care. When a client does not need hospital level of care but cannot be discharged, it is costly and causes other clients who need hospital level of care to remain on the waiting list. Our goal for inpatient services is that less than 10% of total bed days are classified as non-acute bed days.

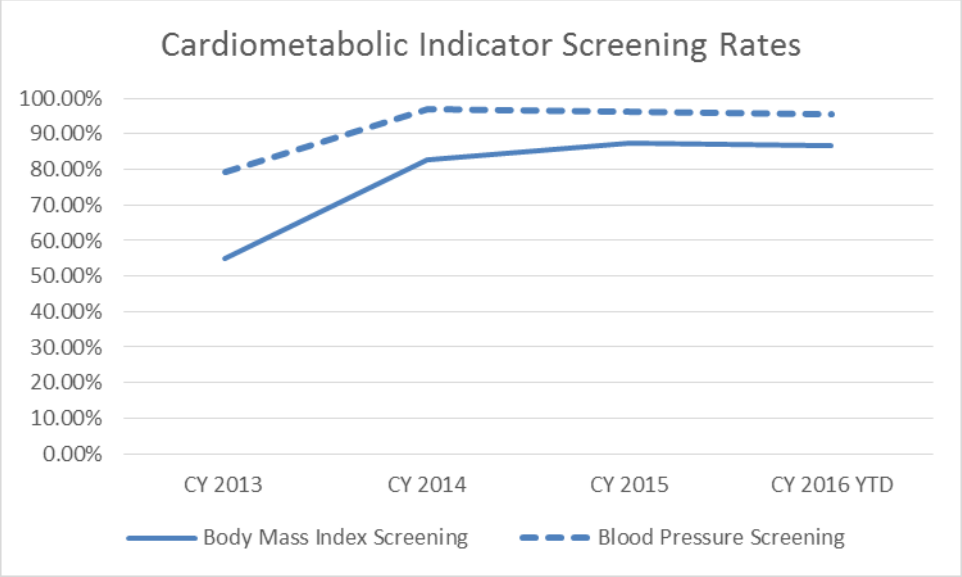


The graph above shows that the non-acute bed day percentage at AMRTC is increasing. This is due in part to the increase in the number of admissions directly from jails. A number of these clients need competency restoration services, but remain at AMRTC as there are no other placements available once they have completed their treatment. The 2016 Legislature appropriated funding to open a new residential Competency Restoration Program (CRP). Once this program is operational, AMRTC clients needing CRP services that meet the criteria will be moved to this program which should result in a decrease in the number of non-acute bed days at AMRTC.

The CBHH non-acute bed days percentage has increased slightly but remains close to the 10% goal. The CABHS program operates few beds, so having just one or two clients who do not meet hospital level of care has a great impact on the non-acute bed day measure.

Another measure of success is the screening for cardiometabolic syndrome indicators. Cardiometabolic Syndrome prevention is a key component of improving the lives of those we support and mirrors national trends towards improvement healthcare quality systems. Increasing the number of people who are at a healthy weight will help us reduce the incidence of metabolic syndrome and chronic diseases among our patients. These rates also help to determine appropriate interventions. Integrating Body Mass Index (BMI) education into existing programming can reduce the likelihood of the onset and progression of obesity and related chronic diseases, as well as increase healthy eating and physical lifestyle skills. We are collecting information via our Electronic Medical Record (EMR) and monitoring it closely to help those served maintain an appropriate BMI, reduce incidences of chronic disease and enable them to live healthier lives.

Managing and maintaining a healthy blood pressure reduces an individual's risk of cardiovascular disease and other chronic diseases. Increasing the number of people with a healthy blood pressure will help us assist our patients to lead healthier lives. Increased screening will also aid in the development of appropriate interventions, increase disease management and prevention, and assist with creating individualized treatment plans.



The graph above shows the work that has been done to improve screening for two key components of cardiometabolic syndrome, Body Mass Index (BMI) and Blood Pressure. Our goal is to have a 95% screening rate for both BMI and Blood Pressure. There has been a slight reduction in screening rates this calendar year and work is underway to better support sites in increasing screening rates and using the information for meaningful interventions.

Minnesota Statutes sections 246.01 to 246.70 (https://www.revisor.mn.gov/statutes/?id=246) provide the legal authority for Direct Care and Treatment State Operated Services.

NOTE: The budget structure for DHS Direct Care and Treatment programs was modified for the 2018-2019 Biennial Budget. In order to better reflect the services provided and administrative structures supporting them, this budget brings all of DCT under a single Budget Program housing five Budget Activities that better reflect services provided and populations served by DCT.

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
1000 - General	112,107	114,828	111,854	152,182	114,116	114,116	118,313	121,204
2000 - Restrict Misc Special Revenue	2,884	2,835	2,749	3,927	3,713	3,713	3,713	3,713
4101 - Dhs Chemical Dependency Servs	20,466	19,372	18,173	19,304	19,304	19,304	19,699	20,101
6000 - Miscellaneous Agency	129	103	120	125	125	125	125	125
Total	**135,586**	**137,138**	**132,896**	**175,538**	**137,258**	**137,258**	**141,850**	**145,143**
Biennial Change				35,710		(33,918)		(21,441)
Biennial % Change				13		(11)		(7)
Governor's Change from Base								12,477
Governor's % Change from Base								5

Expenditures by Category

Compensation	113,128	114,685	108,341	145,052	113,914	113,914	118,101	121,308
Operating Expenses	21,496	21,546	23,538	30,014	23,184	23,184	23,589	23,675
Other Financial Transactions	731	660	689	312	0	0	0	0
Grants, Aids and Subsidies	193	201	328	160	160	160	160	160
Capital Outlay-Real Property	39	46	0	0	0	0	0	0
Total	**135,586**	**137,138**	**132,896**	**175,538**	**137,258**	**137,258**	**141,850**	**145,143**
Full-Time Equivalents	**1,328.5**	**1,296.6**	**1,154.8**	**1,514.0**	**1,157.0**	**1,134.6**	**1,194.1**	**1,197.7**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	2,539	0	10,670	0	0	0	0
Direct Appropriation	122,738	116,814	145,326	151,625	114,116	114,116	118,708	122,001
Receipts	0	0	0	0	0	0	0	0
Net Transfers	(8,489)	(4,412)	(22,802)	(10,113)	0	0	(395)	(797)
Cancellations	0	113	0	0	0	0	0	0
Expenditures	**112,107**	**114,828**	**111,854**	**152,182**	**114,116**	**114,116**	**118,313**	**121,204**
Balance Forward Out	2,141	0	10,670	0	0	0	0	0
Biennial Change in Expenditures				37,101		(35,804)		(24,519)
Biennial % Change in Expenditures				16		(14)		(9)
Gov's Exp Change from Base								11,285
Gov's Exp % Change from Base								5
Full-Time Equivalents	1,097.3	1,066.2	975.4	1,325.6	971.5	952.3	1,005.1	1,008.7

2000 - Restrict Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	216	574	0	214	0	0	0	0
Direct Appropriation	2,713	2,713	2,713	3,713	3,713	3,713	3,713	3,713
Net Transfers	500	(410)	250					
Cancellations	0	42	0	0	0	0	0	0
Expenditures	**2,884**	**2,835**	**2,749**	**3,927**	**3,713**	**3,713**	**3,713**	**3,713**
Balance Forward Out	545	0	214	0	0	0	0	0
Biennial Change in Expenditures				957		750		750
Biennial % Change in Expenditures				17		11		11
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0
Full-Time Equivalents	21.7	22.9	21.3	21.3	21.3	21.3	21.3	21.3

4101 - Dhs Chemical Dependency Servs

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	3	95	41	38	38	38	38	38
Receipts	15,464	11,715	8,544	13,191	13,313	13,313	13,313	13,313
Net Transfers	5,000	7,600	9,626	6,113	5,991	5,991	6,386	6,788

(Dollars in Thousands)

4101 - Dhs Chemical Dependency Servs

Expenditures	**20,466**	**19,372**	**18,173**	**19,304**	**19,304**	**19,304**	**19,699**	**20,101**
Balance Forward Out	0	38	38	38	38	38	38	38
Biennial Change in Expenditures				(2,361)		1,131		2,323
Biennial % Change in Expenditures				(6)		3		6
Gov's Exp Change from Base								1,192
Gov's Exp % Change from Base								3
Full-Time Equivalents	209.5	207.5	158.1	167.1	164.2	161.0	167.7	167.8

6000 - Miscellaneous Agency

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	**FY15**	**FY16**	**FY17**	**FY18**	**FY19**	**FY18**	**FY19**
Balance Forward In	7	3	3	1	1	1	1	1
Receipts	125	102	119	125	125	125	125	125
Net Transfers	0							
Expenditures	**129**	**103**	**120**	**125**	**125**	**125**	**125**	**125**
Balance Forward Out	3	3	1	1	1	1	1	1
Biennial Change in Expenditures				14		5		5
Biennial % Change in Expenditures				6		2		2
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

Program: Direct Care and Treatment
Activity: Community Based Services

mn.gov/dhs/people-we-serve/adults/services/direct-care-treatment/index.jsp

AT A GLANCE

- 530 people served by Community Support Services mobile teams during FY2015
- 77 children and adolescents with severe emotional disturbance served in individual foster homes during FY2015
- 485 clients with developmental disabilities served in community residential services during FY2015
- 896 clients with developmental disabilities served in day treatment and habilitation vocational services during FY2015
- The structure of budget activities within Direct Care and Treatment has been changed significantly with the FY2018-19 biennium.
- The overall level of spending in DCT was $ 418.1 million in FY2015, which represents 2.7% of the Department's overall budget.

PURPOSE & CONTEXT

- As part of the Department of Human Services Direct Care and Treatment (DCT) Administration, Community Based Services (CBS) provides treatment and residential care to individuals with behavioral health issues and developmental disabilities. CBS programs specialize in the treatment of vulnerable people with complex needs for whom no other providers are available.
- The majority of CBS programs operate as an Enterprise service. Enterprise services operate on the revenues generated from services provided to clients. Revenues are collected from third-party payment sources such as Medical Assistance, private insurance, and the clients themselves.

SERVICES PROVIDED

Service programs within this activity include:

- **Community Support Services (CSS)** – statewide specialized mobile teams providing crisis support services to individuals with mental illness and/or disabilities in their home community or transitioning back to their home community. Their overall goal is to support people in the most integrated setting by addressing behavior associated with mental illness or intellectual disabilities that would cause individuals to be admitted to institutional settings.
- **Crisis Residential Services and Minnesota Life Bridge (MLB)** – crisis and MLB have a total of eight short-term residential programs throughout the state. Their overall goal is to support people in the most integrated setting close to their home community or natural supports by addressing behavior associated with mental illness or intellectual disabilities that would cause individuals to lose their placements or be admitted to a less integrated setting.
- **Minnesota Intensive Therapeutic Homes (MITH)** – provides foster care to children and adolescents who have severe emotional disturbance and serious acting-out behaviors. Homes are located throughout the state. Each child's treatment structure is individualized and is based on a combination of multidimensional treatment, wrap-around services and specialized behavior therapy.
- **Minnesota State Operated Community Services (MSOCS) Residential Services** – provides residential services in small group homes (typically 4 beds) located throughout the state for individuals with mental illness and/or developmental disabilities. Staff members assist clients with activities of daily living and help integrate them into the local communities. Individual service agreements are negotiated with counties through the Rate Management System (RMS) for each client based on their needs.
- **Minnesota State Operated Community Services (MSOCS) Vocational Services** – provides vocational support services for people with developmental disabilities. Staff provide evaluations, training, and client assistance at job sites. Individual services agreements are negotiated for each client or based on historic rates established for the identified vocational site.

RESULTS

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	The average number of individuals residing within MSOCS residential services on a daily basis	454	411	FY2014 vs. FY2016
Quantity	The percent of individual workers within MSOCS vocational services who have community employment[1]	71%	74%	June 2014 vs. June 2016

Minnesota Statutes, sections 246.01 to 246.70 (https://www.revisor.mn.gov/statutes/?id=246) provide the legal authority for Direct Care and Treatment State Operated Services

NOTE: The budget structure for DHS Direct Care and Treatment programs was modified for the 2018-2019 Biennial Budget. In order to better reflect the services provided and administrative structures supporting them, this budget brings all of DCT under a single Budget Program housing five Budget Activities that better reflect services provided and populations served by DCT.

[1] Community Employment offers a more person-centered approach to employment by giving individuals the opportunity to secure a variety of employment options outside the traditional contracted services that are brought into a Day Treatment & Habilitation (DT&H) site based employment setting.

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
1000 - General	0	0	0	0	9,307	9,307	9,505	9,740
2000 - Restrict Misc Special Revenue	6,693	4,498	1,834	148	10	5	10	5
2403 - Gift	6	6	7	22	15	8	15	8
4100 - Sos Tbi & Adol Ent Svcs	1,636	1,772	1,621	2,051	2,051	2,051	2,051	2,051
4350 - Mn State Operated Comm Svcs	95,418	99,902	103,496	104,626	91,626	91,626	101,703	98,743
Total	**103,753**	**106,178**	**106,959**	**106,847**	**103,009**	**102,997**	**113,284**	**110,547**
Biennial Change				3,875		(7,800)		10,025
Biennial % Change				2		(4)		5
Governor's Change from Base								17,825
Governor's % Change from Base								9

Expenditures by Category

Compensation	88,259	94,096	92,500	92,656	87,759	87,759	96,736	94,011
Operating Expenses	14,439	11,012	13,511	13,972	14,968	14,956	16,266	16,254
Other Financial Transactions	129	72	29	0	63	63	63	63
Grants, Aids and Subsidies	914	998	919	206	206	206	206	206
Capital Outlay-Real Property	12	0	0	13	13	13	13	13
Total	**103,753**	**106,178**	**106,959**	**106,847**	**103,009**	**102,997**	**113,284**	**110,547**
Full-Time Equivalents	**1,407.9**	**1,471.1**	**1,408.7**	**1,455.9**	**1,290.1**	**1,265.2**	**1,401.4**	**1,326.6**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Direct Appropriation	1,000	1,000	9,626	20,113	15,298	15,298	25,573	22,848
Net Transfers	(1,000)	(1,000)	(9,626)	(20,113)	(5,991)	(5,991)	(16,068)	(13,108)
Expenditures	0	0	0	0	**9,307**	**9,307**	**9,505**	**9,740**
Biennial Change in Expenditures						18,614		19,245
Gov's Exp Change from Base								631
Gov's Exp % Change from Base								3
Full-Time Equivalents	0.0	0.0	0.0	0.0	67.5	66.2	69.3	69.9

2000 - Restrict Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	891	695	713	151	8	3	8	3
Receipts	6,235	4,110	1,272	5	5	5	5	5
Expenditures	**6,693**	**4,498**	**1,834**	**148**	**10**	**5**	**10**	**5**
Balance Forward Out	433	307	151	8	3	3	3	3
Biennial Change in Expenditures				(9,208)		(1,967)		(1,967)
Biennial % Change in Expenditures				(82)		(99)		(99)
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0
Full-Time Equivalents	69.5	46.1	15.8	0	0	0	0	0

2403 - Gift

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	62	56	50	45	25	10	25	10
Receipts	0	0	2	2	1	1	1	1
Expenditures	**6**	**6**	**7**	**22**	**15**	**8**	**15**	**8**
Balance Forward Out	56	50	45	25	10	2	10	2
Biennial Change in Expenditures				17		(6)		(6)
Biennial % Change in Expenditures				136		(22)		(22)
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

(Dollars in Thousands)

4100 - Sos Tbi & Adol Ent Svcs

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	410	446	425	234	234	234	234	234
Receipts	1,740	1,977	1,430	2,051	2,051	2,051	2,051	2,051
Net Transfers	(75)	(225)						
Expenditures	**1,636**	**1,772**	**1,621**	**2,051**	**2,051**	**2,051**	**2,051**	**2,051**
Balance Forward Out	439	425	234	234	234	234	234	234
Biennial Change in Expenditures				264		430		430
Biennial % Change in Expenditures				8		12		12
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0
Full-Time Equivalents	29.4	30.8	24.0	28.0	28.0	28.0	28.0	28.0

4350 - Mn State Operated Comm Svcs

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	5,372	188	173	2,909	0	0	0	0
Receipts	90,387	96,028	93,061	87,717	91,626	91,626	91,626	91,626
Net Transfers	(340)	3,707	13,170	14,000			10,077	7,117
Expenditures	**95,418**	**99,902**	**103,496**	**104,626**	**91,626**	**91,626**	**101,703**	**98,743**
Balance Forward Out	0	22	2,909	0	0	0	0	0
Biennial Change in Expenditures				12,802		(24,870)		(7,676)
Biennial % Change in Expenditures				7		(12)		(4)
Gov's Exp Change from Base								17,194
Gov's Exp % Change from Base								9
Full-Time Equivalents	1,309.0	1,394.2	1,369.0	1,427.9	1,194.6	1,171.0	1,304.1	1,228.7

Human Services Budget Activity Narrative

Program: Direct Care and Treatment
Activity: Forensic Services

mn.gov/dhs/people-we-serve/adults/services/direct-care-treatment/index.jsp

AT A GLANCE

- Minnesota Security Hospital (MSH) served 242 individuals during FY2015 with an average length of stay of 2.6 years.
- Transition Services served 132 individuals during FY2015 with an average length of stay of 5.3 years
- Secure Competency Restoration Program served 116 individuals during FY2015 with an average length of stay of 176 days
- Forensic Nursing Home served 49 individuals during FY2015 with an average length of stay of 197 days
- Overall, the Forensic Services census is currently forecasted to increase by 2-3 individuals per year
- The structure of budget activities within Direct Care and Treatment has been changed significantly with the FY2018-19 biennium.
- The overall level of spending in DCT was $ 418.1 million in FY2015, which represents 2.7% of the Department's overall budget.

PURPOSE & CONTEXT

- As part of the Department of Human Services Direct Care & Treatment (DCT) Administration, Forensic Services in St. Peter is a secure treatment facility that provides multidisciplinary treatment services to adults and adolescents with severe mental illness that have endangered others and present a serious risk to the public.
- Clients are admitted as a result of judicial or other lawful orders. Clients come from throughout the state. Most are under a civil commitment as mentally ill and dangerous.
- The 2014 Legislature appropriated $56 million in bonding to construct new residential and program areas to help create a safer and more therapeutic environment at MSH. These new areas are projected to open in October, 2016.
- The 2016 Legislature appropriated $6.5 million for FY2017 to operate a new residential Competency Restoration Program in the St. Peter community.

SERVICES PROVIDED

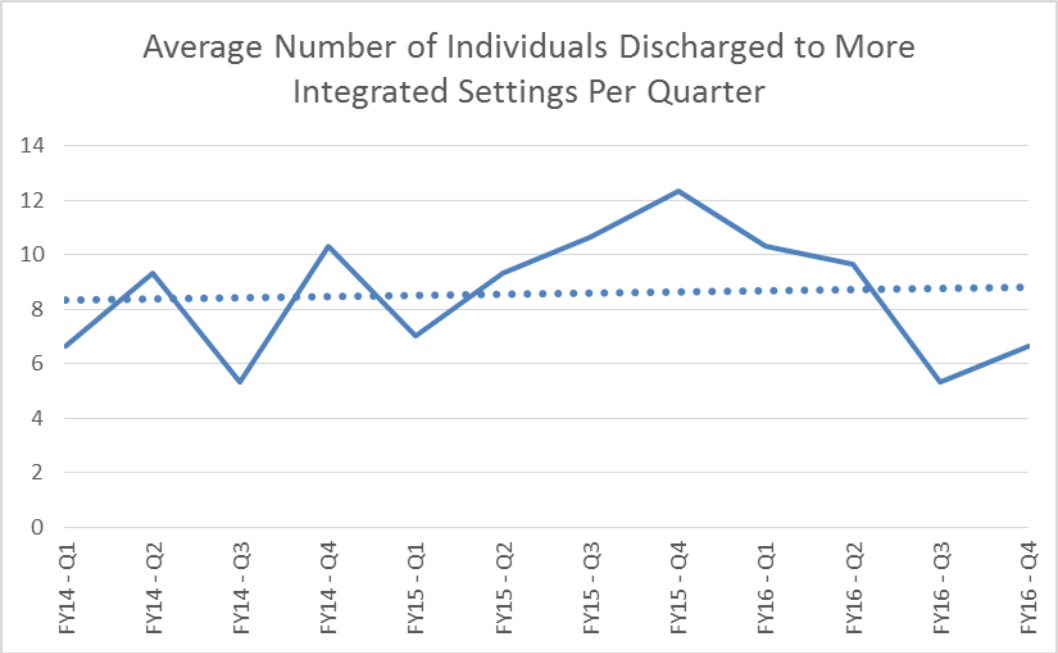
Forensics Services programs provide a continuum of services:

- **Minnesota Security Hospital** – provides a secure inpatient setting for treatment of severe mental illness for individuals committed as mentally ill and dangerous.
- **Competency Restoration Services** – provide treatment and evaluation of individuals who have been committed for competency restoration under Minnesota Court Rules of Criminal Procedure Rule 20.01 Subd. 7 (https://www.revisor.mn.gov/court_rules/rule.php?name=cr-20).
- **Transition Services** - provide a supervised residential setting offering social rehabilitation treatment to increase self-sufficiency and build skills necessary for a safe return to the community.
- **Forensic Nursing Home** - provides nursing home level of care to individuals committed as mentally ill and dangerous, a sexual psychopathic personality, sexually dangerous person or on medical release from the Department of Corrections.
- **Court-ordered evaluations** – include evaluations of a person's competency to stand trial and pre-sentencing mental health evaluations. These can be done on either an inpatient basis at the Minnesota Security Hospital or in a community setting, including a community corrections facility.

All of these services are provided through a direct general fund appropriation.

RESULTS

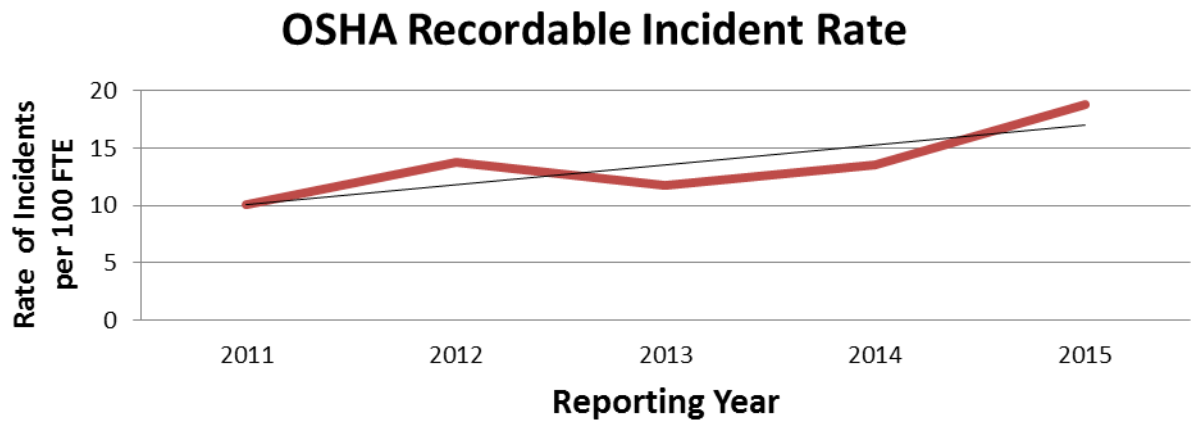
We measure success by the number of individuals discharged from Forensics Services programs to more integrated settings. Reflective of the Minnesota Olmstead Plan. In the chart below, the solid line is the average number of discharges. The dotted line is the trend line over the period reflected in the chart.



From April – June, 2016, the monthly average number of discharges from Forensic Services to a more integrated setting was 6.7 compared to 5.3 in the previous quarter. During the same period, the monthly average total number of discharges from Forensic Services was 15.66.

It should be noted that in January 1, 2016, the definition for more integrated settings was converted from data on discharges to any non-forensic/correctional setting, to data on discharges to non-segregated settings.

We care about the safety of our clients and staff. One measure of safety is the rate at which employees have injuries or illnesses that are reportable to the federal Occupational Safety Health Administration (OSHA). Many efforts are underway at MSH to lower this rate. In the chart below, the dashed line is baseline annual data. It is imposed on top of an underlying solid trend line.



The OSHA Recordable Incident Rate is the total number of workplace injuries or illnesses per 100 full time employees (FTE) working in a year that must be reported to the federal Occupational Safety and Health Administration. After DHS consulted with the Department of Labor and Industry in 2014, it was determined that our facility was best placed under Industry code 623000. For 2014, the national average among State Government Nursing and residential care facilities (623000) was 12.6 incidents per 100 FTE.

Minnesota Statutes, sections 246.01 to 246.70 (https://www.revisor.mn.gov/statutes/?id=246) provide the legal authority for State Operated Services. Also see Minnesota Statutes, sections 253.20 to 253.26 (https://www.revisor.mn.gov/statutes/?id=253) for additional authority that is specific to Forensic Services.

NOTE: The budget structure for DHS Direct Care and Treatment programs was modified for the 2018-2019 Biennial Budget. In order to better reflect the services provided and administrative structures supporting them, this budget brings all of DCT under a single Budget Program housing five Budget Activities that better reflect services provided and populations served by DCT.

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
1000 - General	77,739	83,852	83,799	97,711	91,658	91,675	103,007	109,488
2000 - Restrict Misc Special Revenue	1,106	822	842	801	750	750	750	750
6000 - Miscellaneous Agency	1,438	1,512	1,665	1,600	1,600	1,600	1,600	1,600
Total	**80,282**	**86,186**	**86,306**	**100,112**	**94,008**	**94,025**	**105,357**	**111,838**
Biennial Change				19,949		1,615		30,777
Biennial % Change				12		1		17
Governor's Change from Base								29,162
Governor's % Change from Base								16

Expenditures by Category

Compensation	65,119	69,590	72,084	83,711	82,481	82,722	93,830	100,535
Operating Expenses	12,692	14,018	11,694	13,784	8,911	8,687	8,911	8,687
Other Financial Transactions	364	344	226	374	373	373	373	373
Grants, Aids and Subsidies	2,031	2,152	2,302	2,243	2,243	2,243	2,243	2,243
Capital Outlay-Real Property	76	83	0	0	0	0	0	0
Total	**80,282**	**86,186**	**86,306**	**100,112**	**94,008**	**94,025**	**105,357**	**111,838**
Full-Time Equivalents	**812.7**	**823.1**	**817.2**	**939.5**	**866.8**	**849.8**	**974.0**	**1,008.9**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	1,021	0	222	0	0	0	0
Direct Appropriation	78,582	75,839	84,021	93,289	91,658	91,675	103,007	109,488
Net Transfers		7,000		4,200				
Cancellations	0	8	0	0	0	0	0	0
Expenditures	**77,739**	**83,852**	**83,799**	**97,711**	**91,658**	**91,675**	**103,007**	**109,488**
Balance Forward Out	843	0	222	0	0	0	0	0
Biennial Change in Expenditures				19,919		1,823		30,985
Biennial % Change in Expenditures				12		1		17
Gov's Exp Change from Base								29,162
Gov's Exp % Change from Base								16
Full-Time Equivalents	811.2	820.4	814.3	936.5	863.8	846.8	971.0	1,006.0

2000 - Restrict Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	694	224	224	208	158	158	158	158
Receipts	585	760	826	750	750	750	750	750
Expenditures	**1,106**	**822**	**842**	**801**	**750**	**750**	**750**	**750**
Balance Forward Out	173	162	208	158	158	158	158	158
Biennial Change in Expenditures				(286)		(143)		(143)
Biennial % Change in Expenditures				(15)		(9)		(9)
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0
Full-Time Equivalents	1.5	2.7	3.0	3.0	3.0	3.0	3.0	3.0

6000 - Miscellaneous Agency

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	353	378	410	324	225	207	225	207
Receipts	1,463	1,533	1,580	1,502	1,582	1,582	1,582	1,582
Expenditures	**1,438**	**1,512**	**1,665**	**1,600**	**1,600**	**1,600**	**1,600**	**1,600**
Balance Forward Out	378	400	324	225	207	189	207	189
Biennial Change in Expenditures				316		(65)		(65)
Biennial % Change in Expenditures				11		(2)		(2)

6000 - Miscellaneous Agency

Gov's Exp Change from Base			0
Gov's Exp % Change from Base			0

Program: Direct Care and Treatment
Activity: Minnesota Sex Offender Program

mn.gov/dhs/people-we-serve/adults/services/sex-offender-treatment/

AT A GLANCE

- Minnesota Sex Offender Program population as of July 1, 2016 was 723.
- Clients progress across three phases of treatment through active participation in group therapy and opportunities to demonstrate meaningful change.
- As of July 1, 2016, 85 percent of MSOP treatment-eligible clients voluntarily participated in treatment.
- As of July 1, 2016, five MSOP client are provisionally discharged in the community.
- All funds spending for the DCT Minnesota Sex Offender Program activity for FY 2015 was $84.7 million. This represented 0.6% of the Department of Human Services overall budget.

PURPOSE & CONTEXT

- As part of the Department of Human Services Direct Care and Treatment (DCT) Administration, the Minnesota Sex Offender Program (MSOP) provides services to individuals who have been civilly committed to receive sex offender treatment.
- MSOP's mission is to promote public safety by providing sex offender treatment.
- Minnesota is one of 20 states with civil commitment laws for sex offenders.
- Most MSOP clients come from the Department of Corrections through the civil commitment process after they have finished their period of incarceration.
- Transfer, provisional discharge or discharge from MSOP must be ordered by the court.

SERVICES PROVIDED

We accomplish our mission by:

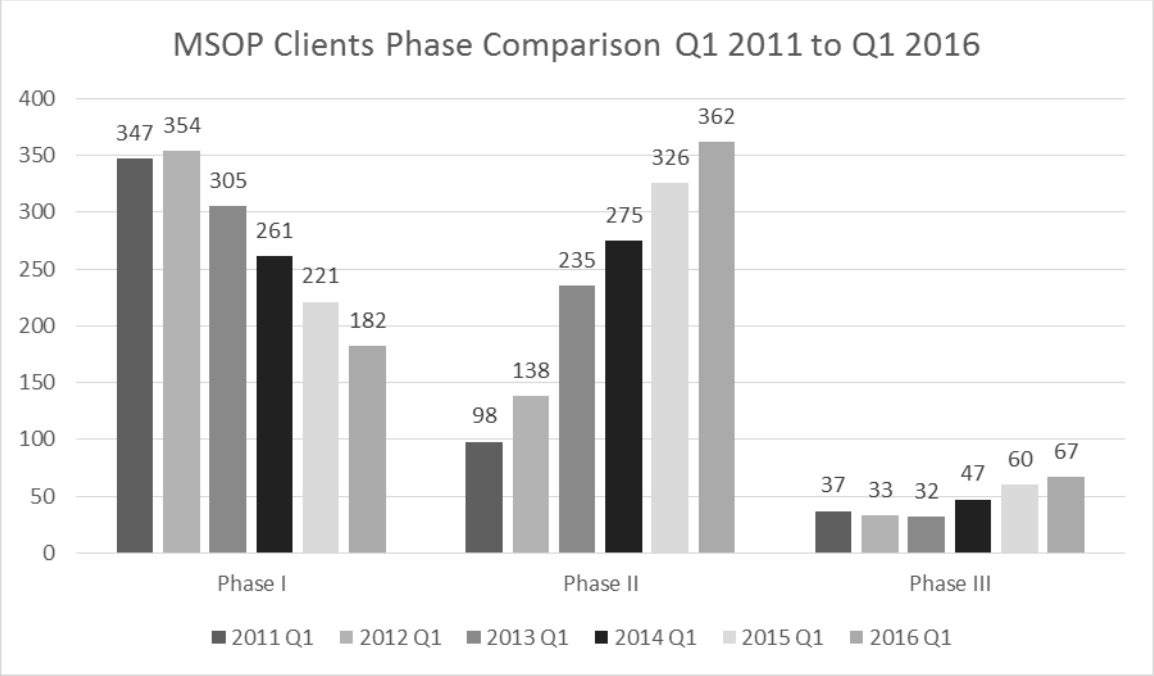
- Creating a therapeutic environment that is safe for clients and staff. The treatment model is client-centered and has a clear progression for each phase of treatment.
- Providing group therapy and opportunities to demonstrate meaningful change during three phases of treatment through participation in rehabilitative services, including education, therapeutic recreational activities and vocational work program assignments.
- Providing risk assessment and professional treatment reports to courts to assist in their decisions.
- Using our resources responsibly and efficiently.
- Working together with community, policy makers, and other governmental agencies.
- Developing resources for provisionally discharged clients to succeed in the community.

MSOP uses a three-phase treatment process. Clients initially address treatment-interfering behaviors and attitudes (Phase I) in preparation for focusing on their patterns of abuse and identifying and resolving the underlying issues in their offenses (Phase II). Clients in the later stages of treatment focus on deinstitutionalization and reintegration, applying the skills they acquired in treatment across settings and maintaining the changes they have made while managing their risk for re-offense (Phase III).

MSOP is funded by general fund appropriations. When a county commits someone to the program, the county is responsible for part of the cost of care. For commitments initiatied before August 2011, the county share is ten percent. For commitments after that date, the county share is 25 percent. When a client is court ordered to provisional discharge (continued community supervision by MSOP), there is no county share.

RESULTS

As more clients move through the program, we expect to see increases in the number of clients participating in the latter stages of treatment. The chart below shows the treatment progression of clients over the past calendar year.



- The legislature requires an annual performance report on the Minnesota Sex Offender Program. Two important measures in the performance report are the program wide per diem and client counts. For MSOP the program wide per diem is the calculated daily comprehensive cost of the program for each client.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	Per diem	$318.00	$344.00	FY14 to FY16
Quantity	Increase in client population	697	723	FY14 to FY16
Quality	Increase in client population on Provisional Discharge	1	5	FY14 to FY16

Results Notes

- Treatment progression graph is produced by the MSOP Research Department.
- The reported measure is the published per diem rate. It is the rate charged to counties when figuring a county's share of the cost of a client's care.
- Client population counts in the table below are as of June 30th (the end of each fiscal year).

Minnesota Statutes, chapter 246B governs the operation of the Sex Offender Program and chapter 253D governs the civil commitment and treatment of sex offenders.

NOTE: The budget structure for DHS Direct Care and Treatment programs was modified for the 2018-2019 Biennial Budget. In order to better reflect the services provided and administrative structures supporting them, this budget brings all of DCT under a single Budget Program housing five Budget Activities that better reflect services provided and populations served by DCT.

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
1000 - General	76,569	79,040	81,924	84,929	83,645	83,645	88,031	89,872
2000 - Restrict Misc Special Revenue	0	0	0	0	0	0	1,800	1,800
4503 - Minnesota State Industries	1,767	2,680	1,170	1,685	1,900	1,900	100	100
6000 - Miscellaneous Agency	2,687	3,025	3,449	3,480	3,500	3,500	3,500	3,500
Total	**81,023**	**84,745**	**86,543**	**90,094**	**89,045**	**89,045**	**93,431**	**95,272**
Biennial Change				10,869		1,454		12,067
Biennial % Change				7		1		7
Governor's Change from Base								10,613
Governor's % Change from Base								6

Expenditures by Category

Compensation	62,549	67,385	68,291	66,562	65,276	65,276	70,112	71,953
Operating Expenses	16,128	14,675	15,308	20,177	20,414	20,414	19,964	19,964
Other Financial Transactions	329	188	120	4	4	4	4	4
Grants, Aids and Subsidies	1,980	2,497	2,823	3,351	3,351	3,351	3,351	3,351
Capital Outlay-Real Property	36	0	0	0	0	0	0	0
Total	**81,023**	**84,745**	**86,543**	**90,094**	**89,045**	**89,045**	**93,431**	**95,272**
Full-Time Equivalents	**835.8**	**863.8**	**831.4**	**933.7**	**893.3**	**875.7**	**941.3**	**938.7**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	0	877	0	2,071	0	0	0	0
Direct Appropriation	79,769	80,922	87,081	89,596	86,731	86,731	91,117	92,958
Net Transfers	(2,559)	(2,554)	(3,086)	(6,739)	(3,086)	(3,086)	(3,086)	(3,086)
Cancellations	0	204	0	0	0	0	0	0
Expenditures	**76,569**	**79,040**	**81,924**	**84,929**	**83,645**	**83,645**	**88,031**	**89,872**
Balance Forward Out	641	0	2,071	0	0	0	0	0
Biennial Change in Expenditures				11,243		437		11,050
Biennial % Change in Expenditures				7		0		7
Gov's Exp Change from Base								10,613
Gov's Exp % Change from Base								6
Full-Time Equivalents	833.8	852.5	829.6	932.0	891.6	874.0	939.5	937.0

2000 - Restrict Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Receipts	0	0	0	0	0	0	1,800	1,800
Expenditures	0	0	0	0	0	0	**1,800**	**1,800**
Biennial Change in Expenditures								3,600
Gov's Exp Change from Base								3,600

4503 - Minnesota State Industries

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	1,674	1,740	971	965	1,090	1,000	1,090	1,000
Receipts	1,735	1,457	1,164	1,810	1,810	1,810	10	10
Expenditures	**1,767**	**2,680**	**1,170**	**1,685**	**1,900**	**1,900**	**100**	**100**
Balance Forward Out	1,642	517	965	1,090	1,000	910	1,000	910
Biennial Change in Expenditures				(1,592)		946		(2,654)
Biennial % Change in Expenditures				(36)		33		(93)
Gov's Exp Change from Base								(3,600)
Gov's Exp % Change from Base								(95)
Full-Time Equivalents	2.0	11.3	1.8	1.8	1.8	1.8	1.8	1.8

(Dollars in Thousands)

6000 - Miscellaneous Agency

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	391	297	387	180	180	180	180	180
Receipts	2,593	3,112	3,242	3,480	3,500	3,500	3,500	3,500
Expenditures	**2,687**	**3,025**	**3,449**	**3,480**	**3,500**	**3,500**	**3,500**	**3,500**
Balance Forward Out	297	384	180	180	180	180	180	180
Biennial Change in Expenditures				1,218		71		71
Biennial % Change in Expenditures				21		1		1
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

Program: Direct Care and Treatment
Activity: DCT Operations

mn.gov/dhs/people-we-serve/people-with-disabilities/services/direct-care-treatment/

AT A GLANCE

- DCT offers programs in over 200 sites throughout Minnesota.
- We provide services to over 12,000 individuals annually.
- There are over 4,500 employees in DCT with an annual budget of over $450 million.
- The structure of budget activities within Direct Care and Treatment has been changed significantly with the FY2018-19 biennium. The overall level of spending in DCT was $ 418.1 million in FY2015, which represents 2.7% of the Department's overall budget.

PURPOSE & CONTEXT

Direct Care and Treatment (DCT) Operations provides administrative and support services to the Direct Care and Treatment Administration within the Department of Human Services (DHS). DCT, as a health care system, provides a wide range of services to individuals with behavioral health needs. These services are provided throughout the state. DCT Operations provides the daily core services to support the 24/7 operations of sites that include psychiatric hospitals, residential treatment sites, vocational services, secure facilities and community clinics. We provide compliance, financial management, facilities management, staff learning and development, Health Information Management, and other administrative and support functions necessary to assure the programs within DCT have the necessary support to care for the individuals they serve.

SERVICES PROVIDED

The Direct Care and Treatment (DCT) Administration provides overall executive leadership and direction of the organization to support the strategic direction of the administration.

Our **Compliance Office** is responsible for managing the relationships with several regulating entities that provide oversight to DCT programs. The staff in this area work with program staff to assure that the programs understand the regulatory, court and legislative requirements and that all standards are being followed.

Our **Health Information Management Services (HIMS)** manages all patient and client records to assure that information is properly documented and protected. HIMS provides support to the direct care staff to assure medical records are updated, laws are followed related to civil commitment, records are properly stored and access to private information is appropriate and documented.

Our **Utilization Management** is responsible for assuring that all patient care is appropriate and is being provided within the right level of care. When individuals are being served in the proper level of care they are able to receive the most appropriate services to meet their needs. Services can then be billed which allows the state to recapture the cost of serving the individual.

On-going training is essential to providing quality care within a health care organization. Our **Learning and Development** office ensures that staff have the necessary training needed to meet regulatory standards and to best serve the individuals in our care. Each division within DCT has a team of individuals that help to see that training is adequate and complete and that ongoing training supports the needs of the employees and is appropriately documented.

Performance Improvement is a regulatory compliance requirement. This office ensures our programs meet quality assurance and performance improvement standards. Performance improvement projects are done with a goal of improving the processes and systems that support our healthcare services. Projects allow us to be pro-active in identifying areas of risks and potential problems but also to respond to a problem that has been identified by an oversight entity so measures can be put in place to eliminate future risks.

Our **Safety and Infection Control** staff ensure that standards set by various licensing agencies are in place to protect the people we serve and our staff. On-going identification of hazards assures that practices are put in place to maintain safety and supports the business continuity planning and emergency response by the organization. This includes the ongoing monitoring of things such as tuberculosis, influenza, safe patient handling, falls prevention, and safe operation of equipment.

Our **Financial Management** office provides fiscal services and controls the financial transactions and reporting to assure prudent use of public resources. Core functions in this area include preparing operating and legislative budget requests, patient services billing and accounts receivable, contract management support, accounts payable, Medicare and/or Medicaid Cost reporting for our hospitals and clinics, financial reporting, and resident trust services for our institutional patients and clients.

Our **Facilities Management** unit is responsible for buildings occupied by DCT programs including the strategic planning necessary to complete Capital Budget requests. Core functions include leasing of space for DCT, project management of design and construction projects and strategic planning to meet on-going needs of our programs.

RESULTS

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quantity	The number of background checks completed for hand gun permits [1]	7,766	10,118	FY14 & FY16
Quantity	The number of requests for releasing client specific information	1,409	2,085	FY14 & FY16
Quantity	The number of unique claims processed for client billings	138,258	140,203	FY14 & FY16

[1] DCT HIMS staff complete the process as required under Minnesota Statute 245.041 to provide commitment information to local law enforcement agencies for the sole purpose of facilitating a firearms background check.

Minnesota Statutes sections 246.01 to 246.70 (https://www.revisor.mn.gov/statutes/?id=246) provide the legal authority for Direct Care and Treatment State Operated Services.

NOTE: The budget structure for DHS Direct Care and Treatment programs was modified for the 2018-2019 Biennial Budget. In order to better reflect the services provided and administrative structures supporting them, this budget brings all of DCT under a single Budget Program housing five Budget Activities that better reflect services provided and populations served by DCT.

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
1000 - General	0	25	0	0	33,278	33,278	41,510	42,961
2000 - Restrict Misc Special Revenue	2,921	2,919	2,660	4,673	4,013	3,878	4,013	3,878
2001 - Other Misc Special Revenue	423	874	720	750	750	750	750	750
2403 - Gift	0	0	0	0	0	0	0	0
Total	**3,345**	**3,818**	**3,380**	**5,423**	**38,041**	**37,906**	**46,273**	**47,589**
Biennial Change				1,640		67,144		85,059
Biennial % Change				23		763		966
Governor's Change from Base								17,915
Governor's % Change from Base								24

Expenditures by Category

Compensation	3,060	1,554	1,293	2,473	32,024	32,024	36,226	37,677
Operating Expenses	231	2,208	2,073	2,950	5,767	5,632	9,797	9,662
Other Financial Transactions	34	17	10	0	250	250	250	250
Grants, Aids and Subsidies	17	5	4	0	0	0	0	0
Capital Outlay-Real Property	2	34	0	0	0	0	0	0
Total	**3,345**	**3,818**	**3,380**	**5,423**	**38,041**	**37,906**	**46,273**	**47,589**
Full-Time Equivalents	**32.3**	**18.1**	**11.7**	**25.7**	**245.9**	**241.5**	**279.5**	**282.9**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Direct Appropriation	0	35	0	0	42,244	42,244	50,476	51,927
Net Transfers					(8,966)	(8,966)	(8,966)	(8,966)
Cancellations	0	11	0	0	0	0	0	0
Expenditures	0	**25**	0	0	**33,278**	**33,278**	**41,510**	**42,961**
Biennial Change in Expenditures				(25)		66,556		84,471
Biennial % Change in Expenditures				(100)				
Gov's Exp Change from Base								17,915
Gov's Exp % Change from Base								27
Full-Time Equivalents	0.0	0.0	0.0	0.0	220.2	215.8	253.8	257.2

2000 - Restrict Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	851	852	628	1,068	280	145	280	145
Receipts	2,784	2,731	3,123	3,884	3,878	3,878	3,878	3,878
Net Transfers		(37)	(23)					
Expenditures	**2,921**	**2,919**	**2,660**	**4,673**	**4,013**	**3,878**	**4,013**	**3,878**
Balance Forward Out	714	628	1,068	280	145	145	145	145
Biennial Change in Expenditures				1,493		558		558
Biennial % Change in Expenditures				26		8		8
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0
Full-Time Equivalents	32.3	18.1	11.7	25.7	25.7	25.7	25.7	25.7

2001 - Other Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	562	453	285	188	188	188	188	188
Receipts	314	707	623	750	750	750	750	750
Expenditures	**423**	**874**	**720**	**750**	**750**	**750**	**750**	**750**
Balance Forward Out	453	285	188	188	188	188	188	188
Biennial Change in Expenditures				172		30		30
Biennial % Change in Expenditures				13		2		2
Gov's Exp Change from Base								0

(Dollars in Thousands)

2001 - Other Misc Special Revenue

Gov's Exp % Change from Base							0

2400 - Endowment

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	60	60	60	61	61	61	61	61
Receipts	0	0	0	0	0	0	0	0
Balance Forward Out	60	60	61	61	61	61	61	61

2403 - Gift

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	8	8	8	8	8	8	8	8
Receipts	0	0	0	1	0	0	0	0
Expenditures	**0**	0	**0**	0	0	0	0	0
Balance Forward Out	8	8	8	8	8	8	8	8
Biennial Change in Expenditures				0		0		0
Biennial % Change in Expenditures				(85)		(100)		(100)
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

4100 - Sos Tbi & Adol Ent Svcs

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	106	107	107	108	108	108	108	108
Receipts	0	1	1	1	1	1	1	1
Balance Forward Out	107	107	108	108	108	108	108	108

6000 - Miscellaneous Agency

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	166	167	168	169	170	171	170	171
Receipts	1	1	1	1	1	1	1	1
Net Transfers	0							
Balance Forward Out	167	168	169	170	171	171	171	171

6000 - Miscellaneous Agency

Program: Fiduciary Activities
Activity: Fiduciary Activities

mn.gov/dhs/people-we-serve/children-and-families/services/child-support/

AT A GLANCE

- In FY2015 roughly $657 million was collected and dispersed through this budget activity.
- Child Support program payments are the bulk of this activity, amounting to $624.5 million in the same year.
- All funds spending for the Fiduciary Activities activity for FY 2015 was $656.8 million.

PURPOSE & CONTEXT

The Fiduciary Activities budget program:

- Collects money from individuals and organizations (for example people who owe child support)
- Distributes the collected funds to people owed the money (such as children receiving child support)

Because these are not state funds and belong to others, they are not included in the state's budget or consolidated fund statement.

SERVICES PROVIDED

The following services make up most of the transactions of this budget activity:

- **Child Support Payments:** Payments made to custodial parents, collected from non-custodial parents
- **Recoveries:** Money recovered from clients that cannot be processed in the state computer systems. Funds are held here until they can be credited to the correct area, such as to:
  - US Treasury
  - Supplemental Security Income (SSI)
  - Counties
  - Clients
- **Long Term Care Penalties:** These are funds collected by the federal government (Centers for Medicare and Medicaid Services) related to penalties for nursing home violations. We use these to fund approved projects to improve nursing homes.

RESULTS

The Child Support Program makes timely distribution of collected child support payments to custodial parents and ranks in the top tier of states in terms of percent collections and payments on both current obligations and arrears.

State Performance on Current Obligations

State	FFY 2014 (%)	Due 2014 in Millions ($)	Paid 2014 in Millions ($)	FFY 2013 (%)	FFY 2012 (%)
Pennsylvania	83.5	1,299	1,085	83.6	83.9
North Dakota	74.1	108	80	74.3	75.1
Iowa	73.9	331	245	73.9	72.8
Wisconsin	73.0	684	500	72.5	71.6
Minnesota	**72.4**	**631**	**457**	**71.8**	**71.3**

State Performance on Obligations in Arrears

State	FFY 2014 (%)	Cases with Arrears (2014)	Cases with Payment Towards Arrears (2014)	FFY 2013 (%)	FFY 2012 (%)
Pennsylvania	83.5	292,082	243,949	83.4	83.4
Vermont	71.6	15,655	11,216	69.7	70.0
Iowa	71.0	136,092	96,752	71.3	70.5
Minnesota	**70.9**	**191,267**	**135,784**	**70.4**	**70.5**
Wyoming	70.7	28,467	20,142	69.5	71.4

Source: 2015 Minnesota Child Support Performance Report (https://edocs.dhs.state.mn.us/lfserver/Public/DHS-4252P-ENG)

Several state statutes underlie the activities in the Fiduciary Activities budget program. These statutes are M.S. sections 256.741 (https://www.revisor.mn.gov/statutes/?id=256.741), 256.019 (https://www.revisor.mn.gov/statutes/?id=256.019), 256.01 (https://www.revisor.mn.gov/statutes/?id=256.01), and 256B.431 (https://www.revisor.mn.gov/statutes/?id=256B.431).

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
2000 - Restrict Misc Special Revenue	2,630	2,717	2,114	2,500	2,500	2,500	2,500	2,500
6000 - Miscellaneous Agency	30,685	29,630	29,678	210,558	209,122	209,122	209,122	209,122
6003 - Child Support Enforcement	624,394	624,544	615,740	640,336	640,336	640,336	640,336	640,336
Total	**657,709**	**656,891**	**647,531**	**853,394**	**851,958**	**851,958**	**851,958**	**851,958**
Biennial Change				186,326		202,991		202,991
Biennial % Change				14		14		14
Governor's Change from Base								0
Governor's % Change from Base								0

Expenditures by Category

Compensation	13	0	0	0	0	0	0	0
Operating Expenses	5,742	5,982	4,866	5,080	5,080	5,080	5,080	5,080
Other Financial Transactions	637,135	635,927	627,668	652,611	652,611	652,611	652,611	652,611
Grants, Aids and Subsidies	14,819	14,982	14,997	195,703	194,267	194,267	194,267	194,267
Total	**657,709**	**656,891**	**647,531**	**853,394**	**851,958**	**851,958**	**851,958**	**851,958**
Full-Time Equivalents	**0.2**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

(Dollars in Thousands)

2000 - Restrict Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	4,592	6,362	5,699	4,691	4,809	4,739	4,809	4,739
Receipts	5,109	3,260	2,752	3,535	3,755	3,630	3,755	3,630
Net Transfers	(709)	(1,230)	(1,646)	(917)	(1,325)	(1,030)	(1,325)	(1,030)
Expenditures	**2,630**	**2,717**	**2,114**	**2,500**	**2,500**	**2,500**	**2,500**	**2,500**
Balance Forward Out	6,362	5,675	4,691	4,809	4,739	4,839	4,739	4,839
Biennial Change in Expenditures				(733)		386		386
Biennial % Change in Expenditures				(14)		8		8
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

6000 - Miscellaneous Agency

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	1,865	1,968	4,618	3,720	0	0	0	0
Receipts	30,915	30,827	28,780	206,838	209,122	209,122	209,122	209,122
Net Transfers	(142)	(5)						
Expenditures	**30,685**	**29,630**	**29,678**	**210,558**	**209,122**	**209,122**	**209,122**	**209,122**
Balance Forward Out	1,953	3,160	3,720	0	0	0	0	0
Biennial Change in Expenditures				179,921		178,009		178,009
Biennial % Change in Expenditures				298		74		74
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0
Full-Time Equivalents	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0

6003 - Child Support Enforcement

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	9,709	9,811	9,904	9,380	0	0	0	0
Receipts	624,495	624,637	615,216	630,956	640,336	640,336	640,336	640,336
Expenditures	**624,394**	**624,544**	**615,740**	**640,336**	**640,336**	**640,336**	**640,336**	**640,336**
Balance Forward Out	9,811	9,904	9,380	0	0	0	0	0
Biennial Change in Expenditures				7,138		24,596		24,596
Biennial % Change in Expenditures				1		2		2
Gov's Exp Change from Base								0

6003 - Child Support Enforcement

Gov's Exp % Change from Base			0

Program: Technical Activities
Activity: Technical Activities

AT A GLANCE

- Processed roughly $349 million in federal administrative reimbursement to counties, tribes and other local agencies during FY 2015.
- Processes and returns roughly $40 million each year in administrative reimbursements to the state Treasury.
- All funds spending for the Technical Activities activity for FY 2015 was $499 million.

PURPOSE & CONTEXT

The Technical Activities budget program includes transfers and expenditures between federal grants, programs and other agencies that would result in misleading distortions of the state's budget if the Department of Human Services did not account for them in a separate budget activity. This arrangement helps us to make sure that these transfers and expenditures are still properly processed in the state's accounting system and helps us comply with federal accounting requirements.

SERVICES PROVIDED

We include several different types of inter-fund and pass through expenditures 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 the general fund, health care access fund or special revenue fund under state law and policy.
- Transfers between federal grants, programs and state agencies that are accounted for as expenditures in the state's SWIFT accounting system.
- Other technical accounting transactions.

Staff members in our Operations Administration, which is part of our Central Office, are responsible for the accounting processes we use to manage the Technical Activities budget program.

RESULTS

We maintain necessary staff and information technology resources to adequately support accurate, efficient, and timely federal fund cash management. We measure the percentage of federal funds deposited within two working days.

Type of Measure	*Name of Measure*	*Previous*	*Current*	*Dates*
Quality	Percent of federal fund deposit transactions completed (deposited in State treasury) within two working days of the amount being identified by the SWIFT accounting system.	94%	98.5%	FY2013 to FY2015

M.S. sections 256.01 (https://www.revisor.mn.gov/statutes/?id=256.01)to 256.011 (https://www.revisor.mn.gov/statutes/?id=256.011) and Laws 1987, chapter 404, section 18, provide the overall state legal authority for DHS's Technical Activities budget program.

(Dollars in Thousands)

Expenditures By Fund

	Actual FY14	Actual FY15	Actual FY16	Estimate FY17	Forecast Base FY18	Forecast Base FY19	Governor's Recommendation FY18	Governor's Recommendation FY19
2000 - Restrict Misc Special Revenue	3,307	3,607	3,510	3,913	3,913	3,913	3,913	3,913
2001 - Other Misc Special Revenue	3,059	4,493	4,389	4,442	4,151	4,151	4,151	4,151
3000 - Federal	523,632	527,123	599,321	616,780	623,353	622,483	623,353	622,483
3001 - Federal TANF	78,930	75,215	81,708	83,870	84,384	84,258	84,384	84,258
Total	**608,928**	**610,437**	**688,928**	**709,005**	**715,801**	**714,805**	**715,801**	**714,805**
Biennial Change				178,568		32,672		32,672
Biennial % Change				15		2		2
Governor's Change from Base								0
Governor's % Change from Base								0

Expenditures by Category

Operating Expenses	197,240	196,411	229,681	242,392	250,173	249,303	250,173	249,303
Other Financial Transactions	4,653	6,449	6,306	5,570	5,570	5,570	5,570	5,570
Grants, Aids and Subsidies	407,036	407,577	452,940	461,043	460,058	459,932	460,058	459,932
Total	**608,928**	**610,437**	**688,928**	**709,005**	**715,801**	**714,805**	**715,801**	**714,805**
Full-Time Equivalents	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

(Dollars in Thousands)

1000 - General

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Direct Appropriation	0	455,000	0	0	0	0	0	0
Net Transfers		(455,000)						

2000 - Restrict Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	1,077	908	95	40	17	17	17	17
Receipts	78	62	41	60	60	60	60	60
Net Transfers	3,037	2,760	3,415	3,829	3,853	3,853	3,853	3,853
Expenditures	**3,307**	**3,607**	**3,510**	**3,913**	**3,913**	**3,913**	**3,913**	**3,913**
Balance Forward Out	886	122	40	17	17	17	17	17
Biennial Change in Expenditures				509		403		403
Biennial % Change in Expenditures				7		5		5
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

2001 - Other Misc Special Revenue

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	385	210	478	628	0	0	0	0
Receipts	1,343	1,666	1,799	180	180	180	180	180
Net Transfers	1,597	3,094	2,740	3,634	3,970	3,970	3,970	3,970
Expenditures	**3,059**	**4,493**	**4,389**	**4,442**	**4,151**	**4,151**	**4,151**	**4,151**
Balance Forward Out	268	478	628	0	0	0	0	0
Biennial Change in Expenditures				1,280		(530)		(530)
Biennial % Change in Expenditures				17		(6)		(6)
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

2360 - Health Care Access

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Net Transfers		455,000						

(Dollars in Thousands)

2360 - Health Care Access

Cancellations	0	455,000	0	0	0	0	0	0

3000 - Federal

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	545	1,387	344	245	0	0	0	0
Receipts	523,323	526,014	599,223	616,535	623,354	622,484	623,354	622,484
Expenditures	**523,632**	**527,123**	**599,321**	**616,780**	**623,353**	**622,483**	**623,353**	**622,483**
Balance Forward Out	235	279	245	0	0	0	0	0
Biennial Change in Expenditures				165,346		29,735		29,735
Biennial % Change in Expenditures				16		2		2
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

3001 - Federal TANF

	Actual	Actual	Actual	Estimate	Forecast Base		Governor's Recommendation	
	FY14	FY15	FY16	FY17	FY18	FY19	FY18	FY19
Balance Forward In	12,062	25,403	44,875	63,858	40,016	15,336	40,016	15,336
Receipts	92,271	94,687	100,691	60,028	59,704	68,922	59,704	68,922
Expenditures	**78,930**	**75,215**	**81,708**	**83,870**	**84,384**	**84,258**	**84,384**	**84,258**
Balance Forward Out	25,403	44,875	63,858	40,016	15,336	0	15,336	0
Biennial Change in Expenditures				11,432		3,064		3,064
Biennial % Change in Expenditures				7		2		2
Gov's Exp Change from Base								0
Gov's Exp % Change from Base								0

FY 2018-19 Federal Funds Summary

(Dollars in Thousands)

Federal Agency and CFDA#	Federal Award, Grant Purpose, People Served	SFY 2016 Actuals	SFY 2017 Budget	SFY 2018 Base	SFY 2019 Base	Required State Match or MOE Y /N	FTE
Dept. of Health & Human Services, CMS 93.506	ACA-Nationwide Program for National and State Background Checks for Direct Patient Access Employees of Long-term Care Facilities and Providers: DHS conducts background studies for health and human services programs licensed by DHS, MDH, and some at the Department of Corrections (DOC). This new grant will provide increased fingerprint identification resources and will include a "rap back" feature to identify staff who may need to be disqualified after the initial routine background check.	$1,191	$1,509	$1,153	$1,153	Yes	9.0
Dept. Of Agriculture, Food and Nutrition Service 10.551	Supplemental Nutrition Assistance Program (SNAP): Provides help with food for more than 475,000 persons per month receiving an average monthly payment of $108.	$569,390	$590,609	$591,468	$593,844	No	0.0
Dept. of Health & Human Services, Admin.for Children and Families 93.558	Temporary Assistance for Needy Families (TANF) Block Grant: Grants to assist needy families with children so that children can be cared for in their own homes; to reduce dependency by promoting job preparation, work, and marriage; to reduce and prevent out-of-wedlock pregnancies; and to encourage the formation and maintenance of two-parent families. These funds are used to provide grants to counties and tribes to provide support services for Minnesota Family Investment Program (MFIP)/Diversionary Work Program (DWP) participants that include job search/skills, adult basic education, GED classes, job coaching, short-term training, county programs to help with emergency needs, and help accessing other services such as child care, medical care and CD/Mental health services. In 2015, an average of 27,000 people were enrolled in employment services each month. TANF also helps fund the MFIP/DWP cash benefit program and child care assistance programs as well as other	$237,044	$272,566	$276,251	$266,905	Yes	14.7

Federal Agency and CFDA#	Federal Award, Grant Purpose, People Served	SFY 2016 Actuals	SFY 2017 Budget	SFY 2018 Base	SFY 2019 Base	Required State Match or MOE Y /N	FTE
	programs that help low-income families with children.						
Dept. of Health &Human Services; Admin. For Children & Families 93.575 and 93.596	Child Care and Development Block Grant (CCDF): Provides funds to States to increase the availability, affordability, and quality of child care services for low-income families where the parents are working or attending training or educational programs. This grant helps fund the Minnesota Family Investment Program (MFIP) and Basic Sliding Fee Child Care Assistance Programs that help low-income families pay for child care so that parents may pursue employment or education leading to employment. Also funded are Child Care Development Grants that promote services to improve school readiness, and the quality and availability of child care in Minnesota. In FY 2013, an average of 16,988 families per month received child care assistance subsidies. Also in FY 2013, 19,500 parents received referrals to find child care and child care-related training was provided to more than 32,000attendees through Child Care Resource & Referral agencies.	$132,960	$138,138	$130,213	$130,213	93.575-Yes 93.596 - No	33.9
Dept. of Health & Human Services, CMS	Federal Basic Health Funding: The MinnesotaCare program is currently operating as a federal basic health plan (BHP) under sectrion 1331 of the Affordable Care Act. Under the BHPHS currently recieves federal basic health plan funding equal to 95 percent of federal tax credits and cost sharing subsidies available to people who would otherwise enroll in a health insurance exchange. This funding supports comprehensive health care coverage for 110,000 lower income Minnesotans.	$333,992	$364,218	$399,644	$411,176	Yes	0.0
Dept. of Health & Human Services, CMS 93.777	State Survey and Certification of Health Care Providers and Suppliers: This grant provides funding for a contract with Minnesota Department of Health (MDH) to certify nursing homes and rehabilitation providers in accordance with requirements from the Centers for Medicare and Medicaid Services. These providers may not participate in the Medicaid program unless they are certified.	$8,523	$8,523	$8,523	$8,523	Yes	0.0

Federal Agency and CFDA#	Federal Award, Grant Purpose, People Served	SFY 2016 Actuals	SFY 2017 Budget	SFY 2018 Base	SFY 2019 Base	Required State Match or MOE Y /N	FTE
Dept. of Health & Human Services, CMS	Medical Assistance Program: Medicaid program grants provide comprehensive health care coverage and access to long term care services and supports to an average 1.1 million uninsured or underinsured Minnesotans who meet income and other eligibility requirements. This program is managed by the state under guidance from the federal government. The amounts reported here are the federal share of spending for this joint federal-state program.	$6,428,039	$6,255,439	$6,974,475	$7,231,942	Yes	0.0
Dept. of Health & Human Services, CMS 93.778	Medcial AssistanceProgram: The Federal Children's Health Insurance Program (SCHIP) grants provide coverage to over 3,500 uninsured low-income children and pregnant women who do not qualify for regular Medicaid. Minnesota also applies a portion of its federal CHIP allotment to enhance the regular 50 percent federal share for children on Medical Assistance with household incomes above 138 percent of poverty.	$90,860	$109,252	$97,486	$97,486	Yes	0.0
Dept. of Health &Human Services, CMS 93.778	Medical Assistance Program: The state earns administrative FFP for activities which support Medical Assistance (MA) which is Minnesota's Medicaid program. This grant is an administrative pass-through of federal financial participation (FFP) to counties, DHS systems, and the state general fund for approved MA administrative activities.	$358,488	$442,479	$453,317	$454,390	Yes	0.0
Dept. of Health & Human Services, CMS 93.778	State Innovation Model Testing: This grant builds upon the Minnesota health care delivery system reforms with a focus on patient centered services across a continuum of health care, mental health, long-term care , and other services. The goal of this grant is to create multi-payer models with a broad mission to raise community health status and reduce long term health risks for beneficiaries of Medicare, Medicaid, and CHIP. The Minnesota Accountable Health Model will offer a comprehensive, statewide, imitative to close the current gaps in health information technology, secure exchange health information, quality improvement infrastructure, and workforce capacity needed to provide team-based coordinated care.	$16,480	$16,283	$5,305	$0	No	8.0

Federal Agency and CFDA#	Federal Award, Grant Purpose, People Served	SFY 2016 Actuals	SFY 2017 Budget	SFY 2018 Base	SFY 2019 Base	Required State Match or MOE Y /N	FTE
Dept. of Health & Human Services, Substance Abuse & Mental Health Administration 93.959	Block Grants for Prevention and Treatment of Substance Abuse: The Consolidated Chemical Dependency Treatment Fund (CCDTF) combines otherwise separate funding sources – the federal Substance Abuse, Prevention and Treatment block grant, MA, Minnesota Care and other state appropriations – into a single fund. (The CCDTF provides funding for residential and non-residential addiction treatment services for eligible low-income Minnesotans who have been assessed as needing treatment for chemical abuse or dependency. In CY2013 there were 51,203 substance abuse treatment admission for Minnesota residents, the CCDTF fund covered services for 22,526 (44%) of these admissions. Almost all treatment providers in the state are enrolled as CCDTF providers). These amounts are the federal CD block grant.	$24,480	$24,876	$24,805	$24,805	Yes	31.7
Dept. Of Agriculture, Food and Nutrition Service 10.561	State Administrative Matching Funds for the Supplemental Nutrition Assistance Program (SNAP): These service grants represent revenues to the general fund from the federal Supplemental Nutrition Assistance Program (SNAP) Employment & Training program which provides 50% federal matching funds for support services such as child care and other employment supports provided to eligible SNAP recipients. There are approximately 39,900 participants in SNAP employment and training activities during the year. Matching funds for child care and diversionary work program end 6/30/17.	$6,814	$10,645	$7,245	$7,245	Yes	0.0
Dept. of Health & Human Services; Admin. for Children & Families 93.563	Child Support Enforcement: This funding is the federal financial participation (FFP) for the Supreme Court, Department of Corrections, county federal incentives, County Income Maintenance (both administrative and indirect costs), systems fund, general fund and 1115 grants.	$113,142	$118,744	$118,744	$118,744	Yes	0.0

Federal Agency and CFDA#	Federal Award, Grant Purpose, People Served	SFY 2016 Actuals	SFY 2017 Budget	SFY 2018 Base	SFY 2019 Base	Required State Match or MOE Y /N	FTE
Dept. of Health & Human Services, Admin.for Children and Families 93.597	Grants to States for Access & Visitation Programs: Grant provides recources to states to help establish programs to support and facilitate noncustodial parents' access to and visitation of their children. The grant went to two grantees in FFY15, FamilyWise Services and Central Minnesota Legal Services. The grant served approximately 437 families in FFY 2015.	$188	$312	$138	$138	No	0.0
Dept. of Health & Human Services, Admin for Children & Families	Federal financial participation (FFP) to states who opt to provide guardianship assistance payments for the care of children by relatives who have assumed legal guardianship of eligible children for whom they previously cared as foster parents. This assistance is intended to prevent inappropriately long stays in foster care and to promote the healthy development of children through increased safety, permanency, and well-being.	$754	$3,240	$3,240	$3,240	Yes	0.0
Dept. of Health & Human Services: Admin. for Children & Families 93.556	Promoting Safe and Stable Families(Tit;e IV-B2 Child Welfare Program): Grant provides funds to help prevent the unnecessary separation of children from their families, improve the quality of care and services to children and their families, and ensure permanency for children by reuniting them with their parents, by adoption or by another permanent living arrangement. Funding provides grants to community-based agencies, counties and tribes to provide services to families to reduce the risk of maltreatment, to prevent child maltreatment and improve family functioning for families reported to child protection services, and provide child protective services to strengthen families and prevent out-of-home placement when it is safe to do. This grant helps serve approximately 20,000 families.	$2,376	$3,622	$3,620	$3,620	Yes	3.6

Federal Agency and CFDA#	Federal Award, Grant Purpose, People Served	SFY 2016 Actuals	SFY 2017 Budget	SFY 2018 Base	SFY 2019 Base	Required State Match or MOE Y /N	FTE
Dept. of Health & Human Services; Admin. for Children & Families 93.556	Promoting Safe and Stable Families: Child Welfare Phase 1 Planning: This is a federal (Children's Bureau) planning grant to study the intersection of foster care and homelessness and to plan an intervention for older foster youth (14 – 21) to prevent homelessness. The planning grant began October 1, 2013 and ended Sept. 30, 2015. DHS did not receive an implementation grant.	$20	$0	$0	$0	No	1.0
Dept. of Health & Human Services: Admin. for Children & Families 93.590	Community-Based Child Abuse Prevention Grants (Child Trust Fund) : Grant supports community-based efforts to develop, operate, expand, and enhance, and coordinate initiatives, programs, and activities to prevent child abuse and neglect and to support the coordination of resources and activities to better strengthen and support families to reduce the likelihood of child abuse and neglect; and (2) to foster understanding, appreciation and knowledge of diverse populations in order to effectively prevent and treat child abuse and neglect. Funds provide grants to community based agencies (such as non-profits, school districts, and human service agencies) to provide services to families to reduce the risk of child maltreatment and enhance family capacities.	$1,529	$2,157	$2,051	$2,051	Yes	1.4
Dept. of Health & Human Services, Admin. for Children & Families 93.599	Chafee Education and Training Vouchers Program (ETV): Grant provides resources to States to make available vouchers for postsecondary training and education to help defray the costs of post-secondary education to 119 youth who aged-out of foster case at age 18 in FY 2016, were adopted from foster care on or after their 16th birthday, or custody was transferred to a relative from foster care on or after their 16th birthday.	$672	$833	$833	$683	Yes	0.7
Dept. of Human Services: Admin. for Children & Families 93.603	Adoption Incentive Payments: provide incentives to States to increase annually the number of foster child adoptions, special needs adoptions, and older child adoptions. These funds are used for grants to providers for adoption-related services, including post adoption.	$23	$173	$87	$87	No	0.0

Federal Agency and CFDA#	Federal Award, Grant Purpose, People Served	SFY 2016 Actuals	SFY 2017 Budget	SFY 2018 Base	SFY 2019 Base	Required State Match or MOE Y /N	FTE
Dept. of Health Human Services; Admin. For Children & Families 93.643	Children's Justice Grants to States: Grants to encourage states to enact reforms designed to improve (1) the assessment and investigation of suspected child abuse and neglect cases, including cases of suspected child sexual abuse and exploitation, in a manner that limits additional trauma to the child and the child's family; (2) the assessment and investigation of cases of suspected child abuse-related fatalities and suspected child neglect-related fatalities; (3) the investigation and prosecution of cases of child abuse and neglect, including child sexual abuse and exploitation; and (4) the assessment and investigation of cases involving children with disabilities or serious health-related problems who are suspected victims of child abuse or neglect. In Minnesota these grants provide training for county and tribal law enforcement, county attorney, and county and tribal child protection professionals on assessment and investigations, including training on forensic interviewing of potential child abuse victims. This grant supports training for approximately 183 participants annually.	$378	$298	$298	$298	No	1.0
Dept. of Health & Human Services; Admin. For Children & Families 93.645	Child Welfare Services Title IV-B1: Grant to promote state flexibility in the development and expansion of a coordinated child and family services program that utilizes community-based agencies and ensures all children are raised in safe, loving families. These funds provide grants to counties and tribes to provide core child protection services to strengthen families and to prevent out-of-home placement when it is safe to do so. Grants support services to approximately 30,000 families per year.	$3,734	$4,552	$4,552	$4,552	Yes	35.5
Dept. of Health & Human Services; Admin. For Children & Families CFDA 93.658	Foster Care Title IV-E: This grant helps states provide temporary safe and stable out-of-home care for children whose parents cannot safely care for them. Of the approximately 13,600 children in out-of-home placements in 2015, foster families provided care to 10,000 of them.	$53,970	$50,143	$52,591	$54,114	Yes	0.0

Federal Agency and CFDA#	Federal Award, Grant Purpose, People Served	SFY 2016 Actuals	SFY 2017 Budget	SFY 2018 Base	SFY 2019 Base	Required State Match or MOE Y /N	FTE
Dept. of Health & Human Services, Admin. for Children & Families 93.659	Adoption Assistance: Federal financial participation for payments to individuals adopting Title IV-E special needs children. In 2015, approximately 7,127 children receive IV-E adoption assistance. This assistance is intended to prevent inappropriately long stays in foster care and to promote the healthy development of children through increased safety, permanency and well-being.	$26,397	$30,127	$34,966	$41,212	Yes	0.0
Dept. of Health &Human Services; Admin. For Children & Families CFDA 93.669	Child Abuse Prevention and Treatment Act (CAPTA): Grant is used to improve child protective services systems. In Minnesota, grants to five counties are used to administer the federally required Citizen Review Panels for child protection services. The counties are Chisago, Hennepin, Ramsey, Washington and Winona. This is a requirement of all states to be able to access other federal reimbursement.	$314	$549	$548	$549	No	3.2
Dept. of Health & Human Services, Admin. for Children & Families 93.674	Chafee Foster Care Independence Program: Federal funding passed in 1999, provides funding to and governs the program known as the Support for Emancipation and Living Functionally (SELF) Program in Minnesota. The intent of the funds is to reduce the risk that youth aging out of long term out-of-home placement will become homeless or welfare dependent. Funds are therefore awarded for the provision of services designed to help older youth, currently or formerly in out-of-home care, prepare for a successful transition to adulthood. Approximately 1,420 high-risk youth served CY 2015.	$1,775	$2,076	$1,976	$1,976	Yes	2.8
Dept. of Health & Human Services: Admin. for Children & Families 93.667	Social Service Block Grant (Title XX): Grant provides social services best suited to meet the needs of individuals that must be directed to one or more of five broad goals: Achieve or maintain economic support to prevent, reduce or eliminate dependency, achieve or maintain self-sufficiency, including reduction or prevention of dependency, preventing or remedying neglect, abuse or exploitation of children and adults unable to protect their own interest or preserving, rehabilitating or reuniting families, preventing or reducing inappropriate institutional care by providing for community-based care,	$31,587	$32,165	$32,164	$32,164	No	11.7

Federal Agency and CFDA#	Federal Award, Grant Purpose, People Served	SFY 2016 Actuals	SFY 2017 Budget	SFY 2018 Base	SFY 2019 Base	Required State Match or MOE Y /N	FTE
	home-based care or other forms of less intensive care, securing referral or admission for institutional care when other forms of care are not appropriate or providing services to individuals in institutions. Funds provide grants to counties to purchase or provide services for vulnerable children and adults who experience dependency, abuse, neglect, poverty, disability, or chronic health conditions. This grant contributes to costs for services to more than 311,000 adults and children annually. Grants also provide child care in a number of counties for children whose parents, guardian or current caretakers have changed residence recently to obtain employment in a temporary or seasonal agricultural activity (approx. 900 children per year) and grants provide legal advocacy, training and technical assistance in cases regarding custody, Children's Medicaid, permanency, adoption, tribal court proceedings, long-term foster care and others services to the Indian Child Welfare Law Center.						
Dept. Of Agriculture, Food and Nutrition Service 10.551	Supplemental Nutrition Assistance Program: SNAP reimbursement is received for some Group Residential Housing (GRH) recipients who live in certain facilities where they receive all their meals.	$16,473	$14,003	$14,003	$14,003	No	0.0
Dept. Of Agriculture, Food and Nutrition Service 10.551	Supplemental Nutrition Assistance Program (SNAP): Grant benefits cash out provided to SSI and elderly recipients.	$23,077	$21,500	$21,500	$21,500	No	0.0
Dept. of Agriculture, Food and Nutrition Service 10.561	State Administrative Matching Funds for the Supplemental Nutrition Assistance Program (SNAP): Under Federal Supplemental Nutrition Assistance Program (SNAP, formerly Food Stamps) regulations, states have the option to include nutrition education activities in the State Plan filed with the Food and Nutrition Service (FNS) of the United States Department of Agriculture. This option allows states to include the costs of nutrition education activities as administrative costs of SNAP. Minnesota adopted this option in the early 1990's. The Minnesota Department of Human Services (DHS)	$14,200	$12,639	$7,770	$7,770	Yes	2.6

Federal Agency and CFDA#	Federal Award, Grant Purpose, People Served	SFY 2016 Actuals	SFY 2017 Budget	SFY 2018 Base	SFY 2019 Base	Required State Match or MOE Y /N	FTE
	contracts with the University of Minnesota Extension (U of M), White Earth Nation, Red Lake Nation, Leech Lake Band of Ojibwe, Bois Forte Band of Chippewa, Grand Portage Band of Chippewa, Fond du Lac Band of Lake Superior Chippewa, and Mille Lacs Band of Ojibwe to provide nutrition education services.						
Dept. Of Agriculture, Food and Nutrition Service 10.561	State Administrative Matching Funds for the Supplemental Nutrition Assistance Program: Federal funds for State and County administrative costs for the Supplemental Nutrition Assistance Program (SNAP).	$52,839	$45,895	$53,517	$53,517	Yes	0.0
Dept. Of Agriculture, Food and Nutrition Service 10.561	State Administrative Matching Funds for the Supplemental Nutrition Asssitance Program: Federal funds for state and county costs related to employment and training for Supplemental Nutrition Assistance Program (SNAP) recipients.	$1,735	$1,415	$1,415	$1,415	No	2.0
Dept. Of Agriculture, Food and Nutrition Service 10.561	State Administrative Matching Funds for the Supplemental Nutrition Assistance Program (SNAP): Grants to Community Action Agencies and anti-hunger organizations to conduct statewide outreach to assist people in determining if they are eligible for SNAP benefits. Under Federal Supplemental Nutrition Assistance Program (SNAP, formerly Food Stamps/Food Support) regulations, states have the option to include outreach activities in the State Plan filed with the Food and Nutrition Service (FNS) of the United States Department of Agriculture. This option allows states to include the costs of outreach activities as administrative costs of SNAP. Costs are reimbursed by FNS at a rate of 50%. In 2016, more than 444,000 Minnesotans received nutrition assistance through the program every month.	$2,149	$2,300	$1,448	$1,448	Yes	2.0

Federal Agency and CFDA#	Federal Award, Grant Purpose, People Served	SFY 2016 Actuals	SFY 2017 Budget	SFY 2018 Base	SFY 2019 Base	Required State Match or MOE Y /N	FTE
Dept. Of Agriculture, Food and Nutrition Service 10.568	Emergency Food Assistance Program: Provides funding to States to enable processing storage and distribution costs incurred in providing food assistance to needy persons. Funds are used to Distribute U.S. Department of Agriculture (USDA) donated food commodities to individuals and families who use on-site meal programs, food shelves and shelters. This program design ensures an equitable distribution of commodities to all 87 counties.	$1,105	$816	$816	$816	Yes	1.9
Dept. of Housing and Urban Development; Office of Community Planning & Development CFDA 14.231	Emergency Solutions Grant Program: Grant provides funding to: (1) engage homeless individuals and families living on the street; (2) improve the number and quality of emergency shelters for homeless individuals and families; (3) help operate these shelters; (4) provide essential services to shelter residents, (5) rapidly re-house homeless individuals and families, and (6) prevent families and individuals from becoming homeless. This grant provides funding to shelters for operating costs, essential services, and homelessness prevention and costs to administer the federal grant. In 2016 4,369 individuals were served in shelters with these funds and 449 people were served with rapid rehousing funds.	$2,091	$2,086	$1,254	$1,254	Yes	1.0
Dept. of Health &Human Services; Admin. for Children & Families 93.569	Community Services Block Grant (CSBG): Grants to Community Action Agencies and Tribal Governments to focus local, state, private and federal resources to support low-income families and individuals to attain the skills, knowledge and motivation to become economically secure. In 2015, served 514,578 low income individuals in 201,262 families. These funds provide grants for emergencies and special projects.	$10,321	$15,279	$7,814	$7,814	No	2.9

Federal Agency and CFDA#	Federal Award, Grant Purpose, People Served	SFY 2016 Actuals	SFY 2017 Budget	SFY 2018 Base	SFY 2019 Base	Required State Match or MOE Y /N	FTE
Dept. of Health & Human Services, Admin. for Children & Families 93.566	Refugee Cash and Medical Assistance Program: Grant reimburses states for the cost of cash and medical assistance provided to refugees (and certain Amerasians from Viet Nam, Cuban and Haitian entrants, asylees, victims of a severe form of trafficking, and Iraqi and Afghan Special Immigrants) who are not eligible for the Minnesota family Investment Program or Medical assistance. Refugees and other populations are eligible for Refugee Cash or Medical Assistance during the first eight months after their arrival in the U.S. or grant of asylum. 456 cases served per month in Refugee Cash Assistance. Also funds program coordination and planning expenses of DHS Resettlement Program Office and oversight of statewide refugee health screening administration.	$2,762	$3,301	$3,398	$3,398	No	8.0
Dept. of Human Services; Admin. For Children & Families 93.566	Refugee Social Services: Grants provide funding for employment-related and other social services for refugees, certain Amerasians from Vietnam, Cuban and Haitian Entrants, asylees, victims of a severe form of trafficking, and Iraqi and Afghan Special Immigrants. An arrival must be within five years of arriving in this country or grant of asylum to be eligible for services under these grants. Approximately 4,200 individuals served annually.	$3,269	$3,869	$3,869	$3,869	No	0.0
Dept. of Human Services; Admin. For Children & Families 93.576	Services to Older Refugees: This grant has been discontinued, but the services it funded are now supported in the general Refugee Social Services grant.	($8)	$0	$0	$0	No	0.0
Dept. of Health & Human Services, Admin. for Children & Families 93.576	Refugee School Impact: Grants provide funding to school districts to achieve three student outcomes: 1) Improve academic outcomes, 2) acquisition of leadership skills, and 3) participation in mental health services if needed. 300 students served annually. The funding line eliminated as of 9/30/2017. Rolled over into Refugee Social Services.	$466	$590	$0	$0	No	0.0

Federal Agency and CFDA#	Federal Award, Grant Purpose, People Served	SFY 2016 Actuals	SFY 2017 Budget	SFY 2018 Base	SFY 2019 Base	Required State Match or MOE Y /N	FTE
Dept. of Health &Human Services, Admin. For Children & Families 93.584	Refugee Targeted Assistance Grant: Program provides funding for employment-related and other social services for refugees, certain Amerasians from Vietnam, Cuban and Haitian Entrants, asylees, victims of a severe form of trafficking, and Iraqi and Afghan Special Immigrants in areas with large refugee populations. An arrival must be within five years of arriving in this country or grant of asylum to be eligible for services under these grants. Approximately 33 people per month served.	$799	$934	$934	$934	No	0.0
Dept. of Health & Human Services: CMS 93.536	Affordable Care Act, Medicaid Incentives for Prevention of Chronic Disease Demonstration Project: These funds go to partner agencies included in the $10 million grant from the Centers for Medicare and Medicaid Services to cover costs for the study, administration, and implementation of the Diabetes Prevention Program (DPP) incentives and evaluation. The DPP provided funds to eligible clinics in the Minneapolis/St. Paul MSA to administer the DPP, targeting Medicaid participants with prediabetes or who have a history of prediabetes.	$2,087	$1,900	$1,900	$1,900	No	0.3
Dept. of Health & Human Services, CMS 93.609	Affordable Care Act (ACA); Medicaid Adult Quality Grants: This two year federal grant will support the development of at least two Medicaid quality improvement projects in Minnesota using new measures developed from claim and encounter data. Data collected through this grant will be publically reported and incorporated into quality improvement efforts.	$227	$0	$0	$0	No	0.0
Dept. of Health & Human Services, CMS 93.628	Affordable Care Act Implementation: State Demo Medcaid Enrollees Support for State Demonstraitons to Integrate Care for Medicare-Medicaid Enrollees	$495	$872	$0	$0	No	2.0

Federal Agency and CFDA#	Federal Award, Grant Purpose, People Served	SFY 2016 Actuals	SFY 2017 Budget	SFY 2018 Base	SFY 2019 Base	Required State Match or MOE Y /N	FTE
Dept. of Health & Human Services, CMS93.778	Medical Assistance Program: The Medicaid Electronic Health Record (EHR) incentive program provides eligible providers and hospitals 100% federally funded incentives to adopt meaningful electronic health record technology. DHS administration and implementation costs are funded at a 90% federal match. This funding is authorized under the American Recovery and Reinvestment Act (ARRA) through the Health Information technology for Clinical and Economic Health (HITECH) act. Funding for this project commenced in October 2012.	$31,799	$74,210	$74,210	$74,210	N0	0.0
Dept. of Health & Human Services, Admin. for Community Living 93.041	Elder Abuse Grants (Elder Abuse Prevention) : OAA grants to service providers to provide activities related to elder abuse prevention. The grant includes administrative funding to administer and implement the grant.	$91	$76	$76	$76	No	1.0
Dept. of Health & Human Services, Admin. for Community Living 93.042	Special Programs for the Aging (Ombudsman Supplement) : This OAA grant supplements funding for the Ombudsman for Long Term Care office. The principal role of the Ombudsman Program is to investigate and resolve complaints made by or on behalf of residents of nursing homes or other long-term care facilities. This grant also promote policies and practices needed to improve the quality of care and life in long-term care facilities and educate both consumers and providers about residents' rights and good care practices.	$269	$257	$257	$257	No	3.0
Dept. of Health & Human Services, Admin. for Community Living 93.043	Special Programs for the Aging (Aging Preventive Health): OAA grants to AAAs and service providers to provide preventive health information and services to seniors	$309	$317	$317	$317	Yes	0.0

Federal Agency and CFDA#	Federal Award, Grant Purpose, People Served	SFY 2016 Actuals	SFY 2017 Budget	SFY 2018 Base	SFY 2019 Base	Required State Match or MOE Y /N	FTE
Dept. of Health & Human Services: Admin. for Community Living 93.044	Special Programs for the Aging (Aging Social Services) : OAA grants to AAAs and local providers to provide a variety of community-based social services. OAA grants to AAAs for administrative purposes, program development and coordination activities. The grant includes administrative funding to administer and implement the grant.	$7,163	$7,253	$7,253	$7,253	Yes	10.2
Dept. of Health & Human Services, Admin. for Community Living 93.045	Special Programs for the Aging: Older Americans Act (OAA) grants to AAAs and service providers to provide home delivered meal services targeted to seniors in the greatest economic and social need. (Funding coordinated with the general fund Senior Nutrition grant)	$2,529	$3,200	$3,200	$3,200	Yes	2.0
Dept. of Health & Human Services, Admin. for Community Living 93.045	Special Programs for the Aging (Congregate Meals) : OAA grants to AAAs and service providers to provide congregate meal services targeted to seniors in the greatest economic and social need. The grant is coordinated with the state funded Senior Nutrition grant. This grant includes administrative funding to administer and implement the grant.	$5,660	$6,250	$6,250	$6,250	Yes	2.0
Dept. of Human Services, Admin. for Community Living 93.048	Special Programs for the Aging (MN Medcial Care Demo Project): Grants to Area Agencies on Aging (AAA's) and service providers to help seniors obtain health insurance benefits and report fraud, waste and abuse within the health care system.	$174	$277	$249	$249	No	1.7
Dept. of Health & Human Services: Admin. for Community Living 93.048	Special Programs for the Aging: CMS grants to AAAs to increase capacity to provide information and assistance regarding Medicare. The grant funding also includes administrative funds to administer and implement the grant.	$116	$192	$192	$192	Yes	0.0
Dept. of Health & Human Services: Admin. for Community Living 93.048	Affordable Care Act, Medicare Improvements for Patients and Providers (MIPPA) ACL grants to ADRC's to increase capacity to provide information and assistance regarding Medicare.	$160	$102	$102	$102	Yes	0.0

Federal Agency and CFDA#	Federal Award, Grant Purpose, People Served	SFY 2016 Actuals	SFY 2017 Budget	SFY 2018 Base	SFY 2019 Base	Required State Match or MOE Y /N	FTE
Dept. of Health & Human Services: Admin. for Community Living 93.048	Special Programs for the Aging(AOA Evidenced Based Grants) : Grant from OAA to 1) integrate a statewide set of services and supports through a fully coordinated single entry point system, with a particular focus on care transitions; and (2) ensure access to a consistent set of essential services, evidence-based risk management and self-directed in-home supports to high risk individuals, including those with dementia, family caregivers and veterans. This grant includes administrative funding to administer and implement the grant. Grant discontinued after FY2016	$198	$0	$0	$0	Yes	0.0
Dept. of Health & Human Services, Admin. for Community Living93.051	Alzheimer's Disease Demonstration Grants to States: Grant from OAA that will: (1) integrate a statewide set of services/supports through a fully coordinated dementia capable single entry point with a particular focus on care transitions in cooperation with health care homes; and (2) ensure seamless regional access to a consistent set of high quality, sustainable, dementia capable evidence-based/informed supports for persons with dementia and their caregivers.	$92	$248	$35	$2	Yes	0.0
Dept. of Health & Human Services, Admin. for Community Living 93.052	National Family Caregiver Support (3E Care Giver Grants) : OAA grants to AAAs and service providers to provide information, respite, education, training and support groups to family caregivers. The grant also includes 3E Grandparents Raising Grandchildren Grants and 3E Statewide Activites Grant. In addition, the grant is to a service provider to provide caregiver support services to grandparents raising their grandchildren. The grant also provides statewide training, education and caregiver support activities.	$1,735	$2,400	$2,400	$2,400	Yes	2.0
Dept. of Health & Human Services, Admin. for Community Living 93.053	Nutrition Services Incentive Program (NSIP): OAA grants to AAAs and local nutrition providers as a separate allocation based on the number of meals served in the previous project year. (This grant is coordinated with general fund Senior Nutrition funding).	$1,859	$1,900	$1,900	$1,900	Yes	0.0

Federal Agency and CFDA#	Federal Award, Grant Purpose, People Served	SFY 2016 Actuals	SFY 2017 Budget	SFY 2018 Base	SFY 2019 Base	Required State Match or MOE Y /N	FTE
Dept. of Health & Human Services: Admin. for Community Living 93.518	Affordable Care Act, Medicare Improvements for Patients and Providers (MIPPA) ACL grants to ADRC's to increase capacity to provide information and assistance regarding Medicare.	$123	$107	$107	$107	Yes	0.0
Dept. of Health & Human Services, CMS 93.624	ACA State Innovation Models: Funding for Model Design and Model Testing Assistance: Grant that tests and evaluates new assessments of capacity for persons receiving community based long term services and supports (LTSS). The grant provides resouces for improved coordination of service and quality related information through the establishment of an electronic personal health record (PHR) across all beneficiaries using LTSS. It identifies and harmonizes electronic LTSS standards particularly for persons receiving Medical assistance home and community based waiver services.	$782	$1,512	$1,150	$1,150	No	2.5
Department of Health and Human Services, Admin. For Community Living	Adult Protection Person-Centered Date Reporting system. The work of the grant will move the state from data reporting by the number of reports and the number of allegations of maltreatment to a person-centered data system with data reporting focused on the vulnerable person who was the subject of the report. Grant outcomes will include the creation of a data warehouse for enhanced data reporting on vulnerable adults and scate case level submission to the National Adult Maltreatment reporting system. (NAMRS).	$0	$206	$206	$0	Yes	1.0
Dept. of Health & Human Services, Admin. for Community Living 93.761	Evidenced Based Falls Prevention Programs Financed Soley by Prevention and Public Health Funds. The Minnesota Board on Aging (MBA) received a grant to increase the number of evidence based falls prevention programs across Minnesota and to work with the Area Agencies on Aging (AAA) and their partners to build a network that provides information and access to evidence based falls prevention programs.	$76	$184	$30	$0	NO	1.0

Federal Agency and CFDA#	Federal Award, Grant Purpose, People Served	SFY 2016 Actuals	SFY 2017 Budget	SFY 2018 Base	SFY 2019 Base	Required State Match or MOE Y /N	FTE
Dept. of Health & Human Services, Admin. for Community Living 93.763	Alzheimer's Disease Initiative: Specialized Supportive Services Project: (ADI-SSS) thru Prevention and Public Health Funds (PPHF). MBA received a grant to further the development of dementia capable home and community based services and health care systems to deliver high quality and effective supportive services to persons living alone with Alzheimer's disease and related dementias and in family caregivers of people with dementia who need behavioral symptom management training and consultation.	$0	$500	$500	$0	Yes	0.0
Dept. of Health & Human Services, CMS 93.779	Health Insurance Counseling: Grants to AAAs and service providers to provide health insurance counseling, education and assistance services to seniors to help obtain health insurance benefits. (Also coordinated with Information and Assistance grants-general fund). The grant also includes administrative funds that are used to implement and administer the grant.	$970	$1,055	$1,000	$1,000	No	3.3
Dept. of Health & Human Services, CMS 93.791	Money Follows the Person Rebalancing Demonstration: Grant from CMS that supports the transition of Medicaid participants of all ages who have long term stays in institutions to the community and rebalances MN long term care system to achieve sustainability. Administrative funding throughout DHS to administer and implement the grant. In State Fiscal year, 2015, the demonstration served 81 people, up from 59 in the preceding fiscal year. DHS was approved to participate in the Money Follows the Person Tribal Initiative (TI) which allows states and tribes to target resources to build sustainable community-based long term services and supports for tribal members.	$5,158	$17,893	$17,673	$16,905	Yes	14.0
Department of Education 84.027	Special Education Grants to States: The Individuals With Disabilities Education Act (IDEA) Part B grant from U.S. Department of Education is awarded to the Minnesota Department of Education (MDE). MDE in turn, completes an interagency agreement with DHS to develop coordinated benefits and policy for youth with disabilities.	$67	$85	$60	$60	No	0.0

Federal Agency and CFDA#	Federal Award, Grant Purpose, People Served	SFY 2016 Actuals	SFY 2017 Budget	SFY 2018 Base	SFY 2019 Base	Required State Match or MOE Y /N	FTE
Dept. of Health & Human Services, Health Resources and Services Administration 93.917	HIV Care Formula Grants: Dedicated federal funding that helps individuals with HIV / AIDS obtain access to necessary medical care, nutritional supplements, dental services, mental health services, support services and outreach to high risk, underserved populations. Federal funding dedicated to maintain private insurance coverage for people living with HIV and/or purchase HIV related drugs. Funds used in conjunction with state and special revenue funds. (Approximately 2,400 people served.).Federal funding to provide outreach and education services to minority populations by identifying individuals with HIV/AIDS and make them aware of and enroll them in treatment service programs. (Approximately 100 people served). Grant includes administrative funding for administering and implementing the grant.	$8,078	$10,799	$9,821	$7,421	No	18.5
Dept. of Health & Human Services, Health Resources and Services Administration 93.917	HIV Care Formula Grants: This grant which supplements the Ryan White grant is a competitive grant that is awarded to states with demonstrated need. The funding helps low income persons living with HIV/AIDS get access to HIV/AIDS medications. The Supplemental grant also covers outreach to underserved high risk populations.	$513	$650	$0	$0	No	0.0
Dept. of Health & Human Services, Substance Abuse & Mental Health Administration 93.150	Projects for Assistance in Transition from Homelessness (PATH): Grants to counties and non-profit agencies for outreach and mental health services to homeless people. About $500,000 per year of Adult MH Integrated state funds are used as match for these federal funds. (CY2013 3,934 people served)	$1,493	$704	$808	$808	Yes	0.3

Federal Agency and CFDA#	Federal Award, Grant Purpose, People Served	SFY 2016 Actuals	SFY 2017 Budget	SFY 2018 Base	SFY 2019 Base	Required State Match or MOE Y /N	FTE
Dept. of Health & Human Services, Health Resources and Services Administration 93.829	Improve Community MH Services: The grant provides funding to states to develop an application to participate in a two-year federal demonstration program (Section 223 Demonstration Program). The grant supports state's to develop certification and payment methodologies. Program activities aim to integrate behavioral health with physical health care, increase consistent use of evidence-based practices, and improve access to high-quality care. Community Behavioral Health Clinics and their states are required to improve data collection and reporting systems.	$143	$1,185	$0	$0	Yes	1.0
Dept. of Health & Human Services, Substance Abuse & Mental Health Administration 93.958	Block Grants for Community Mental Health Services: Grants to counties and non-profit agencies for innovative projects based on best practices. Projects include children's mental health collaborative, crisis services for children and adults, adult mental health initiatives and self-help projects for consumers. As required by state law, 25% of the Federal MH Block Grant is used for grants to American Indian Tribes and non-profit agencies to provide mental health services, particularly community-support services, to American Indians.	$8,990	$17,430	$10,090	$7,953	Yes	11.0
Dept. of Health & Human Services, Health Resources and Services Administration 93.243	Substance Abuse and Mental Health Services: Strategic Prevention Framework Partnership for Success (SPF-PFS) program is designed to address two of the nation's top substance abuse prevention priorities: 1) underage drinking amoung persons ages 12 to 20; and 2) prescription drug misuse and abuse amount persons ages 12 to 25.	$1,047	$1,626	$1,626	$1,626	No	1.0
Dept. of Health & Human Services, Health Resources and Services Administration 93.243	Strategic Prevention Framework for Prescription Drugs: The SPF Rx grant program provides an opportunity to target the priority issue of prescription drug misuse. The program is designed to raise awareness about the dangers of sharing medications and work with pharmaceutical and medical communities on the risks of overprescribing to young adults. SPF Rx will also raise community awareness and bring prescription drug abuse prevention activities and educations to schools, communities, parents,	$0	$453	$372	$372	No	0.5

Federal Agency and CFDA#	Federal Award, Grant Purpose, People Served	SFY 2016 Actuals	SFY 2017 Budget	SFY 2018 Base	SFY 2019 Base	Required State Match or MOE Y /N	FTE
	prescribers, and their patients. In addition, SAMHSA will track reductions in opioid overdoses and the incorporation of Prescription Drug Monitoring Program (PDMP) data into needs assessments and strategic plans as indicators of the program's success.						
Dept. of Health & Human Services, Substance Abuse & Mental Health Administration 93.788	Opioid State Targeted Response: Expedites opioid treatment and recovery resources, and supports integration of services at each point in the continuum (e.g. behavioral treatment and Office Based Opioid Treatment (OBOT)/(MAT) Medication Assisted Treatment). Expect to serve 109,852 individuals in the State of Minnesota through the proposed MN Opioid STR.	NEW	$185	$9,172	$1,402	NO	5.65
Dept. of Health & Human Services, Substance Abuse & Mental Health Administration 93.104	Community MH Services for Children with Serious Emotional Disturbances: Develop children's mental health system of care to improve behavioral health outcomes for Minnesota children and youth with (birth to 21) with serious emotional disturbance. 18,000 children and youth served by year 4.	NEW	$0	$2,250	$3,000	YES	8.15
	Total Federal Funds	$8,658,802	$8,762,183	$9,496,637	$9,748,960		261.7

DHS Federal Grant Totals	FY 2016	FY 2017	FY 2018	FY 2019
Federal 3000 fund February Forecast	$8,421,758	$8,489,432	$9,208,964	$9,477,653
NEW Federal Grants	0	185	11,422	4,402
Federal TANF fund February Forecast	237,044	272,566	276,251	266,905
Total Federal per BPAS February Forecast	$8,658,802	$8,762,183	$9,496,637	$9,748,960

Narrative:

The Department of Human Services (DHS) receives, manages and expends approximately 80% of all federal funds received by state executive branch agencies. Federal Medicaid funding for health and long term care services account for the most of the agency's federal fund expenditures, amounting to 72% of projected DHS federal expenditures in SFY 2018. DHS expenditures of federal funds increased by over 50% from FY2012 to FY2016, driven largely by expansion and change in matching fund arrangements of the Medical Assistance program.

Many of the large entitlement programs administered by DHS are funded through a combination of state and federal funds, and are governed by various matching fund and maintenance of effort requirements. Base budgets for these entitlement programs (and the associated federal share of funds) are set consistent with state law on expenditure forecasts and the state budget. Examples of these forecasted programs include Medical Assistance (Medicaid), Minnesota Care (Basic Health Program), Supplemental Nutrition Assistance Program (SNAP), Minnesota Family Investment Program (Temporary Assistance for Needy Families or "TANF"), Child Care, and Children's Foster Care program (Title IV-E).

DHS also receives and distributes a number capped or non-entitlement federal grants, including a number of "block grants" which supplement state and local expenditures for specific categories of services. Examples of these include the Social Services Block Grant, the Child Development Block Grant, the Community Mental Health Services Block Grant, the Substance Abuse Prevention and Treatment Block Grant and others. Budgets for these types of grants are typically tied to the annual federal allocations to the state, and then translated from a federal fiscal year basis to a state fiscal year basis.

Finally, DHS receives a number of smaller, time-limited federal grants that are available to help meet specialized needs, or to help facilitate improvements in human services delivery.

Grants Funding Detail

Dollars in thousands ($000's)

State Grant Name (Citation)	Purpose / Recipients / Eligibility	FY 2016 Actual	FY 2017 Budget
Forecasted Grants (current law) 2016 November: General Fund			
Minnesota Family Investment Program (MFIP) / Diversionary Work Program (DWP) (M.S. 256J)	Minnesota Family Investment Program (MFIP) / Diversionary Work Program (DWP) grants provide temporary financial support to help meet basic needs of low-income families with children and low-income pregnant women. In FY 2015, an average of 34,300 low income families per month received help through these programs, 71 percent of people on the program are children. See also federal funds.	$103,453	$88,321
MFIP Child Care Assistance Grants (M.S. 119B)	The Minnesota Family Investment Program (MFIP) Child Care Assistance grants provide financial subsidies to help low-income families pay for child care so children are well-cared for and prepared to enter school ready to learn and parents may pursue employment or education leading to employment. This grant serves families who currently participate in the MFIP or DWP programs, or who have recently done so. In FY 2015, an average of 7,588 families with 15,328 children per month were served.	$78,221	$96,153
General Assistance Grants (M.S. 256D)	General Assistance (GA) grants provide state-funded, monthly cash grants for very low-income people without children who are unable to work and do not have enough money to meet their basic needs. The most common eligibility reason for people at enrollment is illness or incapacity. In 2015, an average of 23,250 people per month received these grants.	$50,444	$59,649
MN Supplemental Assistance (MSA) Grants (M.S. 256D)	Minnesota Supplemental Aid (MSA) grants provide a state-funded monthly cash supplement to help people who are aged, blind or disabled, and who receive federal Supplemental Security Income (SSI) benefits to meet their basic needs that are not met by SSI alone. In 2015, an average of 30,441 people per month received these grants.	$37,735	$39,303
Group Residential Housing (GRH) Grants (M.S. 256I)	Group Residential Housing (GRH) is a state-funded income supplement program that pays for room and board costs in approved locations for adults with low incomes who have a disability or are 65 years or older. These grants assist individuals who have illnesses or disabilities, including developmental disabilities, mental illnesses, chemical dependency, physical disabilities, advanced age, or brain injuries, to prevent or reduce institutionalization or homelessness. In FY 2015, an average of 19,461 people received GRH payments each month.	$147,461	$159,690
GRH Grants- People Inc. (Laws of Minnesota 2007, Chapter 147, Article 19, Sec. 3, subd. 4(k))	Group Residential Housing (GRH) provides a legislatively authorized grant to People Incorporated to operate two licensed board and lodge facilities for individuals who have been homeless for at least one year, one in Ramsey County and one in Hennepin County. Services include community support, and 24-hour supervision. In FY 2015, an average of 36 people received GRH in these settings (combined) each month.	$460	$460
Northstar Care for Children (M.S. 256N)	Northstar Care for Children is a new program that began in January 2015. It is designed to help children who are removed from their homes and supports permanency through adoption or transfer of custody to a relative if the child cannot be safely reunified with parents. Northstar Care for Children consolidates and simplifies administration of three programs: Family FosterCare, Kinship Assistance (which replaces Relative Custody Assistance) and Adoption Assistance. 13,612 children experienced an out-of-home placement in 2015; 988 children were either adopted or had a permanent transfer of legal custody to a relative in 2015.	$42,689	$54,887

State Grant Name (Citation)	Purpose / Recipients / Eligibility	FY 2016 Actual	FY 2017 Budget
Medical Assistance (MA) Grants General Fund (M.S. 256B)	These funds meet the state's matching funds requirement for Minnesota's Medicaid programs that provide health and long term care coverage to an average of 800,000 uninsured or underinsured Minnesotans who meet income eligibility requirements. This program is managed by the state under guidance from the federal government.	$4,134,042	$4,561,848
Medical Assistance (MA) Grants- HCAF (M.S. 256B)	These funds meet the state's matching funds requirement for Minnesota's Medicaid programs that provide health and long term care coverage to an average of 800,000 uninsured or underinsured Minnesotans who meet income eligibility requirements. This program is managed by the state under guidance from the federal government.	$588,188	$240,720
Alternative Care (AC) Grants (M.S. 256B.0913)	The Alternative Care (AC) Program is a cost-sharing program that supports certain home- and community-based services for eligible Minnesotans age 65 and over. In November 2013 the program became eligible for federal Medicaid financial participation through an approved waiver. The program provides services to prevent and delay transitions to Medical Assistance-funded services, such as Elderly Waiver and nursing home care. The AC program served a monthly average of 3,874 older Minnesotans in FY2015, at an average monthly cost of $849.	$12,866	$43,590
Minnesota Care Health Care Grants; BACT 31: Health Care Access Fund (HCAF)			
Minnesota Care Grants M.S. 256L and 256B	Minnesota Care Grants pay for health care services for about 130,000 Minnesotans who lack access to affordable health insurance.	$144,902	$55,087
Chemical Dependency Entitlement Grants; BACT 35 : Special Revenue Fund			
Consolidated Chemical Dependency Treatment Fund (CCDTF) Grants M.S. 254B.02, Sund.1	The Consolidated Chemical Dependency Treatment Fund (CCDTF) provides funding for residential and non-residential addiction treatment services for eligible low-income Minnesotans who have been assessed as needing treatment for chemical abuse or dependency. In calendar year 2015 there were 52,596 substance abuse treatment admissions for Minnesota Residents, the CCDTF fund covered services for 21,635 (41%) of these admissions. Almost all treatment providers in the state are enrolled as CCDTF providers.	$161,379	$170,675
Support Services Grants BACT 41: General Fund			
MFIP Consolidated Support Services Grants M.S. 256J.626	The Minnesota Family Investment Program Consolidated Fund is allocated to counties and tribes to provide an array of employment services for MFIP/DWP participants including job search, job placement, training and education. In FY15, approximately 27,000 individuals per month were served. Funds provide other supports such as emergency needs for low-income families with children and also fund a portion of counties' costs to administer MFIP and DWP. See also Federal Funds.	$8,698	$8,715
CFS Injury Protection Program M.S. 256J.68	Payments to medical providers for the treatment of injuries suffered by persons while participating in a county or tribal community work experience program.	$ -	$10
Food Stamp Employment and Training (FSET) Service Grants M.S. 256D.051	Grants to counties to provide employment supports to adults who receive benefits through the Supplemental Nutrition Assistance Program. The grant is now called Supplemental Nutrition Assistance Program Employment & Training (SNAP E & T). In SFY15, the SNAP E&T Program served an average caseload of 1,106 participants per month.	$19	$26

State Grant Name (Citation)	Purpose / Recipients / Eligibility	FY 2016 Actual	FY 2017 Budget
MFIP Paid Work Experience Laws of Minnesota 2013, Chapter 108, Article 14, Sec. 2, subd. 6(a)	Paid work experience for long-term Minnesota Family Investment Program participants which includes full and partial wage subsidies and other related services such as job development, marketing, pre-worksite training, etc. In SFY15, Minnesota Subsidized and Transitional Employment Demonstration – MSTED enrolled 829 participants in the study but served 422 in the program group. This was lower than the initial 1000 participants to be enrolled in random assignment, because of a declining MFIP caseload and a tighter labor market.	$3,640	$ -
MFIP Work Study Laws of Minnesota 2013, Chapter 108, Article 14, Sec. 2, subd. 6(a)	Funds for work-study wages. Projects support Minnesota Family Investment Program participants who are pursuing post-secondary education by linking participants with services at the colleges and in the broader community and providing work-study jobs. In SFY15, two participants received work-study wages. This initiative provided work study jobs for eligible student parents at six partnering colleges. Approximately 23 percent of eligible students participated. College partners spent approximately 17 percent of their grants (in 2015 and 2016). Implementation challenges shortened the two year project to a 15-month period and data-sharing challenges made it difficult for college partners to directly recruit students. Overall, 38 student parents receiving MFIP earned $86,210 in work study wages.	$488	$ -
MFIP Disparities Reduction Laws of Minnesota 2013, Chapter 108, Article 14, Sec. 2, subd. 6(a)	Grants to counties or tribal nations to fund projects that focus on services for African Americans and American Indians participating in the Minnesota Family Investment Program who are experiencing poor employment outcomes. Services include case management, employment activities and job-matching for approximately 760 people. In SFY15 approximately 254 people received services.	$2,979	$ -
MFIP Teen Parent Home Visiting Laws of Minnesota 2013, Chapter 108, Article 14, Sec. 2, subd. 6(a)	Funding for four sites to initiate or advance collaboration between public health home visiting services and the Minnesota Family Investment Program. In SFY15, the program served approximately 300 teen parents on MFIP.	$ -	$ -
Basic Sliding Fee Child Care Grants BACT 42 : General Fund			
Basic Sliding Fee (BSF) Child Care Assistance Grants M.S. 119B	BSF child care assistance grants provide financial subsidies to help low-income families pay for child care so that parents may pursue employment or education leading to employment, and children are well cared for and prepared to enter school ready to learn. Funds purchased child care for 15,267 children in 8,121 families (2015). As of May 2016, 7,420 families were on the waiting list for BSF child care.	$48,439	$51,559
Child Care Development Grants BACT 43: General Fund			
Child Care Resource and Referral Grants M.S. 119B	Grants to child care resource and referral agencies to support the child care infrastructure through information for parents, supports and training resources for providers, coordination of local services and data collection to inform community planning. Provide 5,000 parents with phone referrals and on-line information to more than 105,000 users. Over 2,800 training classes offered with over 47,000 participants.	$1,007	$1,007
Child Care Integrity Grants M.S. 119B	Grants to counties to support fraud prevention activities.	$147	$147
Migrant Child Care Grants M.S. 119B	Provides grant funds to community based program for comprehensive child care services for migrant children throughout the state. Approximately 850 migrant children under 14 years of age served annually.	$170	$170
Child Care Service Development Grants M.S. 119B	Grants to child care resource and referral agencies to build and improve the capacity of the child care system for centers and family child care providers. Over 1,300 grants were awarded to child care providers in 2015.	$250	$250

State Grant Name (Citation)	Purpose / Recipients / Eligibility	FY 2016 Actual	FY 2017 Budget
Child Care Facility Grants M.S. 119B	Grants and forgivable loans to child care providers and centers in communities to improve child care or early education sites or to plan design and construct or expand sites to increase availability of child care and early education. Almost 20 child care programs received forgivable loans in 2015.	$163	$163
Parent Aware Grants Laws 2015 SS, chapt 3, art. 9, sec 8, subd 9 as amended by Laws 2016, chapt 189, art 31, sec 5.	These funds support a Quality Rating and Improvement System (QRIS). Grants to child care resource and referral agencies provide recruitment and supports to child care programs that participate in the QRIS and support a website that provides ratings to parents and information for participating child care programs, as well as a grant for evaluation of the initiative. As of July 2016, 2,600 child care and early education programs were rated through Parent Aware, Minnesota's QRIS.	$863	$3,610
Child Care Development Grants BACT 43: Special Revenue Fund			
Race to the Top (RTT) - ELC QRIS Grants M.S. 256.011	These funds support a Quality Rating and Improvement System (QRIS). Grants to child care resource and referral agencies provide recruitment and supports to child care programs that participate in the QRIS and support a website that provides ratings to parents and information for participating child care programs, as well as a grant for evaluation of the initiative. As of July 2016, 2,600 child care and early education programs were rated through Parent Aware, Minnesota's QRIS.	$1,656	$629
Race to the Top (RTT) - ELC GW Support Grants M.S. 256.011	These funds provide grants to child care resource and referral agencies and other community-based organizations to provide training, coaching, career guidance, and higher education scholarships to child care providers and other early childhood educators to improve child care quality. In 2015, over 300 child care professionals received scholarships.	$1,957	$1,192
Race to the Top (RTT) – ELC Public Private Partner Grants M.S. 256.011	These funds provide a grant to First Children's Finance to support Greater Minnesota communities in addressing child care shortages through public-private partnerships.	$80	$3
Child Support Grants BACT 44: Special Revenue Fund			
Child Support County Grants M.S. 518A.51	This funding is from the non-federal share of the child support 2% processing fee authorized in the 2011 session and the federal $25 annual collections fee mandated in 2006. Counties earn incentives based on their program performance.	$1,543	$1,543
Child Support Payment Center Recoupment Account M.S. 518.56, subd. 11	Grants to individuals that temporarily fund NSF checks and other child support payment adjustments, which allow child support funds to be distributed within the 48 hour federal requirement.	$(5)	$153
Children's Services Grants BACT 45: General Fund			
Child Protection Grants M.S. 256M.41	These grants are awarded to counties on a formula basis to address staffing for child protection or expand child protection services. Funds must not be used to supplant current county expenditures for these purposes.	$23,350	$23,350
Child Welfare Disparities Grants M.S. 256E.28	These grants are to address disparities and disproportionality in the child welfare system by: • Identifying and addressing structural factors that contribute to inequities in outcomes • Identifying and implementing strategies to reduce disparities in treatment and outcomes • Using cultural values, beliefs and practices of families, communities and tribes for case planning, service design and decision-making processes • Using placement and reunification strategies to maintain and support relationships and connections between parents, siblings, children, kin, significant others and tribes • Supporting families in the context of their communities and tribes to safely divert them from the child welfare system, whenever possible.La	$1,650	$1,650

State Grant Name (Citation)	Purpose / Recipients / Eligibility	FY 2016 Actual	FY 2017 Budget
	Grants were awarded to eight tribes, counties and community agencies.		
American Indian Child Welfare Initiative Program M.S. 256.01, subd. 14(b)	Grants to tribes to provide core child welfare services to American Indian children living on participating tribe's reservations. There are 2 grantees: White Earth and Leech Lake reservations. More than 3,000 children and families were served through this grant. A one-time appropriation for FY2017 funded planning grants to two additional tribes.	$4,751	$5,551
Foster Care Transitional Planning Demo Project (Healthy Transitions and Homeless Prevention) Laws of Minnesota 2005, Chapter 4, Article 9, Sec. 2, subd.4(g)	Grants to providers for transitional planning and housing assistance services to youth preparing to transition out of foster care or who have recently left foster care. These grants served 643 youth in SFY 2015.	$1,054	$1,065
Privatized Adoption Grants (Public Privatized Adoption Initiative) M.S. 256.01, subd. 2	Grants to 5 providers for recruitment of adoptive families; fund child placement agencies' efforts to place children committed to the guardianship of the commissioner in foster care or in extended foster care in adoptive homes. These grants supported services for 203 children and 360 families.	$2,160	$2,620
Child Welfare Reform – Prevention / Early Intervention Grants	Grants to counties for child protection services designed to support families to keep children safely at home. Services include training and counseling support for parents and children, stable housing and safe living conditions. Grants support services for approximately 4,000 families per year.	$786	$786
Foster Care and Adoption Recruitment Grants M.S. 259A	Grants to county and American Indian Child Welfare Initiatives social service agencies for the recruitment of relative adoptive and foster families.	$78	$161
Expand Parent Support Outreach	Statewide allocations to 87 counties and Leech Lake and White Earth Bands of Ojibwe to prevent child maltreatment and improve family functioning for families reported to child protection services. Approximately 4,164 families served per year.	$2,250	$2,250
Private Adoptions Child Specific with Carry Forward Authority M.S. 259A	Child Specific Agreements that were established through the Public Private Adoption Initiative grant take up to three years to complete. This funding is based on legislation that allows carry-forward for the child specific agreements.	$356	$544
Purchased Services Child Specific-Carry forward	Child Specific Placement Service Agreements that take up to three years to complete. This funding is based on legislation that allows carry-forward for the child specific agreements.	$50	$538
Safe Place for Newborns M.S. 260C.139	This grant is a one-time appropriation to increase public awareness of the Safe Place for Newborns law that provides safe and anonymous alternative places for mothers to leave their newborn children. The law was enacted in 2000 and amended in 2012.	$349	$ -
Children's Services Grants; BACT 45 : Special Revenue Fund			
Parent Support Outreach Grant M.S. 256E.22	Statewide allocations to 87 counties and Leech Lake and White Earth Bands of Ojibwe to prevent child maltreatment and improve family functioning for families reported to child protection services. Approximately 4,164 families served per year. See also general fund.	$ -	$75
Children's Trust Fund Grants M.S. 256E.22	Grants to counties and community-based agencies for child abuse and neglect prevention and services to families to reduce the risk of child maltreatment and enhanced family capacities.	$335	$475
Foster Care Recruitment M.S. 256.01, subd. 36	Federal financial participation for foster care recruitment.	$ -	$76
Indian Child Welfare Grants (ICWA) M.S. 260.785	Grants to tribes and urban American Indian social service agencies to provide services to preserve and strengthen American Indian families and reunify children placed in out-of-home placement with their families. *(see also federal funds)*	$1,546	$1,482

State Grant Name (Citation)	Purpose / Recipients / Eligibility	FY 2016 Actual	FY 2017 Budget
Privatized Adoption Grants M.S. 256.01, subd. 36	The source of the funding for this item is federal reimbursement (Title IV-E match) associated with General Fund appropriations for Privatized Adoption Recruitment Grants which serve 200 children and 360 families in 2015.	$ -	$650
Adoption IV-B Grants	Federal reimbursement of Title IV-B activities eligible for Title IV-E reimbursement of adoption services to adoptive families.	$635	$650
Children's Services Grants; BACT 45: Gift Fund			
Forgotten Children's Fund M.S. 16A.016, subd. 2	Private donations received from the American Legion and other private donors and administered by DHS to fund special services or activities to children in foster care. Funds approximately 63 requests per year.	$11	$24
Children & Community Services Grants BACT 46: General Fund			
Children & Community Services Grants M.S. 256M	Grants to all Minnesota counties to purchase or provide services for children, adolescents and other individuals who experience dependency, abuse, neglect, poverty, disability, or chronic health conditions. This grant contributes to costs for services to more than 213,000 people annually.	$55,814	$55,814
Red Lake Band Grants M.S. 245.765	Grants to Clearwater and Beltrami Counties for costs of social services provided to members of the Red Lake Band residing on the Red Lake Reservation.	$487	$487
Red Lake Band Human Services Initiative M.S. 256.01, subd.2(a)(7) and Laws 2016, chapter 189, article 23, sec. 2	Funding to the Red Lake Nation for direct implementation and administrative costs of the Red Lake Human Services Initiative project to operate a federally approved family assistance program (Tribal TANF) or any other program under the supervision of the commissioner.	$ -	$500
White Earth Band Human Services Initiative Laws 2011, First Special Session, chapter 9, article 9, section 18 and Laws 2016, chapter 189, article 23, sec. 2	Funding to the White Earth Nation for direct implementation and administrative costs of the White Earth Band of Ojibwe Human Services Project to transfer legal responsibility to the tribe for providing human services to tribal members and their families.	$ -	$1,400
Children & Economic Assistance Grants BACT 47: General Fund			
Homeless Youth Act M.S. 256K.45	Grants to non-profit agencies for the provision of street outreach, drop-in centers, transitional living programs and supportive housing to runaway and homeless youth. The total number of youth served through Homeless youth funding is 22,066.	$4,052	$4,095
Food Shelf Grants M. S. 256E.34	Grants for purchase and distribution of food to food shelves throughout the state, including some administrative costs. In 2015, families made more than 3.3 million visits to food shelves.	$1,318	$1,318
Food Shelf Grants M. S. 256E.34	Additional grants for purchase and distribution of food to food shelves throughout the state. Families made more than 3.3 million visits to food shelves in 2015.	$375	$375
Aid to Counties- Fraud Prevention Grants (FPG) 256.983	Grants to counties for the Fraud Prevention Investigation Program, enabling early fraud detection and collection efforts.	$1,673	$1,768
Transitional Housing Grants M.S. 256E.33	Grants to private non-profits to provide rent assistance and supportive services to homeless individuals and families so they can secure permanent, stable housing. (Serves 2,400 individuals annually)	$3,184	$3,184
Long Term Homeless Services Grants M.S. 256K.26	Grants to multi-county collaboratives that subgrant funds to service providers assist long-term homeless individuals and families with children to find and maintain permanent housing. In 2015, 2,384 individuals in 1,125 households were served. Funds may also be used at the local level for federal Housing and Urban Development housing match.	$6,422	$6,910
Emergency Services Grants M.S. 256E.35	Grants to non-profits and tribal governments to fund the operating costs of shelters and essential services to homeless families and individuals. Served 6,200 individuals.	$844	$844

State Grant Name (Citation)	Purpose / Recipients / Eligibility	FY 2016 Actual	FY 2017 Budget
MN Community Action Grants M.S. 256E.30	Grants to Community Action Agencies and tribal governments to focus local, state, private and federal resources to support low-income families and individuals to attain the skills, knowledge and motivation to become economically secure. Served over 201,262 low-income families in 2015. Funds used at local level for match.	$3,472	$3,928
Multilingual Referral Line Title VI of the Civil Rights Act of 1964	Grants to non-profit agencies for the provision of language services and the translation of vital documents for non-English speaking recipients of human services.	$26	$86
Minnesota Food Assistance Program M.S. 259D.053	State funded food benefits for legal non-citizens who do not qualify for federal food stamps. In SFY 2015, estimate 423 average monthly cases received these food benefits.	$829	$1,555
Family Assets for Independence Minnesota (FAIM) M.S. 256E.34	Funds help low-income working Minnesotans increase savings, build financial assets, and enter the financial mainstream. Since 1999, 3,190 FAIM accountholders have completed the program and deposited nearly $4.4 million into savings accounts acquiring over 3,190 long-term financial assets including, purchased homes, post-secondary education and capitalized businesses.	$325	$325
Safe Harbor Laws 2013, Chapt 108, Art 14, Sec2, subd 6(g) and Laws 2014, Chapt 312, Art 30, sec 2, subd 4(b)	Grants to 7 private non-profits to provide a new set of programming specific to sex trafficked minors through specialized emergency shelter, transitional living, youth supportive housing programs and specialized foster care. Programs are implementing the no wrong door approach to Safe Harbor for sexually exploited youth. 43 beds are available.	$1,800	$1,833
Group Residential Housing Administrative Support Laws 2015, Ch. 71, Art. 14, Sec. 2, Subd. 5(g)	Grant to Stearns County to offset costs related to administration of Group Residential Housing serving veterans.	$85	$85
Mobile Food Shelf Laws 2015, Chapt 71, Art 14, Sec2, subd 5(g)	This is a one-time grant to Hunger Solutions to award grants of up to $75,000 on a competitive basis to expand the use of mobile food shelves in underserved or unserved communities. 17 food shelves were awarded grants.	$1,000	$1,000
Children & Economic Assistance Grants BACT 47: Special Revenue Fund			
SNAP Outreach and Incentives M.S. 245.771	Funds to conduct Supplemental Nutrition Assistance Program (SNAP) special projects designed to increase program participation. Four projects were funded in 2013 focusing on childhood hunger, Latino outreach, outreach in the 9 county metro and a grocery store incentive project.	$30	$43
SSI-IAR Disability Linkage Line M.S. 256D.06, subd. 5	Grants fund services provided by the Disability Linkage Line® to connect individuals using state benefit programs (General Assistance, Group Residential Housing and Minnesota Family Investment Program) with agencies under contract with the Department of Human Services to provide support and representation in applying for social security benefits.	$99	$140
Health Care Grants BACT 51 : General Fund			
Navigator Outreach Grants -General Fund (M.S. 256.962)	These funds provide incentive payments for the 990 entities and individuals across the state providing application assistance for Medical Assistance enrollees. Approximately 31,000 individuals received application assistance from a navigator in FY2015.	$107	$410
Emergency MA Legal Referral (M.S. 256B.06, Subd. 6)	These grants provide immigration assistance for entities to assist Emergency Medical Assistance recipients who may be eligible for Medical Assistance given a change in their citizenship.	$100	$100
Integrated Care for High Risk Pregnant Women (M.S. 256B.79)	These funds support community based organizations, public health programs, and health care providers who provide targeted, integrated services for pregnant mothers who are at high risk of poor birth outcomes due to drug use or low birth weight in areas of high need.	$ -	$696

State Grant Name (Citation)	Purpose / Recipients / Eligibility	FY 2016 Actual	FY 2017 Budget
Periodic Data Matching (Ch. 71, Art. 14 Laws of Minnesota 2015)	Grants to counties to offset their costs in processing eligibility determinations for individuals flagged as potentially ineligible through periodic data matching.	$ -	$1,276
Health Care Grants; BACT 51: Health Care Access Fund			
Navigator MA Enrollment Grants-HCAF (M.S. 256.962)	These funds provide incentive payments for the 990 individuals and entities across the state providing application assistance for enrollees in the Medical Assistance program.	$310	$310
Navigator RFP Outreach Grants – HCAF (M.S. 256.962)	These funds provide incentive payments for the 990 entities and individuals across the state providing application assistance for MinnesotaCare enrollees.	$40	$40
Navigator BHP – HCAF (M.S. 62V.05, Subd. 4)	These funds provide incentive payments for the 990 entities and individuals across the state providing application assistance for MinnesotaCare enrollees.	$972	$3,115
Other Long Term Care Grants; BACT 52: General Fund			
Other Long Term Care Grants Laws of Minnesota 2015, Chapter 71, Article 7, Section 55.	These funds establish a home and community-based services incentive pool to provide incentives for innovation in achieving outcomes identified in the Olmstead plan, including integrated, competitive employment and living in the most integrated setting in the community. This grant was appropriated in the 2015 legislative session with the first grants appropriated in FY 2017.	$ -	$1,344
Other Long Term Care Grants; BACT 52: Special Revenue Fund			
Money Follows the Person Rebalancing Grant M.S. 256B.04 Subd. 20	Rebalancing funds can be used to provide extended services for individuals with multiple barriers seeking to move to community settings, to fund small pilot or "proof of concept" demonstrations for potential service changes or similar activities.	$ -	$2,490
Aging & Adult Services Grants; BACT 53: General Fund			
Senior Nutrition Program Grants M.S. 256.9752	Grants to Area Agencies on Aging to provide nutrition services including congregate meals to 38,000 people and home-delivered meals to 12,000 people.	$2,694	$2,695
Caregiver Support and Respite Care Project Grants M.S. 256B.0917, subd. 6	Grants to provide caregiver and respite services for families and other caregivers.	$478	$479
Information and Assistance Grants M.S. 256.975, subd. 7	Grants to Area Agencies on Aging to provide information and assistance services regarding home and community based services.	$3,396	$3,449
Eldercare Development Partnership Grants M.S. 256B.0917, subd. 1c	Grants to local organizations to provide statewide availability of service development and technical assistance as it relates to home and community based services for older adults.	$1,757	$1,758
Aging Prescription Drug Assistance Grant M.S. 256.975, subd. 9	Grants to AAAs and service providers to provide statewide outreach and education assistance to low income seniors regarding Medicare and supplemental insurance, including Medicare Part D and programs that the drug companies offer to help low-income older adults.	$1,189	$1,191
Community Services M.S. 256B.0917, subd. 13	Grants to public and non-profit agencies to establish services that strengthen a community's ability to provide a system of home and community based services for older adults. These grants supported 2,612 people in FY2015.	$3,113	$3,128
Community Service Development Grants M.S. 256.9754	Grants to for-profit and nonprofit organizations, and units of government to increase the supply of home and community based services to rebalance the long-term care service system.	$2,979	$2,980
Nursing Facility Return to Community M.S. 256.975, subd. 7	Return to Community is an intensive long-term care options counseling service provided by the Senior Linkage Line®, that helps people successfully remain in their homes after discharge from a nursing home. Since 2010, through November 2016 over 17,764 consumers have been contacted for discharge support. Of those, direct assistance was provided to 4,038 adults.	$3,545	$3,548

State Grant Name (Citation)	Purpose / Recipients / Eligibility	FY 2016 Actual	FY 2017 Budget
Senior Volunteer Programs M.S. 256.976 M.S. 256.977 M.S. 256.9753	Support to more than 17,000 older volunteers per year that provides services through the RSVP, Foster Grandparent, and Senior Companion programs.	$1,931	$1,988
PAS Screening 25% Aging M. S. 256.975, subd. 7a-7d	Grant funding for preadmission screening for everyone admitted to a Medical Assistance certified nursing facility. It was passed as part of Reform 2020 during the 2013 legislative session. The preadmission process was streamlined and the process allows for federal match of 75%.	$707	$2,636
Aging LTCC Grants M.S. 256B.0911 M.S. 256.975, subd. 7	Grant funding for Long Term Care consultation services. These services help people make decisions about long term care needs. These services include early intervention visits, and information and education about local long-term care service options. This was Reform 2020 funding from the 2013 legislative session.	$1,737	$1,739
Gaps Analysis Laws of 2013, Chap. 108, Article 15, subd 2(h)	Provides ongoing support to counties to participate in the biennial gaps analysis survey of the HCBS system. The funding is biennial.	$435	$ -
Aging-Core HCBS Services M.S. 256B.0917 subd 7a	Grant funding to core in-home and community-based providers for projects to provide services and supports to older adults.	$1,584	$1,585
PCA Registry Grants M. S. 256B.0711, subd. 11	Grant to an Area Agency on Aging responsible for data maintenance for MNHelp. Info to maintain the direct support worker registry.	$116	$236
Dementia Grants (M. S. 256.975, subd. 4 (c) (4)	Grants to regional and local projects to increase awareness of Alzheimer's disease, increase the rate of cognitive testing, promote the benefits of early diagnosis and connect caregivers of persons with dementia to education and resources.	$750	$750
Aging & Adult Services Grants BACT 53: Special Revenue Fund			
Nursing Home Advisory Council Minn. Stat. 144A.33; Laws of MN 2014 Chapter 312, Article 7, sect. 4	The account receives license fees that are collected by the Department of Health. The account is used by the Minnesota Board of Aging to provide ongoing education, training, and information dissemination to nursing home resident councils. Per legislative change during the 2014 session, this funding is now administrative rather than grant funding. The funding was moved to an administrative account in FY 15.	$ -	$ -
Veterans Transportation Grant M.S. 256.01 subd. 2	Inter-agency contract with the Minnesota Department of Transportation (MN DOT) to manage Veteran's Transportation and Community Living Initiative.	$130	$ -
Minnesota Help Network Grant M.S. 256.01 subd.2	This was an interagency grant contract with the Minnesota Department of Health. This grant is now completed.	$25	$ -
Deaf & Hard of Hearing Grants BACT 54 : General Fund			
DHHSD Grants M.S. 256.01 subd. 2; 256C.233; 256.25; 256.261	Grants for multiple services and equipment to help Minnesotans who are deaf, deafblind, and hard of hearing or have multiple disabilities, including deafness, to remain independent and part of their communities. In FY15, these grants served 585 people.	$1,833	$1,833
Hearing Loss Mentors M.S. 256.01, subd. 2	Grant funding pays for deaf or hard of hearing mentors/role models to work with families who need to learn American Sign Language and communication strategies to communicate with and support their children who have learning loss. In FY15, 35 families were served.	$42	$42
Deaf and Deaf-Blind Grants Laws of Minnesota 2015, Chapter 71	Grants to eliminate waiting list and increase service hours in deafblind services programs and establish children's mental health services in the northern tier of the state. In FY16 these grants served 25 people; in FY17 the grants are expected to serve 76 additional people. This grant was only appropriated for FY 16 and FY 17.	$350	$500

State Grant Name (Citation)	Purpose / Recipients / Eligibility	FY 2016 Actual	FY 2017 Budget
Deaf & Hard of Hearing Grants; BACT 54: Special Revenue Fund			
Rural Real Time - Grant M. S. 237.32, 256C.30	Grants to rural television stations in Minnesota to provide real-time captioning of news and news programming where real-time captioning does not exist.	$240	$267
Disabilities Grants; BACT 55: General Fund			
Technology Grants; Corporate Foster Care Alternatives Laws of Minnesota 2009, Chapter 79	Technology for Home (T4H) provides in person assistive technology (AT) consultation and technical assistance to help people with disabilities live more independently. Expert consultants provide current, cost effective solutions and work with the person and their supporters to develop a plan for people who receive home care or home and community based waiver services. As of June 30, 2016, Technology for Home consultants had served 972 people with disabilities whose goals for assistive technology had not been met through other services. Approximately half of the people served were children.	$622	$622
PASRR for Person with MI and DD	Funding to reimburse counties for costs associated with completing federally required pre-admission screening and resident reviews (PASRR) of nursing home applicants or residents with a probable mental illness or a developmental disability.	$1	$20
DD Family Support Grants M.S. 252.32	Family Support Grants (FSG) provides cash to families to offset the higher-than-average cost of raising a child with a disability. The goal of FSG is to prevent or delay the out-of-home placement of children and promote family health and social well-being by facilitating access to family-centered services and supports. The Family Support Grant served 1,628 people in FY 2015.	$3,261	$4,277
Disability Linkage Line M.S. 256.01, subd. 24	Disability Linkage Line (DLL) serves people with disabilities and chronic illnesses and their families, caregivers, or service providers to help people learn about options and connect with services and supports. In fiscal year 2015 it received 86,054 inquiries from 30,511 people.	$984	$1,089
Disability Linkage Line MA Eligible 50% M.S. 256.01, subd. 2, (aa)	State share of funding for work done by the Disability Linkage Line that is related to Medical Assistance and therefore eligible for 50% FFP based on activities reporting.	$329	$416
Semi-Independent Living Skills (SILS) Program M.S. 252.275	SILS serves people who are at least 18 years old, have a developmental disability and require supports to function in the community, but are not at risk of institutionalization. SILS serves approximately 1,500 people each year.	$6,385	$8,309
Consumer Support Grants M.S. 256.476	Consumer Support Grant (CSG) is available for people who are eligible for Medical Assistance (MA) as an alternative to home care. CSG helps individuals purchase items and supports needed for the person to live in their own home. On an annual basis, MA funds are transferred to this grant based on the current forecast. There is a small general fund appropriation for CSG. CSG served 2,612 people in FY 2015.	$24,375	$20,309
State Case Management Grants M.S. 256.01 19-20	Funding to clinics and community based organizations for the provision of case management services to persons living with HIV as well as payments to purchase insurance coverage for eligible individuals. (Approximately 2,647 clients served per year from all funding sources). See also Insurance grants.	$1,256	$1,156
HCBS Waiver Growth M.S. 256B.0658	Grants to assist individuals to move out of licensed settings or family homes into homes of their own. This funding was appropriated during the 2007 session as part of the proposal to Limit growth in the disability waivers and manage costs. As part of our experience with this grant, we have revised our housing service coordination process through the Home and Community Based Waivers. Since the fall of 2009, more than 1,700 people have used housing access services to move from licensed or unlicensed settings to homes of their own that are not owned, leased, or controlled by disability services providers.	$487	$489

State Grant Name (Citation)	Purpose / Recipients / Eligibility	FY 2016 Actual	FY 2017 Budget
State Insurance Premium Grants M.S. 256.01 19-20	HIV/AIDS programs assist individuals with health insurance premiums and pay premiums for people with HIV/AIDS who can't get insurance coverage elsewhere. See also - Case management grants.	$964	$1,064
Advocating Change Together –ACT Minnesota Laws of 2009, Chapter 101	A grant to establish and maintain a statewide self-advocacy network for **individuals** with intellectual and developmental disabilities. Grantee informs and educates individuals with disabilities about their legal rights and provides training to people to self-advocate. Funding for this initiative originated from the Legislature's appropriation to the Governor's Council on Developmental Disabilities under the Omnibus State Government Finance Bill (HF 548, 2nd Engrossment) in 2007. Effective July 1, 2011, the Legislature transferred those funds to the Minnesota Department of Human Services as part of Laws of Minnesota, 2009, Chapter 101.	$123	$133
State Quality Council Grant M.S. 256B.097, Subd. 1-3, 6. Minnesota Laws of Minnesota, Chapter 71, Article 14, Section 2, Subd. 5(l).	Grant to establish and maintain regional quality councils to provide technical assistance, monitor and improve the quality of services for people with disabilities, and monitor and improve person-centered outcomes and quality of life indicators for people with disabilities.	$547	$600
Region 10 Grants M.S.256B.095 to 256B.0955	Grant to support the implementation of the Quality Assurance System for persons with disabilities for the purpose of improving services provided to persons with disabilities. Supporting the ongoing planning and operation of the Quality Assurance System for persons with physical, cognitive or chronic health conditions seeking to improve service outcomes. Completing necessary state and federal reports and participation in the evaluation of the system in accordance with Minnesota Statute, sections 256B.095 to 256B.0955.	$94	$100
L**ocal Planning Grants** Laws of Minnesota 2012, Ch. 247, Article 4, Sect 44.	Grants to assist lead agencies and provider organizations in developing alternatives to congregate living within the available level of resources for the HCBS waivers for people with disabilities. Local planning grants are used to create alternatives to congregate living for people with lower needs are available to counties, tribes, and provider organizations. This work supports the planning process under MN Statute sections 144A.351 and 245A.03, subdivision 7, paragraphs (e) and (g).	$254	$254
Intractable Epilepsy Minnesota Laws of 1988, Chapter 689	A grant to support a living skills training program for people with intractable epilepsy who need assistance in the transition to independent living.	$344	$344
Modify Residency Ratios M.S. 256B.492	This grant passed in 2013 and it is to assist people with HIV/AIDS with Housing. It gives an exception to the four unit community living requirement.	$ -	$143
DT&H Facilities Minnesota Laws of 2014, Chapter 312, Sec.75 (b)11	This grant is for rate increases to day training and habilitation facilities to be distributed through an allocation to the counties.	$811	$811
Work-Empower Grant M.S. 256B.021	Grants are intended to assist people with disabilities find integrated competitive employment. This was part of the Reform 2020 legislation passed during the 2013 legislative session.	$500	$502
Autism Respite Grants Minnesota Laws of 2014, Article 30, Section 2	These grants were appropriated one-time for FY 15 during the 2014 legislative session. This grant is to provide respite to families with children with autism. Any unspent funds can be carried forward to FY 17. These grant funds are to establish service development grants for in-home and out of home respite for children and adults.	$950	$1,550

State Grant Name (Citation)	Purpose / Recipients / Eligibility	FY 2016 Actual	FY 2017 Budget
Disabilities Grants; BACT 55: Special Revenue Fund			
ADAP Drug Rebates-Title II Grants M.S. 256.01, subd 20	Dedicated funding resulting from ADAP drug rebates that supplements state (H115) and federal (H119) allocations to maintain private insurance coverage and/or purchase HIV related drugs. These 3 funding streams serve approximately 2,647 persons.	$3,149	$7,810
Hennepin County Title 1 Case Management M.S. 256.01 subd. 2	DHS provided dental healthcare services for 367 clients from March 2015 through February 2016 living with HIV/AIDS in the 13 county metro area. The services were provided by MA fee-for-service qualified providers with reimbursement for services administered through MMIS.	$50	$ -
DEED SGAP Grants M.S. 256.01 subd. 2	The funding is an interagency grant from the Department on Employment and Economic Development that will provide certified Disability Linkage Line (DLL) Community Partner Work Incentive Coordinators (CPWIC) to Vocational Rehabilitation Coordinators (VRS). It also supports VRS in system design and operation components. The funding will serve VRS staff and Independent Living Financial Specialist staff in VRS offices. The grant will also provide benefits summary and analysis to identified VRS customers who are receiving Social Security Disability Insurance (SSDI) benefits and other VR customers as time allows.	$12	$76
Adult Mental Health Grants; BACT 57: General Fund			
South Central Crisis Program Laws of 2010, 1st SS, Ch.1 Art. 25, subd. 10(a)	This grant funds Crisis Residential Stabilization Services in the Mankato area (CY2015 est. 397 adults served).	$700	$600
Mental Illness (MI)-Crisis Housing M.S. 245.99, subd. 1	Grant to nonprofit agency (sole source contract) for the provision of financial assistance to hospitalized clients needing help to pay for their housing. These funds are used only when other funds, such as SSI, are not available. (CY2015 - 242 adults served)	$352	$610
Adult Mental Health Culturally Specific Services M.S. 245.4661, subd 6	Grants to support increased availability of culturally responsive mental health services for racial and ethnic minorities through providing internship placements and clinical supervision to emerging mental health professionals. Over course of the first grant cycle (2010-2015) 71 students were enrolled in this program at different entry levels with three grantees. All of the students in the program were employed as of June 2016 and all were working directly or indirectly serving clients from their ethnic background of origin. Mental health services were provided to African American, American Indian, Caucasian, Hispanic, Hmong and Latino clients.	$247	$300
Culturally Specific Services Adult Mental Health Laws of Minnesota 2015, chapter 71, article 14, section 2, subd 5(m)[1]	Grants to nonprofit organizations to provide resources and referrals for culturally specific mental health services to Southeast Asian veterans born before 1965 who do not qualify for services available to veterans formally discharged from the United States armed forces. Two contracts were awarded through RFP process. Contracts executed Feb 2016 work began in Feb of 2016.	$100	$ -
Rule 78 Adult Mental Health Grant M.S. 256E.12	Grants to counties for community support services to adults with serious and persistent mental illness. Rule 78 and Adult Mental Health Integrated funds collectively serve about 28,200 individually annually.	$7,787	$21,000
Adult Mental Health Integrated Fund M.S. 245.4661, subd. 6 and 256E.12	Grants to counties for Adult Mental Health Initiatives including crisis response and case management services. For most counties, this includes integrated administration of Adult MH Community Support Grants and Residential Treatment Grants. Rule 78 and Adult Mental Health Integrated funds collectively serve about 28,200 individually annually.	$49,320	$34,695
Transition Init Waivered Services M.S. 246.18, subd. 8 (b) (1)	Grants to counties and/or providers to transition individuals from Anoka Metro Regional Treatment Center and the Minnesota Security Hospital to the community when clients no longer need hospital level of care. In SFY 2015, 12 clients were successfully transitioned to the community.	$192	$192

State Grant Name (Citation)	Purpose / Recipients / Eligibility	FY 2016 Actual	FY 2017 Budget
Transition Init. Populations M.S. 256.478	Disability Services and Adult Mental Health divisions are working together to develop contracts to pay for the costs of individuals moving from Anoka, St. Peter including wrap around services to support people in the community. To date 43 clients have been successfully transitioned to the community using these funds.	$1,342	$1,725
Pilot Project M.S. 245.4661	Grant to Zumbro Valley Mental Health Center to implement a pilot project to test an integrated behavioral health care coordination model. CY2015 62 patients were served. Since its inception, primary care clinic staff have treated 238 patients.	$ -	$200
Mobile Crisis Services Grants M.S. 245.4661, subd. 6	Grants to counties in regional partnerships to build psychiatric crisis response capacity, including mobile crisis intervention and follow-up stabilization services. In FY 2015 6,437 adults received a mobile crisis service through these grants. In FY 2014 of 5,051 episodes, the adult remained in their community (did not end up in an inpatient psychiatric unit) 82% of the time.	$3,796	$6,995
Crisis Residential Start-up Grants Minnesota Laws of 2007, Chapter 147, Article 19, Sec. 3, Subd 8(e)	To expand crisis residential services across Minnesota with some focus on greater MN. These were new funds in 2015 and dollars were awarded in 2016.	$500	$ -
Adult Mental Health Int Fund: Non-County Allocation M.S. 245.4661, subd. 6	Grant to providers to develop a resource and training center in evidence-based practices for the treatment of co-occurring mental illness and substance use as well as support training of therapists in an evidence-based treatment for high need individuals (Dialectical Behavior Therapy). In CY2015 The center completed its pilot of E-IMR. It held Monthly trainings and trained over 1400 individuals over the year using different training methods.	$1,881	$1,000
Sustainability Grants M.S. 256b.0622, subd. 11	Grants for Intensive Residential Treatment Services (IRTS), Crisis Residential Services, and Assertive Community Treatment (ACT) providers who are facing financial difficulty due to current payment rate structure. These were new funds in SFY 2016.	$2,125	$2,125
Housing Support Grants M.S. 245.4661, subd. 9	Grants to establish recipients in stable housing and provide a foundation for accessing healthcare and other needed resources. Housing with supports grants fund activities that are designed to assist tenants with significant or complex barriers to housing. For SFY15 HSASMI 417 persons were targeted for services (Housing Support Grants).	$2,013	$2,827
Beltrami County MH 2015 Session Law, Chapter 71, Article 2, Section 41	Grant to fund the planning and development of a comprehensive mental health program for those under arrest or subject to arrest who are experiencing a mental health crisis; those under a transport hold under Minnesota Statutes, section 253B.05, subdivision 2; or those in immediate need of mental health crisis services.	$1,000	$1,000
ACT Quality Improvement & Expansion Grants (Citation)	Enhances and expands Assertive Community Treatment (ACT) services. Provides start-up funding to establish new ACT teams, including a specialized Forensic ACT team to support people with serious mental illnesses who are exiting the correctional system. Clarifies services standards for ACT and provides for enhanced training and oversight to ensure quality and consistency in ACT services across the state. This was a new grant in 2015 and dollars were not awarded until 2016.	$167	$500
Adult Mental Health Grants; BACT 57: Health Care Access Fund			
Adult Mental Health (AMH) Crisis Grants M.S. 245.4661, subd. 6	Adult mental health crisis grants to metro counties to build capacity for mobile crisis teams—particularly to cover costs for uninsured. Administered along with state general fund crisis grant funds that are part of the Adult MH Initiative grants listed above.	$148	$750

State Grant Name (Citation)	Purpose / Recipients / Eligibility	FY 2016 Actual	FY 2017 Budget
Mental Health Housing with Supports Grants M.S. 245.4661, subd. 9	Grants to establish recipients in stable housing and provide a foundation for accessing healthcare and other needed resources. Housing with supports grants fund activities that are designed to assist tenants with significant or complex barriers to housing. For SFY15 HSASMI 417 persons were targeted for services (Housing Support Grants).	$825	$1,723
Children's Mental Health Grants; BACT 58: General Fund			
Adverse Childhood Experiences Grants M.S. 245.4889	Grants to provide training for parents, collaborative partners, and mental health providers on the impact of Adverse Childhood Experiences (ACEs), resilience and trauma toward creating community action plans and resilience initiatives to increase protective factors for children and families. These grants have a base appropriation beginning with $400,000 for FY2018 and then will have ongoing base appropriation of $396,000 beginning in FY2019.	$ -	$ -
Children's MH Crisis Services MS 245.4889	Grants to counties in regional partnerships to build psychiatric crisis response capacity, including mobile crisis intervention and follow-up stabilization services. FY2015 – 4,006 crisis episodes, a 5.5% increase from FY2014. Few were clients with repeat crises: 48% had no history of hospitalization; 55% had no history of residential treatment.	$2,701	$5,424
Children's Mental Health (CMH) - Capacity Respite Grants M.S. 245.4889	Grants to counties to build service capacity for planned and emergency respite to relieve family stress that can result in out-of-home placement, violence, and ER visits. (Children served in CY 2015--2,140).	$1,274	$1,524
CMH - Cultural Competence Provider Capacity Grants M.S. 245.4889	Grants to provider agencies to support cultural minority individuals to become qualified mental health professionals and practitioners; to increase access of mental health services to children from cultural minority families; and to enhance the capacity of providers to serve these populations. During CY2014 and CY 2015 provided approximately 3,180 hours of clinical supervision for 77 interns. 16 individuals achieved licensure and/or clinical supervisor status. 235 new minority children received direct MH services.	$300	$300
Children's Mental Health (CMH) Screening Grant M.S. 245.4889	Grants to county child welfare and juvenile justice agencies to pay for mental health screenings and follow-up diagnostic assessment and treatment; covers children already deeply involved in child-serving systems. (In CY 2015, 9,309 child welfare clients and 3,892 juvenile justice clients served.)	$3,452	$4,412
CMH - Evidence Based Practices M.S. 245.4889	Grants to individual mental health clinicians to train them in the use of scientific evidence to support clinical decision-making and to implement evidence-based interventions across the state. (CY2015 Trained: 80 clinicians from 16 agencies in Trauma-Focused Cognitive Behavioral Therapy)	$711	$750
Children's Mental Health (CMH) - Capacity School Based Services M.S. 245.4889	Grants to provider agencies to integrate mental health service capacity into the non-stigmatized natural setting of children's schools and to cover direct clinical and ancillary services for uninsured and under-insured children. During the 2014-2015 school year 11,419 children received services (45 % receiving services for the first time) -- serves Pre-K to age 21. Beginning in FY2018, the annual base for these grants is $11,004,000 per year.	$9,554	$9,587
CMH - Capacity Early Intervention Grants M.S. 245.4889	Grants to provider agencies to build evidenced-based MH intervention capacity for children birth to age 5 whose social, emotional, and behavioral health is at risk due to biologically-based difficulty in establishing loving, stable relationships with adults; having cognitive or sensory impairments; or living in chaotic or unpredictable environments (CY2015 served 2,746, mostly in child-care and pre-school. DHS training qualified at least one MH professional in all by one county.)	$1,024	$1,024
Text Message M.S. 245.4889	Grant to a nonprofit organization to establish and implement a statewide text message suicide prevention program. CY2015 responded to a total of 9,968 text messages throughout the United States and territories with 4,746 of them in Minnesota.	$1,125	$1,125

State Grant Name (Citation)	Purpose / Recipients / Eligibility	FY 2016 Actual	FY 2017 Budget
First Aid M.S. 245.4889	Grant to train teachers, social service personnel, law enforcement and others who come into contact with children with mental illness, in children and adolescent mental health first aid training. In CY2015, 24 trainings were held in 20 Counties and 3 Reservations covering 16 Regions statewide training a total number of 495 participants.	$23	$23
First Episode Psychosis Grants M.S. 245.4889	Grant to pilot evidence-based practice interventions for youth and adults ages 15-40 who are experiencing a first episode of psychosis. (This is a new grant project beginning in FY 2017.)	$ -	$177
CD Treatment Support Grants; BACT 59 : General Fund			
CD Native American Program M.S. 254.A.03, subd. 2	Provides funds to American Indian tribes, organizations, and communities to provide culturally appropriate alcohol and drug abuse primary prevention and treatment support services. Federal funds also partially support this activity (approx. 30%). During CY2015, 3,662 people were served. Nine projects funded in FY2015.	$1,036	$1,036
CD Treatment Grants M.S. 254.A.03, subd. 1	Grant to nonprofit organization to treat methamphetamine abuse and the abuse of other substances. The focus audience is women with dependent children identified as substance abusers, especially those whose primary drug of choice is methamphetamine. (CY2015 - 34 women served)	$125	$125
Fetal Alcohol Syndrome M.S. 254.A.03, subd. 1	Grant to the Minnesota Organization on Fetal Alcohol Syndrome (MOFAS) to support non-profit Fetal Alcohol Spectrum Disorders (FASD) outreach prevention programs in Olmsted County. 90 women were served in fiscal year 2015. 31 of the 90 women were pregnant. This grant is both treatment and prevention focused.	$250	$250
CD Peer Specialists Grants Minnesota Laws of 2016, Chapter 189, Article 23, Section 002, subd 04F	Grants to recovery community organizations to train, hire, and supervise peer specialists to work with underserved populations as part of the continuum of care for substance use disorders. Recovery community organizations located in Rochester, Moorhead, and the Twin Cities metropolitan area are eligible to receive grant funds. Beginning in FY2018, the annual base for these grants is $725,000 per year.	$ -	$34
CD Prevention Grants Minnesota Laws of 2015, Chapter 71, Article 14, Section 002, subd 05O	Grants to nonprofit organizations to provide chemical dependency prevention programs in secondary schools. These grants were funded one-time in FY2017.	$ -	$150
Gambling Receipts Grants M.S. 297E.02, subd. 3 (c) BACT 57	These funds support the MN Problem Gambling Helpline, a statewide phone and text service that offers crisis assessment, and treatment referral for persons struggling with problem gambling and families of someone dealing with problem gambling issue. Additional funding is appropriated through a grant contract to increase public awareness of problem gambling and to conduct research on problem gambling.	$792	$1,226
CD Treatment Support Grants; BACT 59: Special Revenue Fund			
CCDTF Other Services M.S. 254B.04, subd. 1	Reimburse providers through the Consolidated Fund for the provision of chemical dependency treatment services to persons whose income is over 100% of Federal Poverty. Counties agree to pay 100% of the costs of non-eligible clients. 65 people received reimbursements in calendar year 2015.	$247	$500
Compulsive Gambling Indian Game M.S. 245.98, subd. 4	Funds combined with the Gambling Grants from the lottery to provide funding for problem gambling assessments, outpatient and residential treatment of problem gambling and gambling disorder; training for gambling treatment providers and other behavioral health services providers; and research projects which evaluate awareness, prevention, education treatment service and recovery supports related to problem gambling and gambling disorder. Approximately 700 individuals receive outpatient or residential treatment per year.	$ -	$450
CD Treatment Support Grants; BACT 59: Lottery Fund			
Gambling Grants Lottery Transfer M.S. 297E.02, subd. 3 (c)	Funds transferred from the Minnesota State Lottery to DHS -- provides funding for problem gambling assessments, outpatient and residential treatment of problem gambling and gambling disorder; training for gambling	$1,175	$1,508

State Grant Name (Citation)	Purpose / Recipients / Eligibility	FY 2016 Actual	FY 2017 Budget
	treatment providers and other behavioral health services providers; and research projects which evaluate awareness, prevention, education treatment service and recovery supports related to problem gambling and gambling disorder. 831 individuals receive outpatient or residential treatment per year.		
Problem Gambling Rider M.S. 297E.02, subd. 3 (c)	Funds transferred from the Minnesota State Lottery to grant to the state affiliate recognized by the National Council on Problem Gambling to increase public awareness of problem gambling, education and training for individuals and organizations providing effective treatment services to problem gamblers and their families, and research related to problem gambling	$225	$225